**Systematic review: Protocol**

**The effectiveness of psychoanalytic psychotherapy as an intervention for the prevention of suicide, and the reduction of self-harm/repeated self-harm**

**Abstract**

There is no abstract as this is the protocol. The objectives are as follows:

Primary Objective:

1. To assess whether psychoanalytic psychotherapy is effective in preventing suicide through reducing self-harm (including suicide attempts)[[1]](#footnote-1), reducing symptoms and characteristics linked with known risk factors for suicide/self-harm, and to assess possible adverse effects associated with these interventions

Secondary Objectives:

1. To describe the quality and generalizability of the studies evaluating the effects of psychoanalytic psychotherapy for preventing suicide and reducing self-harm
2. To describe the specific populations evaluated in studies of psychoanalytic psychotherapy for preventing suicide and reducing self-harm, including demographics, experiences of suicidal and self-harming behaviour, psychiatric, psychological, mental health conditions and social context factors, including age, gender, ethnicity.
3. To determine, if possible, which features of interventions are most successful, including the aims and applications of the therapeutic model, frequency of therapy sessions, duration of interventions, intensity of therapy, mode of delivery, and organisational setting, and in what areas/factors changes take place.
4. To highlight areas where further research is most needed

**Background**

***Description of the condition:***

Preventing suicide and reducing self-harm rates are social and health service priorities, and important areas for clinical intervention. Self-harm rates are reported high amongst key population groups, including young people, men in middle age, and people in later life. There is a strongly evidenced connection between an episode of self-harm, repetition and suicide completion; an episode of self-harm increases the chance of suicide completion up to 100 fold (Kendall et al 2011).

Definitions of suicidal behaviour and self-harm have been subject to extensive debate (Hawton et al 2012; Ougrin 2012). On the one hand, the definition adopted by NICE 2011 – “any act of intentional harm to the self, irrespective of method used or intended outcome; therefore including suicide attempts” (NICE 2011)- recognises that self-harm is a risk factor for suicide, and that motives for harm to the self can change within and between episodes. On the other hand, mainly in North America, suicidal behaviour is contrasted with ‘non-suicidal self-injury’. As there is not one single definition in operation currently, this review needs to take account of the multiple uses in the literature. It is necessary to include self-harm and suicide as terms which sit on a spectrum, in many uses, with a considerable overlap between these.

***Description of the Intervention***

Psychological therapies are increasingly important for providing interventions for people at risk of suicide or repeated self-harm, but good quality evidence, especially from Randomised Controlled Trials (RCTs) for the effectiveness of interventions remains low, despite recently increased numbers of trials in this area (NICE 2012).

Psychoanalytic psychotherapy (which is often referred to as ‘psychodynamic psychotherapy’ and uses other derivatives, see synonyms, below) is widely practised world-wide:

“Psychodynamic or psychoanalytic psychotherapy refers to a range of treatments based on psychoanalytic concepts and methods that involve less frequent meetings and may be considerably briefer than psychoanalysis proper. Session frequency is typically once or twice per week, and the treatment may be either time limited or open ended. The essence of psychodynamic therapy is exploring those aspects of self that are not fully known, especially as they are manifested and potentially influenced in the therapy relationship”, (Shedler 2010 page 98).

Recent meta-analyses of evaluations of the effectiveness of this form of psychotherapy, including through (RCTs) have shown that outcomes for psychoanalytic therapies can be empirically assessed (Leichsenring & Rabung 2008; De Maat et al., 2009; Shedler 2010; Midgely & Kennedy 2011). Notably, these studies report effect sizes comparable with those of other therapies, and continued improvements at long-term follow up. A recent review by Abbas et al (2013) states that “Psychodynamic therapy with adults now has a substantial evidence base, demonstrated in a series of reviews and meta-analyses” (page 863) citing 8 sources to support this claim. In his landmark study Shedler (2010) - citing *inter alia* Abbas et al (2006)’s Cochrane supported meta-analysis  of 23 RCTs - concluded that “The perception that psychodynamic approaches lack empirical support does not accord with available scientific evidence and may reflect selective dissemination of research findings” (page 98).

