



Review article

Is psychotherapy effective for reducing suicide attempt and non-suicidal self-injury rates? Meta-analysis and meta-regression of literature data



Raffaella Calati ^{a, b, *}, Philippe Courtet ^{a, b, c}

^a INSERM U1061, University of Montpellier UM1, Montpellier, France

^b FondaMental Foundation, France

^c Department of Emergency Psychiatry & Acute Care, Lapeyronie Hospital, CHU Montpellier, Montpellier, France

ARTICLE INFO

Article history:

Received 6 January 2016

Received in revised form

13 April 2016

Accepted 14 April 2016

Keywords:

Psychotherapy

Suicide attempt

Personality disorder

ABSTRACT

Objective: To determine the efficacy of psychotherapy interventions for reducing suicidal attempts (SA) and non-suicidal self-injury (NSSI).

Methods: Meta-analysis of randomized controlled trials (RCTs) comparing psychotherapy interventions and treatment as usual (TAU; including also enhanced usual care, psychotropic treatment alone, cognitive remediation, short-term problem-oriented approach, supportive relationship treatment, community treatment by non-behavioral psychotherapy experts, emergency care enhanced by provider education, no treatment) for SA/NSSI. RCTs were extracted from MEDLINE, EMBASE, PsycINFO and Cochrane Library and analyzed using the Cochrane Collaboration Review Manager Software and Comprehensive Meta-analysis.

Results: In the 32 included RCTs, 4114 patients were randomly assigned to receive psychotherapy (n = 2106) or TAU (n = 2008). Patients who received psychotherapy were less likely to attempt suicide during the follow-up. The pooled risk difference for SA was -0.08 (95% confidence intervals = -0.04 to -0.11). The absolute risk reduction was 6.59% (psychotherapy: 9.12%; TAU: 15.71%), yielding an estimated number needed to treat of 15. Sensitivity analyses showed that psychotherapy was effective for SA mainly in adults, outpatients, patients with borderline personality disorder, previously and non-previously suicidal patients (heterogeneous variable that included past history of SA, NSSI, deliberate self-harm, imminent suicidal risk or suicidal ideation), long- and short-term therapies, TAU only as a control condition, and mentalization-based treatment (MBT). No evidence of efficacy was found for NSSI, with the exception of MBT. Between-study heterogeneity and publication bias were detected. In the presence of publication bias, the Duval and Tweedie's "trim and fill" method was applied.

Conclusion: Psychotherapy seems to be effective for SA treatment. However, trials with lower risk of bias, more homogeneous outcome measures and longer follow-up are needed.

© 2016 Elsevier Ltd. All rights reserved.

Contents

1. Introduction	9
2. Methods	9
2.1. Search strategy and selection criteria	9
2.2. Outcomes	10
2.3. Data extraction and quality assessment	10
2.4. Data analysis	10
3. Results	10

* Corresponding author. INSERM U1061, University of Montpellier UM1, Montpellier, France.

E-mail address: raffaella.calati@gmail.com (R. Calati).

3.1. Included trials	10
3.2. Primary outcome: suicide attempt rate	15
3.3. Secondary outcome: non-suicidal self-injury rate	17
3.4. Funnel plots and quality assessment	17
4. Discussion	17
Acknowledgments	19
Supplementary data	19
References	19

1. Introduction

In 2012, an estimated 804,000 suicide deaths (SD) occurred worldwide, corresponding to an annual suicide rate of 11.4 per 100,000 people (World Health Organization, 2014). Moreover, for each adult SD there may have been more than 20 suicide attempters. Significantly, in the general population a prior suicidal attempt (SA) is the most important risk factor for suicide.

The inclusion of suicidal behavior disorder in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) highlights the need of additional studies to identify effective strategies for its prevention and treatment. However, one problem in research on suicide is the confusion resulting from the use of different terms to define suicidal behavior (De Leo et al., 2006). Indeed, in the United States, SA (self-harm with an intention to die) is distinguished from non-suicidal self-injury (NSSI; self-harm without intention to die). In the United Kingdom, and more generally in Europe, and in South Africa, Australia and New Zealand, deliberate self-harm (DSH; without focus on the intent) is commonly used. It includes self-harm with suicidal intent, NSSI and self-harm episodes with unclear intent. However, DSH has been criticized because it is too broad (Linehan, 1997). Most studies on adolescents focused on DSH (Ougrin et al., 2012; Ougrin and Boege, 2013), and DSH and NSSI prevalence in adolescents from different countries are similar (Muehlenkamp et al., 2012). Moreover, a meta-analysis of the overall international NSSI prevalence reported that the pooled NSSI prevalence was 17.2% among adolescents, 13.4% among young adults and 5.5% among adults (Swannell et al., 2014).

