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Review article

The relationship between therapeutic alliance and patient's suicidal thoughts, self-harming behaviours and suicide attempts: A systematic review

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ABSTRACT

Background: Suicidality is a common concern for people with mental health problems. The interpersonal nature of suicidality suggests that therapeutic alliance may be important when working clinically with suicidal patients. This paper is a systematic review of studies investigating the association between alliance and treatment outcome relating to suicidal ideation and behaviours.

Methods: Systematic searches of PsychINFO, MEDLINE, AMED, EMBASE, Web of Science and CINAHL were completed using words that captured the concepts of alliance and suicidality. Eligible studies: involved participants aged 18-years-old or over; used a validated measure of therapeutic alliance; and reported associations between alliance and suicidality. Abstracts, qualitative studies and articles not written in English were excluded.

Results: Twelve studies were included. Findings indicated that alliance is associated with suicidality. Alliance was related to suicidality in eleven of the papers. Self-harming behaviours had the strongest association with patient-rated alliance. Suicide attempts had the weakest association, possibly due to the infrequency of suicide attempts in the studies reviewed.

Limitations: The twelve studies were heterogeneous in terms of the measure of alliance used, method of assessing suicidality, clinical setting and professional-type. This variability limited the degree to which findings could be synthesised.

Conclusion: Therapists, care-coordinators and mental health teams should recognise the importance of building a strong therapeutic alliance with suicidal patients. Researchers should use consistent methods of measuring alliance and assessing suicidality in future studies. Clinicians and researchers should note that suicidal thoughts, self-harm and suicide attempts may be related to alliance in different ways and therefore should be assessed as separate constructs.

1. Introduction

Suicidality, including suicidal thoughts, self-harm and suicide attempts, is a common feature in individuals with mental health problems (Healthcare Quality Improvement Partnership, 2016). The number of people who take their life each year globally exceeds 800,000 (World Health Organisation, 2017). Around 4479 people take their own life in England every year and around 28% of these are current mental health patients (Healthcare Quality Improvement Partnership, 2016). Individuals who complete suicide are frequently male (66%), not married (71%) and have previously self-harmed (68%) (Healthcare Quality Improvement Partnership, 2016). Socioeconomic factors such as unemployment, debt and homelessness are also factors which have been shown to contribute to increased rates of completed suicide (Healthcare Quality Improvement Partnership, 2016).

Suicidal thoughts and associated behaviours can be distressing for the individual and loved ones and have a high impact on society (O'Dea and Tucker, 2005). Despite the high prevalence of suicidality, evidenced based interventions for suicidality are scarce (Beautrais, 2014; Gysin-Maillart et al., 2016). Psychological therapy plays an important part in the treatment of suicidality and one review (Comtois and Linehan, 2006) found that psychosocial interventions, such as cognitive therapy (Liberman and Eckman, 1981), Dialectical Behaviour Therapy (DBT, Lieb et al., 2004), problem solving (Hawton et al., 1989) and outreach interventions (Motto and Bostrom, 2001) were effective in reducing suicidality. These approaches are underpinned by different theoretical models and it has been argued that the similarity in effectiveness is due to the importance of therapeutic alliance (Michel, 2011). Therapeutic alliance is defined as patients' confidence in staff and the quality and strength of their relationship (Jobes and Ballard, 2011).

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Suicidal acts are often rooted in interpersonal or social struggles, such as complex or traumatic relationships or the absence of important relationships (Jobes and Ballard, 2011). A patient's relationship with a professional may offer them a previously unknown experience of a secure base; a person who is sensitive and responsive and offers the patient a safe haven (Bowlby, 1988).

Despite the acknowledged importance of building a strong therapeutic alliance with people experiencing suicidality, until relatively recently there was little empirical research in this area and to date no systematic review has been completed. This review aims to systematically analyse the effect of therapeutic alliance on treatment outcome relating to suicidal ideation and behaviours in patients by determining the quality of published literature and summarising relevant findings. The review will aim to answer the following questions: 1) is there an association between therapeutic alliance and patients' treatment outcomes relating to suicidality; 2) does the way in which suicidality is conceptualised and measured impact on the association between alliance and treatment outcome relating to suicidality; 3) does the therapeutic model, setting or professional involved impact on the association between alliance and treatment outcome relating to suicidality; 4) are there differences in the associations between alliance and treatment outcome relating to suicidality when patient-rated alliance, professional-rated alliance or observer-rated is measured. Finally, this review will make recommendations for future research and discuss clinical implications.