Though a few clinical trials of the effectiveness of psychoanalytic psychotherapy for reducing suicide (and self-harm) have been reported over the past decade(Guthrie et al 2001, 2003; Bateman and Fonagy 2008, Clarkin et al 2007; Rossouw and Fonagy 2012), there has been no systematic review of this form of therapy for interventions to prevent suicide and reduce self-harm. Despite this, psychoanalytic psychotherapy has been recognised as potentially suitable as an intervention to reduce self-harm by current Clinical Guidelines (e.g. NICE 2011). Although there is a well-established literature focussing on theory and practice (Maltsberger and Goldblatt 1996; Briggs et al 2008), making use usually of clinical case reports, within specialist journals, as a method of generating hypotheses (Midgley 2006), current knowledge is limited for the effectiveness of psychoanalytic psychotherapy, for suicide and self-harm reduction. It is important, therefore, to review the evidence for the effectiveness of psychoanalytic psychotherapy for reducing suicide in order to inform current and future clinical applications.

It is recognised that psychoanalytic psychotherapy can be a complex intervention to deliver. All psychoanalytic therapy has in common recognition of the importance of unconscious factors, and conflicts, and the influence of past experiences on current functioning and relatedness to others. By establishing a therapeutic relationship, the aim is to understand emotionally conflicted states of mind and through restoring or improving the individual’s capacity to manage difficult thoughts and feelings, improve adjustments to life’s demands, including relatedness to self and other, and reduce symptoms of mental ill health. Recent variations of psychoanalytic psychotherapies, which retain this core of psychoanalytic methods, include Mentalization Based Therapy (MBT), Cognitive Analytic Therapy (CAT), Transference Focussed Therapy. Thus, there are a number of applications of the core psychoanalytic therapeutic method, diverse emphases in the delivery of the therapeutic methods with a range of theories of change (Lemma 2003), and the practice is constantly evolving. It is important for future applications to be clear about how psychoanalytic psychotherapy is applied, in working with suicidal or self-harming populations, and what are the outcomes of interventions. Features of these psychoanalytically-informed interventions which need to be explored include; frequency of therapeutic sessions, intensity of treatment methods, duration of therapy, mode of delivery, characteristics of clients/patients and setting. Thus alongside reviewing effectiveness, and in order to understand what is effective for whom, there is an important need to review these therapeutic approaches to understand how psychoanalytic psychotherapy aims to reduce suicide and self-harm, and for which populations. Studies reporting these interventions exist as a mainly qualitative literature including case studies, studies applying clinical and conceptual research (Leuzinger-Bohleber and Fischmann 2008). These studies are often excluded from consideration in systematic reviews, but it is highly possible that these may provide useful sources for assessing therapeutic factors in these interventions. We need to know how many studies exist, and their quality (or heterogeneity). Systematic reviewing of this literature can assist clinicians through identifying key factors, improve reporting methods, through evaluating quality, and can underpin future trials by identifying best practice, agreements and controversies.

***Why it is important to do this review***

Reducing suicide risks and repeated self-harm is a high priority area for social and health care policies and practice and these are delivered across health and social care systems, in mainstream mental health care practice, and many other organisational settings, including *inter alia*, criminal justice, education, social care, physical health. Psychological therapies constitute an increasingly important approach to intervention for people who are at risk of suicide and/or self-harm, and psychoanalytic psychotherapy is a widely practised intervention. Accurate knowledge of its effectiveness would be highly advantageous for current and future clinical practice, service delivery and as a focus for future research. The current review aims to undertake a comprehensive and exhaustive search and analysis of available evidence.

**Objectives**

This review has the following objectives:

Primary Objective:

1. To assess whether psychoanalytic psychotherapy is effective in preventing suicide through reducing self harm (including suicide attempts), reducing symptoms and characteristics linked with known risk factors for suicide/self-harm, and to assess possible adverse effects associated with these interventions

Secondary Objectives:

1. To describe the quality and generalizability of the studies evaluating the effects of psychoanalytic psychotherapy for preventing suicide and reducing self-harm
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3. To determine, if possible, which features of interventions are most successful, including the aims and applications of the therapeutic model, frequency of therapy sessions, duration of interventions, intensity of therapy, mode of delivery, and organisational setting, and in what areas/factors changes take place.
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**Methods**

**Criteria for considering studies for this review**

***Types of study***

Randomised Controlled Trials (RCTs), cluster RCTs, quasi-RCTs will be included. As it is possible the number of RCTs will be low, the best evidence available will be included; controlled before and after studies; uncontrolled before and after studies; case study designs including single case studies, some of which include some form of independent measure of outcome. Quality assessment criteria will be used (see below).