Very few evidence is available on the usefulness of specific pharmacological interventions for suicidal behavior (Hawton et al., 2015a), with the exception of the recent enthusiasm for ketamine (Bolton et al., 2015). Similarly, consensus is lacking on the effectiveness of psychological interventions for suicidal behavior. It has been reported that a wide range of therapies, such as cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT) and problem-solving approaches, are effective in reducing suicidal thoughts and behaviors, when they are considered as part of an extremely wide outcome variable that includes different indicators, such as SA, suicidal plans, suicidal thoughts together with hopelessness and satisfaction with life measures (Tarrier et al., 2008). Conversely, psychosocial interventions after DSH do not seem to reduce the likelihood of subsequent SD (Crawford et al., 2007). Moreover, a recent review of randomized controlled trials (RCTs) on psychosocial interventions for DSH in children and adolescents found very little evidence supporting the effectiveness of such approaches in these populations (Hawton et al., 2015b). This lack of consensus could be explained by the high between-study heterogeneity due to the difference in suicidal phenotypes (suicidal ideation, NSSI, SA, DSH, SD), treatments, diagnosis [borderline personality disorder (BPD), major depressive disorder, bipolar disorder, schizophrenia, anorexia and anxiety disorders] and

populations (adults, adolescents) included in these RCTs.

A recent meta-analysis evaluated the efficacy of specific therapeutic (psychological, social and pharmacological) interventions in reducing any type of DSH (SA, NSSI and/or self-harm with ambiguous intent) (19 included studies) and SA alone (8 included studies) in adolescents. Evidence of treatment efficacy was only found for the global category of DSH, with high between-study heterogeneity, but not for SA (Ougrin et al., 2015). Therefore, we decided to perform a new meta-analysis to extend the analysis on the efficacy of therapeutic interventions also to adults and to focus only on SA and NSSI outcomes. To this aim, in the present meta-analysis, we primarily evaluated the efficacy of psychotherapeutic interventions (compared with treatment as usual) on the SA outcome in different populations with different diagnoses. We also evaluated the efficacy of psychotherapeutic interventions for the treatment of NSSI/self-harming/self-mutilating behaviors (secondary outcome). Indeed, although there is a considerable overlap between SA and NSSI, the factors contributing to these two conditions could be slightly different (Dougherty et al., 2009). Finally, we also performed sensitivity and meta-regression analyses to take into account the possible between-study heterogeneity. To our knowledge this is the first meta-analysis that evaluated the efficacy of psychotherapies in specifically reducing SA and NSSI rates in both adults and adolescents.

2. Methods

This meta-analysis was performed according the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Statement (PRISMA) (Moher et al., 2009).

2.1. Search strategy and selection criteria

Records were primarily identified by a MEDLINE-based search, but results obtained by interrogating EMBASE, PsycINFO, and the Cochrane Library (until June 2015) databases were also incorporated. The following search terms were used: (psychotherapy OR psychosocial OR acceptance and commitment therapy OR cognitive behavior(u)ral therapy OR cognitive therapy OR dialectical behavior(iu)r therapy OR interpersonal psychotherapy OR mentalization-based treatment OR mindfulness based cognitive therapy OR problem solving therapy OR schema-focused therapy OR transference-focused psychotherapy) AND (suicid* OR self(-)harm OR non-suicidal self-injury OR self-mutilation). The reference lists of the identified studies, reviews and meta-analyses were also examined to extract additional articles.

Studies were included if: they were published in a peer-reviewed journal; they were written in English; they were RCTs; they compared a form of psychotherapy (or a substantial component of psychotherapeutic methods in the treatment) with treatment as usual (TAU) that included also enhanced usual care (such as a facilitated referral process with ongoing clinical monitoring),

Download English Version:

<https://daneshyari.com/en/article/326919>

Download Persian Version:

<https://daneshyari.com/article/326919>

[Daneshyari.com](https://daneshyari.com)