



Managing Self-Harm and Suicide Ideation

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Plan of Talk

- Rates and trends.
- Self harm management.
- Review of the evidence.
- Approaches to managing suicidality.
- Evidence based digital interventions.

Rates of suicidal thoughts & self harm in Ulster University students (2015)

Did you ever...

- have thoughts of killing yourself? **28.2%** (m 23%, f 32%)
 - engage in self harm? **20.3%** (m 13.5%, f 25.3%)
 - make a suicide plan? **20.6%** (m 21.8%, f 19.8%)
 - attempt suicide? **7.9%** (m 6.3%, f 8.9%)
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- 48.6% made more than one attempt.
 - 14 attempted suicide in the past year.
 - 44% of SH also had depression.

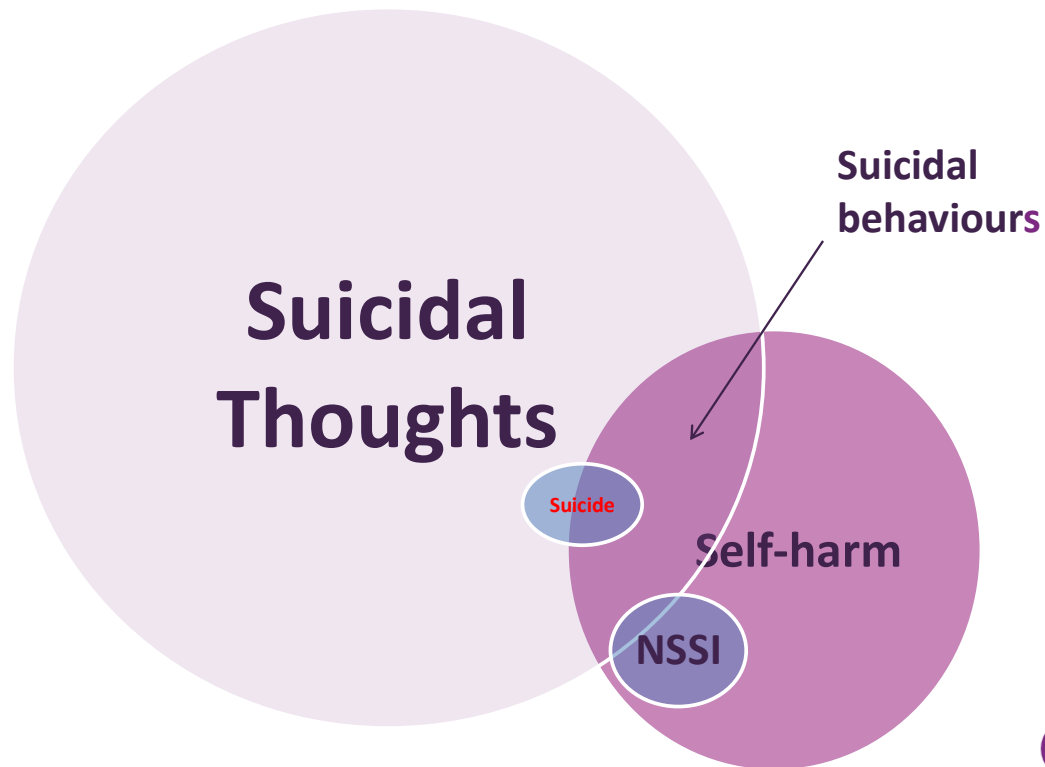
About self-harm

- Methods: cutting, banging/hitting, severe scratching, carving, scraping, ligatures.
- Functions: affect regulation, self-punishment and anti-dissociation/feeling-generation.
- Very commonly associated with BPD (51.7% 20.5%-depending on how BPD diagnosed).
- High levels of emotional dysregulation, low quality of life, and impairment.
- In students – poor attainment, high dropout, high risk of future mental disorders.