Published and unpublished studies in any language will be included. This review will be undertaken by an international team to include English and German language publications. Expert advice will be sought for articles written in other languages.

***Types of participants***

Included will be studies involving the treatment of suicide and self-harm across all age ranges in all settings. Suicide and self-harm will include the various terms in current usage: suicide attempt, para-suicide, (non-suicidal) self-injury, suicidal behaviour, suicidal thoughts, suicidal intent, suicidal threat, suicidal ideation, and self-destructive thoughts and behaviour.

***Types of Intervention***

Psychoanalytic psychotherapy aimed at reducing or preventing suicidal and self-harming behaviour, reducing suicidal intent, ideation and thoughts, and self-destructive behaviour will be included. Psychoanalytic psychotherapy can be described in a number of ways, including: psychoanalysis, psychodynamic (psycho)therapy, mentalisation based therapy, transference-focused psychotherapy, psychosocial psychotherapy, cognitive analytic therapy, all of which will be included.

Treatments of associated disorders, which include: depression, bipolar disorder, borderline personality disorder, anxiety disorder, conduct disorder, dual diagnosis (substance misuse) will be included if there is evidence that the intervention addresses self-harm/suicidal behaviour and this is evidenced by outcome measurement and/or assessment. Interventions will be categorised as above (see types of study).

Interventions will focus on different groups of populations: child, adolescent, adult, later life; male, female, ethnic minorities; social categories, e.g. looked after children, marginalised/deprived, unemployed, in poverty, in migration status, after loss and bereavement.

Control conditions will include any other intervention, no intervention/usual care or waiting list. The main comparison is reduction of suicide/self-harm v. any other intervention/usual care.

***Types of outcome measure***

Terms for suicide and self-harm are subject to multiple definitions, and we will use current definitions (see above) to include suicide attempts and self-harm. This will therefore include a heterogeneous population, and we recognise this. Also suicidal ideation, threat and intent will be taken as synonymous, for cases where actual harm to the body has not occurred.

Primary outcomes:

(1) suicide reduction

(2) self-harm reduction

(3) suicidal ideation reduction

Secondary outcomes:

(1) changes in states of mind which reduce risks of suicide/self-harm and its repetition

(2) increase in capacity for self-protection

(3) improved mental health which reduces risks of suicide/self-harm and its repetition

(4) improved social circumstances reducing risks of suicide/self-harm and its repetition (which may include improved interpersonal relations, better education/employment, improved living arrangements

***Search methods for identification of studies***

1. **Electronic searches:** 
   1. **Data bases:** We will search the following electronic data bases: EBSCO, Psychinfo, MEDLINE, PEPweb, CINAHL, Scopus
   2. **Publishers data bases:** Taylor and Francis, Oxford, Sage
   3. **Search of specified journals** in psychotherapy and suicide: Psychoanalytic Psychotherapy, British Journal of Psychotherapy, Journal of Child Psychotherapy, International Journal of Psychoanalysis, Suicide and Life Threatening Behaviour, Crisis, Archives of Suicide Research, Psyche, Forum der Psychoanalyse, Nervenarzt, PPmP, Suizidprophylaxe, Psychotherapie im Alter, Zeitschrift für Psychosomatische Medizin und Psychotherapie
2. **Other sources:**
   1. Reference lists: Reference lists and citations of relevant, included studies will be checked for relevant material. Citation searches will be carried out using the Social Science Citation Index and Google scholar.
   2. Correspondence: We will contact acknowledged experts and researchers in the field, for information on published and unpublished studies, including international experts
   3. Grey literature: We will make further efforts to retrieve relevant studies via conference proceedings, dissertations, theses and government documents using the Networked Digital Library of Theses and Dissertations (NDLTD), Open Grey ([www.opengrey.eu](http://www.opengrey.eu)) and Google.
3. **Search Terms:** The search strategy will be broad, using free text: suicid\* and “self-harm”.