2. Method

2.1. Study inclusion

Studies were included based on three criteria: a) participants were 18-years-old or over; b) used a validated measure of therapeutic alliance between patients and staff; and c) reported associations between therapeutic alliance and patients' suicidality. To meet criterion b) papers needed to explain, or cite another paper which explained, the validation of the alliance measure. Any measure of suicidality was included to avoid excluding research that used hospital or other official records that are not typically validated but likely to provide relatively reliable information. Conference abstracts, dissertation abstracts, qualitative studies, articles not peer-reviewed and articles not written in English were excluded.

2.2. Search strategy

Electronic searches of PsychINFO, MEDLINE, AMED, EMBASE, Web of Science and CINAHL databases were completed using the search terms (therap* alliance OR therap* relationship* OR work* alliance*) AND (suicid* OR self harm OR self injury). No additional date filters were used and the databases earliest records ranged from 1806 (PsychINFO) to 1985 (AMED). Searches were completed during mid-2016 and repeated in 2017 and include papers published up until this time.

2.3. Selection of papers

A total of 2029 papers were found through the electronic searches. Duplicates were removed and the titles and abstracts of the remaining studies (n = 1826) were screened by the first author to establish if the studies met the inclusion and exclusion criteria. Fig. 1 shows how twelve papers were included. Reasons for excluding articles at full text were: methodological (i.e. qualitative study, case study, n = 20); either therapeutic alliance (n = 11), suicidality (n = 7) or both (n = 3) not measured; or both suicidality and therapeutic alliance being measured, but analysis not being completed on the two variables together (n = 5).

The authors of five papers (Amianto et al., 2011; Cottraux et al., 2009; Davidson et al., 2006; Ellis et al., 2012; Wnuk et al., 2013) which measured suicidality and therapeutic alliance but did not report an association were asked if they could provide the information but none sent usable data. The references of included studies were searched and nineteen additional full texts were accessed but none met the inclusion criteria.

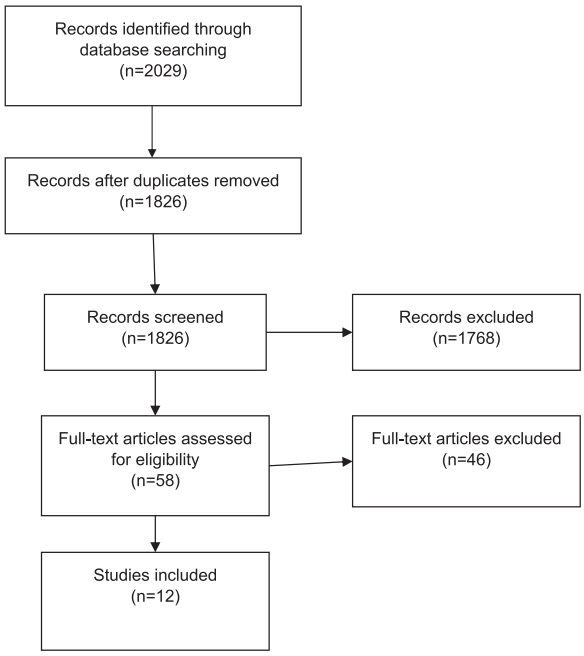

Fig. 1. PRISMA diagram illustrating the process of papers being excluded or included for the systematic review: Therapeutic alliance and suicidality.

2.4. Data extraction and interrater reliability

An extraction table was used to guide data collection, using the following headings: authors and date, patient type, staff type, number of participants, age, gender, suicidality measure, therapeutic alliance measure and key findings. The age and gender of staff data was not reported as only one paper reported on each.

The lead author completed the initial screening of 1826 titles. In addition, these were screened by an additional author resulting in 1648 (90.25%) agreed observations. Uncertainty regarding inclusion of titles was resolved through discussion between the two authors. The lead author and additional author screened all 58 articles accessed at full text level independently and there was 100% agreement in the studies to be included.

3. Results

3.1. Participants and study design

Of the twelve studies (Table 1), two pairs of studies used the same or similar participants. Bedics et al. (2012) and Bedics et al. (2015) used the same participants, but reported different therapeutic alliance measures. Bedics et al. (2012) and Bedics et al. (2015) reported on self-harm, while Bedics et al. (2015) also reported on suicide attempts, hence both were included. Ilgen et al. (2009) and Perron et al. (2009) used overlapping samples and the same measures but different analyses so both were included.

Half of the papers related to patients who met the criteria for Borderline Personality Disorder (BPD; Barnicot et al., 2016; Bedics et al., 2012, 2015; Hirsh et al., 2012; Shearin and Linehan, 1992; Turner, 2000). Two papers focused on veterans diagnosed with bipolar spectrum disorders (Ilgen et al., 2009; Perron et al., 2009) and one focused on those with a psychosis-related diagnosis (Farrelly et al.,