A method of self-regulation

- Self harm is a “learned behaviour”.
- Creates a strong and fast physiological response.
- Compelling, information makes the method appealing.
- Used within groups to create peer connections.
- Used as a means of communicating pain- (different from “cry for help”).
- A maladaptive way of coping with stress.
- Goal directed behaviour to address psychological pain.
- Interpersonal reasons (e.g. "to frighten someone") were least commonly endorsed.
- Adolescents who endorsed wanting to get relief from a terrible state of mind at baseline → more likely to repeat self-harm.

Relationship self-harm to suicide



Self Harm, Suicide and Co-morbidity

- Clinical samples: adolescents and young adults with NSSID, 69.2–83.3% reported a lifetime suicide attempt, and a quarter during the last month.
- Community samples: adolescents who met criteria for NSSID, 20% reported that at least one of their self-injuries during the last year was a suicide attempt.
- Mood disorders commonly co-occurred, with examples of 72.5% and 79.5% for depression (44% in Ulster SWS). A
- Anxiety disorders were also commonly reported (72.5–89%) as was posttraumatic stress disorder (PTSD)(25.0–28.2%).

(Zettergvst, 2015)

Suicidal Behaviour in Northern Ireland

- Ideation: **Seriously considered suicide.**
- Females: 10.6%, Males: 7%
- Made a **plan** for suicide.
- Females: 2.5%, Males: 2.4%
- Suicide **attempt.**
- Females: 4.3%, Males: 2.3%
- Deaths by suicide have doubled in 10 years.
- Highest suicide rates in the UK- no sign of dropping.
- Increased risk of suicidal thoughts/ plans (not attempts) in those affected by traumatic events related to the Troubles.
- Trauma exposed more likely to die on first attempt.

Theories of Suicide

Background

Biological factors

Psychological factors

Life events

Mental illness



Unbearable Pain



Thoughts



CONNECTEDNESS

HOPE

Plan

Suicidal behaviour (capability)



Association with suicide- acquired capability

- Habituation/ exposure to pain (pain threshold?).
- Practice (self-harm/ attempt).
- Exposure to suicide.
- Use of alcohol and other drugs which can influence spontaneity, clarity of thought help people override self preservation reflexes.
- Mental illness prevents people seeing alternatives to suicide.

Treating Self Harm: Cochrane Review (Hawton et al., 2016)

- **CBT-based psychotherapy**
- Helps patients identify and critically evaluate the way in which they interpret and evaluate disturbing emotional experiences and events.
- Problem-solving therapy, recognises that SH is an ineffective and maladaptive coping behaviour. Patients learn skills to actively, constructively and effectively solve their problems.
 - Patients consciously and rationally appraise problems, reduce the negative emotions generated by problems, and develop a range of possible solutions.
 - Treatment goals: helping patients to develop a positive problem-solving orientation, use rational problem-solving strategies, reduce the tendency to avoid problem-solving, and reduce the use of impulsive problem-solving strategies.

Interventions for multiple repetition of SH/probable personality disorder

- **Emotion-regulation training** helps patients find adaptive ways to respond to distress instead of using SH to control or suppress these emotions.
- **Dialectical behaviour therapy (DBT)** combines problem-solving training, skills training, cognitive modification training and mindfulness to encourage patients to accept their thoughts, feelings, and behaviours without necessarily attempting to change, suppress, or avoid them.
- **Aim:** to help patients regulate their emotions, achieve a sense of interpersonal effectiveness, become more tolerant of distressing thoughts and feelings, and become better at managing their thoughts and behaviours.
- **Mentalisation:** the ability to understand the actions of both the self and of others. During times of interpersonal stress, individuals may fail to represent experiences in terms of mental states and instead become overwhelmed with negative thoughts and feelings about the self. SH is deployed to manage these emotions.

Other Approaches

- **Case Management** (more severely ill patients)
- Each person has a 'case manager' who assesses their unique needs; develop a care plan; arrange for suitable care to be provided; monitor the quality of the care provided; and maintain contact with the person.
- Significant role in the aftercare of self-harm patients because of the recognised problem of poor treatment adherence and patients with multiple problems.
- Can also include: provision of a care manager, crisis intervention, problem solving, assistance with getting to clinical appointments, and assertive outreach, tailored to individual patient need.