Key terms will include: “Psychoanalytic psychotherapy” psychoanaly\*, psychodynamic, “mentalisation based therapy”, “transference-focused psychotherapy”, “psychosocial psychotherapy”, “cognitive analytic therapy”, ‘short-term psychodynamic psychotherapy”, “ time-limited psychodynamic psychotherapy”

***Selection of Studies***

Titles and abstracts of studies identified by the searches will be read on screen and assessed for inclusion using the criteria for inclusion (as above). The time limit will be between 1970 and 2015. Studies that appear relevant will have full text retrieved and be assessed for inclusion by two reviewers working independently[[2]](#footnote-2). Any disagreements, which cannot be resolved will be referred to a third member of the team. Studies will be categorised (1) RCT/ quasi RCT (2) Other studies

***Data Extraction and Management***

Details of each study will be independently extracted by 2 assessors using a standardised data extraction form, which is appended below. Discrepancies that cannot be resolved will be referred to a third member of the team. The references will be managed using the bibliographic software EndNote.

***Assessment of methodological quality of included studies***

GRADE will be used to assess the quality of included studies**.** For RCTs, quasi RCTs and other quantitative studies, the following quality issues will be assessed: sequence generation, allocation concealment, blinding of participants, incomplete data assessment; selective outcome reporting; other sources of bias.

***Synthesising the evidence***

Where possible, meta-analysis will be used to synthesise the evidence using Review Manager v5.1. For a given outcome (continuous and dichotomous) where more than 50% of the number randomised to any group are not accounted for by trial authors, the data will be excluded from the review because of the risk of bias. However, where possible, dichotomous efficacy outcomes will be calculated on an intention-to-treat basis (ie a ‘once-randomised-always-analyse’ basis). This assumes that participants who drop out of the study for whatever reason have an unfavourable outcome. Dichotomous outcomes will be analysed as relative risks with the associated 95% confidence interval. Continuous outcomes will be analysed using the standardised mean difference when different measures are used in different studies to estimate the same underlying effect.

***Treatment of Qualitative Research***

The aim of including qualitative research studies is to enhance the review through including studies identified whilst searching for evidence of effectiveness, and, secondly, to extend the review through including studies that address questions relating to effectiveness, e.g. the intervention used. Included qualitative research will be restricted to empirical studies with a description of the sampling strategy, data collection procedures and the type of data-analysis considered, and this may include single case studies of the kind reported in psychoanalytic specialist journals (Midgely 2006).

Critical appraisal of qualitative research will be to assess the methodological soundness of the study, including the appropriateness of the research design to meet the aims of the research, rigour of data-collection and analysis, clarity of explanation of findings, appropriate and demonstrated reflexivity and paradigmatic appropriateness.

Studies will be graded by two researchers independently, according to methodological quality, and relevance to the questions of this review. A sensitivity analysis will evaluate the effects of removing low quality studies.

***Data synthesis***

If participants, interventions and outcomes appear sufficiently similar to suggest meta-analysis as a possibility, statistical tests for heterogeneity will be carried out. Meta-analysis will only be carried out on RCTs. Other studies will be summarised in tables, using narrative synthesis and included in discussion.

***Sub-group analysis*:**

Separate analyses will be carried out for subgroups of studies, grouped through similarities of research questions, based on

(1) Type of intervention (within Psychoanalytic Psychotherapy, there are a range of descriptors to use; theoretical ‘school’, intensity, length of treatment etc);

(2) Type of outcome measured: reduction of suicide/self-harm; increase in self-protection; reduction of risk factors for suicide; mental health improvement, etc.

(3) type of setting – outpatient/inpatient; different organisational settings in health, social care, education and criminal justice.

**Sensitivity analysis:** A sensitivity analysis will be undertaken to explore the effects of addition/removal of lower quality studies from the results

**References**

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**Appendices:**

1. **Flowchart through the review**

Additional Publications identified through other sources (n= ….)

Publications included in analysis (RCT and not RCT)

(n =…)

Full text publications assessed for eligibility

(n = ….)

Publications excluded (n =..)

Publications excluded with reasons e.g. no full text, not meeting criteria etc (n…)

Publications screened for relevance (n =….)

Total publications after duplicates removed (n =…)

Publications identified through data base searching (n=….)

1. **Data extraction proforma**

|  |  |
| --- | --- |
| Date of study |  |
| Reviewer |  |
| Bibliographic details of study |  |
| Purpose of study |  |
| Study design |  |
| Population (sample) |  |
| Intervention |  |
| Comparative intervention |  |
| Outcomes |  |

1. Definition of self-harm used will be that in NICE (2011): see below [↑](#footnote-ref-1)
2. Masked assessment (that is, blind to the journal from which the article comes, the authors, the institution and the magnitude of the effect) will not be used because it is unclear that doing so reduces bias (NICE 2011).

   [↑](#footnote-ref-2)