Remote contact interventions

- Sending regular letters, postcards or electronic contact.
- 'Gesture of caring' may help social isolation many SH patients experience. This sense of "social connectedness" may have a stabilising emotional effect.
- Emergency cards may encourage patients to seek help in times of distress and offer on-demand emergency psych contact.
- GPs can also facilitate provision of care directly following SH.
- Telephone contact following discharge from hospital can help ensure continuity of care and immediate advice/ psychotherapy for crisis management (in safety plan).

Review Conclusions

- CBT-based psychological therapy **can result in fewer individuals repeating SH**; however, the quality of this evidence ranged between **moderate and low**.
- Dialectical behaviour therapy for people with multiple episodes of SH/probable personality disorder **may lead to a reduction in frequency** of SH, but this finding is based on **low quality evidence**.
- Case management and remote contact interventions **did not appear to have any benefits** in terms of reducing repetition of SH.
- Other therapeutic approaches were mostly evaluated in single trials of **moderate to very low quality** such that the evidence relating to these interventions is **inconclusive**.


Interventions for suicidality

1. Asking about suicidal thoughts

- Nature of the suicidal thoughts; frequency; intensity; persistence; intended outcome.
- Perception of the future as persistently negative and hopeless; hope; alternatives.
- Degree of planning; Internet research; learning about method; looking for place and time.
- Degree of preparation; putting affairs in order; stockpiling tablets; masking discovery.
- Ability to resist acting *on* their thoughts of suicide or self harm.

Assessment and treatment planning

- **Demographic and Social:** Perception of lack of social support, living alone, stressful life event (e.g. recently bereaved, debt/financial worries, loss of attachment/major relationship instability, job loss, moving house, engagement with criminal justice system).
- **Personal Background:** Substance misuse alcohol/drugs, family history of suicide or exposure to suicidal behavior of key others (family, peers, favourite celebrity), use of suicide-promoting websites or social media, access to means.
- **Clinical Factors in History:** Previous self-harm or suicide attempt (regardless of intent, including superficial cutting), mental illness especially recent relapse or discharge from in-patient care, impulsivity or PD diagnosis, medical condition, recent gen hospital discharge, especially pain.
- **Mental State Examination and Suicidal Thoughts:** Emotional pain & negative thoughts, (hopelessness, guilt, 'I'm a burden'), sense of entrapment, shame, escalation of suicidal thoughts, a well formed plan and/or preparation, psychotic phenomena especially if distressing: persecutory & nihilistic delusions; command hallucinations.

- 
- If immediate risk of suicidal behaviour, the patient will require: in patient care or family care, a robust safety plan (see below), adequate support and removal of access to means.

Therapeutic Strategies

(Bank of Hope, Cole-King *et al*, 2009)

- **Maximise the power of the individual not to act on their suicidal thoughts:**
- **Increase wellbeing and resilience** - enhance protective factors.
- **Increase emotional resourcefulness** and share simple problem solving techniques to better equip them to deal with their triggers for suicidal thoughts or adverse events.
- **Increase internal locus of control** – ‘do not be a *passive victim* of suicidal thoughts’.
- **Increase self-efficacy** – skills and techniques not to act on suicidal thoughts.

- **Reduce the power of suicidal thoughts:**
- Help patients see that suicidal thoughts don’t last forever.
- Intense suicidal feelings are often short lived (although acknowledge that long lasting suicidal thoughts can be very distressing).
- Share examples of others who made serious suicide attempts but who changed their mind and realised that their real wish was to feel better, not to die.
- Help the individual to view those thoughts as ‘a symptom of distress’ (like having a temperature due to a virus), rather than a powerful magical impulse that they cannot resist.

Safety Planning

- A safety plan should include:
- Reasons for living and reasons not to harm themselves.
- A plan to create a safe environment. How they can remove or secure things they could use to harm themselves? Can they identify and avoid things that they know make them feel worse? These are called distress triggers.
- Activities to lift mood, calm or distract.
- People to talk to if distressed. Include contacts for general support (not necessarily confiding their suicidal thoughts) and specific suicide prevention support.
- Professional support such as 24 hour crisis telephone lines.
- Emergency NHS contact details.
- Personal agreement that Safety Plan was co-produced and a commitment to follow when required
- Include names and all phone numbers for people to be contacted.

Solution Focused Interviewing

- Words with a positive connotation (i.e. 'good', 'success' and 'solution'), can be more helpful in building a sense of hopefulness and/or self-efficacy compared to those with negative connotations (i.e. 'bad', 'failure' and 'problem').
- The miracle question....
- However it is important to acknowledge the individual's current level of suffering.
- Pre-suppositions, 'implicit, unconscious suggestions', are v-rarely resisted and impact at a deeper level, often promoting self-efficacy and future orientated thinking.
- Pre-suppositional open questions:
 - "How did you cope with previous difficult/distressing situations?"
 - "How have you coped with this situation up to now?"
 - "When you are feeling just a little more optimistic, what thoughts about the future might you be having?"
 - "When you look back on this testing period in your life, what do you think the main thing will have been, that got you through it?"

Managing suicidal thoughts

Collaborative assessment and management of suicidality (CAMS) (David Jobes)

- Suicide is primary focus of intervention.
- Systematic assessment & management of suicidal risk.
- Therapeutic relationship and hope for recovery are vital.
- Honest assessment of key features of suicidal pain (psychological pain, stress, agitation, hopelessness and self hate).
- Strength of suicidal thoughts and triggers identified.
- Safety plan and commitment to safety.
- Problem solving.
- Treating mental disorders.

CAMS Suicide Status Form (SSF-IV-R) Tracking/Update Interim Session

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (Patient):

Rate each item according to how you feel right now.

- 1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):

Low pain: 1 2 3 4 5 :High pain

- 2) RATE STRESS (your general feeling of being pressured or overwhelmed):

Low stress: 1 2 3 4 5 :High stress

- 3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):

Low agitation: 1 2 3 4 5 :High agitation

- 4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):

Low hopelessness: 1 2 3 4 5 :High hopelessness

- 5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect):

Low self-hate: 1 2 3 4 5 :High self-hate

- 6) RATE OVERALL RISK OF SUICIDE:

Extremely low risk: 1 2 3 4 5 :Extremely high risk
(will not kill self) (will kill self)

In the past week: Suicidal Thoughts/Feelings Y__ N__ Managed Thoughts/Feelings Y__ N__ Suicidal Behavior Y__ N__

Section B (Clinician):

Resolution of suicidality, if: current overall risk of suicide <3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings ☐ 1st session ☐ 2nd session

****Complete SSF Outcome Form at 3rd consecutive resolution session****

In the past week: Suicidal Thoughts/Feelings Y__ N__ Managed Thoughts/Feelings Y__ N__ Suicidal Behavior Y__ N__

Section B (Clinician):

Resolution of suicidality, if: current overall risk of suicide <3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings ☐ 1st session ☐ 2nd session

****Complete SSF Outcome Form at 3rd consecutive resolution session****

TREATMENT PLAN UPDATE

Patient Status:

☐ Discontinued treatment ☐ No show ☐ Cancelled ☐ Hospitalization ☐ Referred/Other: _____

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	<i>Self-Harm Potential</i>	<i>Safety and Stability</i>	<i>Stabilization</i> <i>Plan Updated</i> <input type="checkbox"/>	
2				
3				

Patient Signature

Date

Clinician Signature

Date

What have you learned from your clinical care that could help you if you became suicidal in the future?

Section B (Clinician):

Third consecutive session of resolved suicidality: ____ Yes ____ No (if no, continue CAMS tracking)

****Resolution of suicidality, if for third consecutive week: current overall risk of suicide <3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings**

OUTCOME/DISPOSITION (Check all that apply):

____ Continuing outpatient psychotherapy ____ Inpatient hospitalization

____ Mutual termination ____ Patient chooses to discontinued treatment (unilaterally)

____ Referral to: _____

____ Other. Describe: _____

Next Appointment Scheduled (if applicable): _____

Patient Signature

Date

Clinician Signature

Date

Digital Interventions: Ecological Momentary Assessment (EMA)

- Uses repeated, real time (momentary) data collection (assessment) in people's natural environment (ecological)
- Also referred to using terms: experience sampling, ambulatory monitoring, diary method.
- Experience sampling: collect data from random samples of experiences (e.g., beep person at random times to assess mood, thoughts, behaviours).
- Ambulatory monitoring: collect continuous physiological data
- Daily diary: collect data via self report at fixed time each day (e.g., end of day report of days events).

Why use EMA?

- Digital phenotyping: moment by moment quantification of the individual level phenotype in situ using data from personal digital devices (Onnela & Rauch, 2016).
- Capture fine-grained, dynamic changes/fluctuations in phenomenon (e.g., how do thoughts, feelings, behaviours change during manic episode?).
- Decrease influence of recall bias.
- Observe behaviour in context (vs. laboratory or interview room) (e.g., what does experience of drug/alcohol use or self-injury look like?).
- Test existing theories using ecologically valid data, collect never before available data to develop new theories.
- Provide novel opportunities for intervention BEFORE problem occurs.

EMA in suicide prevention

What do suicidal thoughts look like?

- Self-injurious thoughts and behaviors are transient phenomena and rarely occur *during* assessment.
- Prior assessment methods rely on long-term, retrospective, aggregate reports:
 - “How many times in your life have you ____”
 - “How intense were your thoughts of ____”
- Important that therapist understands:
 - Exactly how frequent are self-injurious thoughts and behaviors?
 - How long do they last?
 - In what contexts do they most often occur?
 - What predicts transition from thought to action?

EMA Real-time monitoring of suicidal thoughts

- Examine natural occurrence of self-destructive thoughts and behaviors among self-injurious adolescents and young adults using electronic diary assessment.
- (1) Feasibility: What is rate of use and compliance among adolescent self-injurious population?
 - (2) Characteristics: What is frequency, intensity, and duration of self-destructive thoughts and behaviors?
 - (3) Context: In what contexts do these thoughts occur? What factors predict transition from thought to action?
 - (4) Function: Why do adolescents engage in these behaviors?



Electronic diaries
and graphic tools
for health care and special education

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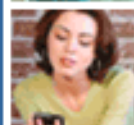
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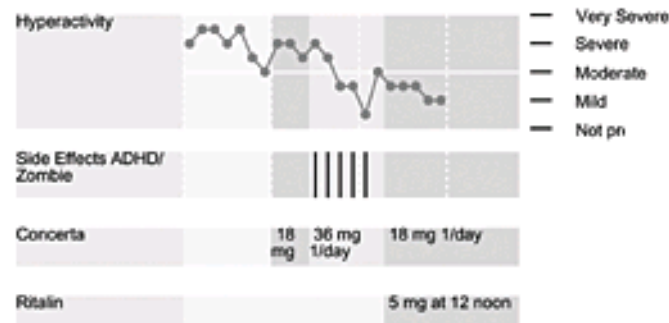
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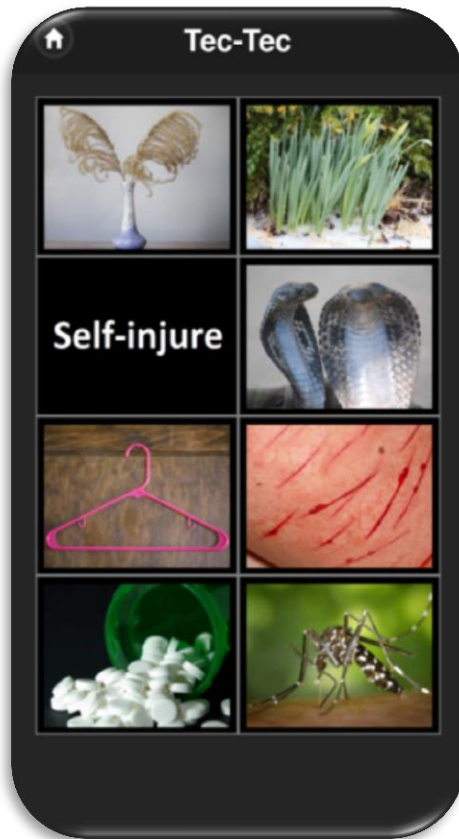
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Therapeutic Evaluative Conditioning



Brief game-like app

Tested in 3 large web-based RCTs

42-49% reduction in self cutting

21-64% reduction in suicide plans

27-57% reduction in suicidal behaviours

psytablab.com/treatments

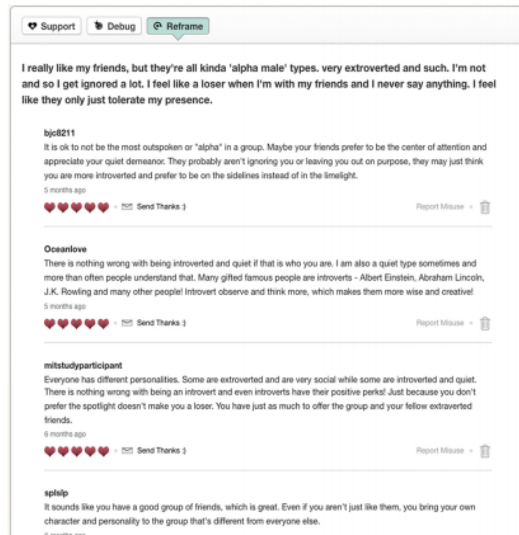
App store [tec.tec](https://apps.apple.com/gb/app/tec-tec/id1211111111)

KOKO: crowdsourced cognitive therapy



Web-based, crowdsourced,
peer-to-peer CT

Tested in Web-Based RCT



Significant reductions in depression

Increase in use of reappraisal, which
mediated treatment effects

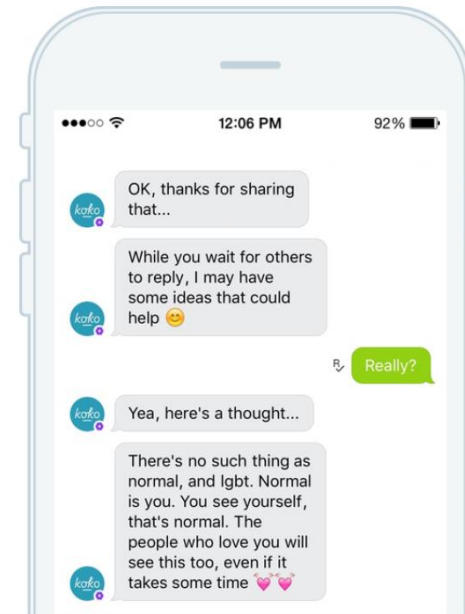
Now self-deploys in response to R
messaging



Making machines empathetic 🤖💕

Koko provides *emotional support as a service* for any product, including chatbots, voice assistants, and online communities.

Contact us for more info



What users say...

"I've been doubting myself for a long time, 25-28 years to be exact, but this app has helped me in the span of 10 minutes."

"Just want to share that I've seen some AMAZING responses - they've moved me to tears (and occasionally laughter!) with their care & insight."

"Koko helps calm my anxieties. The Koko community is always around when I need it."

"Just wanted to say THANK YOU...I've been part of koko for over a year now (!) and it's made a *significant* difference to my life."



Thank you!

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