Research Bulletin

Is there a place for family-based interventions in reducing suicide-related behaviours in young people?

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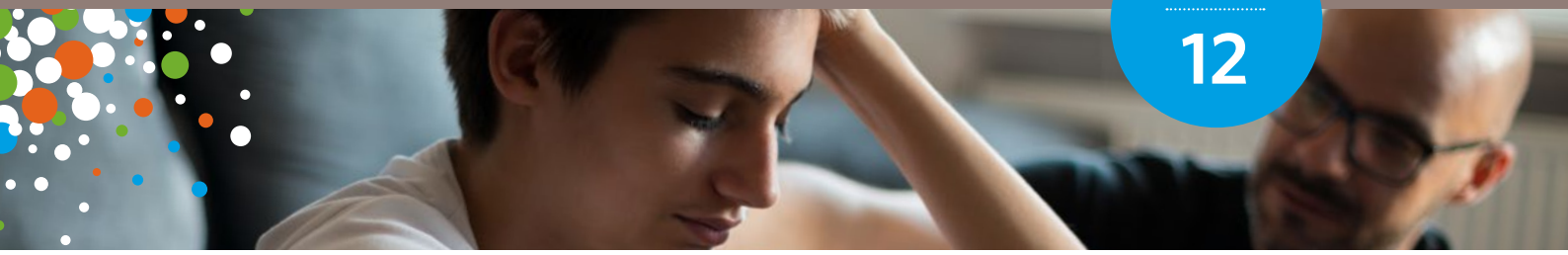

Clinical approaches to reducing self-harm and suicide-related behaviours in young people usually focus on the individual young person; however, therapies that involve their family can also play a role. Traditional family therapy encompasses a broad range of approaches including structural, strategic, and systemic family therapy.[1, 2] In more recent years, a range of other therapeutic approaches have incorporated the family into therapy, including attachment-based therapy, cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT), and mentalisation-based therapy. Collectively, we refer to these approaches as 'family-based interventions'. This research bulletin summarises the findings from high-quality studies that have examined whether family-based interventions are effective in helping to reduce suicide-related behaviours in young people up to the age of 25 years.

Background

Worldwide, and in Australia, suicide and self-harm are significant public health issues.[3, 4] Suicide is one of the main causes of death among young people worldwide [5, 6] and the leading cause of death in young Australians aged 15–24 years.[7] Self-harm, suicide attempts, and thoughts of suicide – collectively referred to here as 'suicide-related behaviours' – are more common than death by suicide. It is estimated that 13.3% of Australians aged 16–85 years have experienced suicidal ideation at some point in their lifetime,[8] while approximately 7.5% of adolescents, aged 12–17 years, have seriously contemplated suicide in the past year.[9]

Research indicates that 10% of Australian adolescents have self-harmed at some point in the past 12 months,[10] and the number of young people being hospitalised for self-harm is rising.[11] However, the true rates of self-harm in the community are likely to be much higher, with many young people concealing their injuries and never receiving clinical care for their distress.[4]

Defining self-harm

There are a variety of different terms used to describe self-harming behaviours, with terms such as self-poisoning, suicide attempt, and non-suicidal self-injury often used interchangeably. Self-harm can, but doesn't always, occur in the context of suicidal ideation and/or an intent to die, and some young people engage in self-harming behaviours as an alternative to ending their life.[12] As the intent for self-harming behaviours in young people can change and fluctuate, it is not always possible, or helpful, to separate self-harm into that which occurs with and without suicidal intent. For the purpose of this research bulletin, the term self-harm refers to self-harming behaviours that may occur with or without suicidal intent.

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Suicide-related behaviours can negatively impact a young person in a variety of ways, such as by affecting their relationships with family and peers, as well as impacting on school and/or work commitments. In the long-term, there is an increase in the risk of a young person dying by suicide, misusing substances, experiencing mental ill-health, and/or physical health problems,[13] which highlights the importance of early intervention.

Family factors and suicide-related behaviour in young people

Families, in particular parents, can be a valuable source of support for young people during their adolescent and young adult years,[14] and can play a particularly important role in supporting those young people engaging in suicide-related behaviour.[15] However, the relationship between family factors and such behaviour in young people is complex, and sometimes family interactions and behaviours may operate as a factor that maintains the risk in this regard. For example, family conflict,[16] low levels of family connections and low levels of family monitoring,[17] are all associated with self-harm, whereas family adaptability and cohesion appear to be protective factors against such behaviour.[18]

A young person's self-harming behaviour can also impact on other family members.[19] Parents have described feelings of distress, decreased overall wellbeing, and doubt surrounding their parenting abilities when caring for their child who is self-harming.[20] Furthermore, some parents have reported depression and anxiety that they attribute to the distress associated with their child's behaviour.[21] In some cases, parents feel that the time and support they dedicate to their at-risk child is impacting on their capacity to parent their other children.[22, 23] It is clear that in many situations a young person's self-harm is a behaviour that affects the whole family, including siblings.[19, 24] Therefore, it is important to support family members to manage their own emotions, feel confident in how to respond to their child/sibling's

Table 1. Family-based maintaining and protective factors for suicide-related behaviour in young people

Maintaining factors	Protective factors
Perceived lack of family support	Sense of family connectedness
Family conflict	Parental awareness of suicide-related behaviour
Familial emotional, physical, and/or sexual abuse	Family adaptability – the ability to effectively change and respond to situations
Low levels of family connectedness	Family cohesion – the emotional bonding family members experience towards each other
Low levels of family monitoring	

For comprehensive reviews, see Fortune, Cottrell and Fife,[25] and King and Merchant.[26]

self-harming behaviour both in and outside of a crisis situation, and to talk with them about self-harm in a calm, constructive, and respectful way.

What role can family-based interventions play?

Although it remains unclear whether, or how, family factors may affect suicide-related behaviours, family-based interventions have the capacity to impact on a young person's recovery journey.[25] The focus of family-orientated treatment with this population should focus on maximizing cohesion, attachment, adaptability, family support, [and] parental warmth while reducing maltreatment, scapegoating and moderating parental control.[25]

Clinical practice guidelines advise that where possible, families should be engaged in the clinical care of a young person who is self-harming.[27] There are several points at which families can become involved in their child's treatment and recovery. For example, a family member may accompany a young person who is presenting to an emergency department experiencing suicide-related behaviours, or the experience itself may result in a family member being informed of their child's behaviours. For other young people, a school counsellor, general practitioner (GP), or outpatient mental-health service may manage their care, with family members being informed of the self-harm behaviour at varying times in the young person's treatment journey. The needs of families are diverse and there is no one approach that fits every family. As a result, family-based interventions vary in their therapeutic focus, location, mode, and length of delivery. For example, some interventions, such as the Family-Based Crisis Intervention (FBCI) are delivered in the ED,[28] whereas others are delivered on an outpatient basis.[29–32]

For this research bulletin, we summarise the findings from high quality studies that have examined whether family-based interventions are effective in helping to reduce suicide-related behaviour in young people. These findings are summarised below to aid clinicians to see how the evidence may match with their particular practice setting.

Emergency department (ED) interventions

Asarnow JR, Baraff LJ, Berk M, et al. **An emergency department intervention for linking paediatric suicidal patients to follow-up mental health treatment.** *Psychiatric Services.* 2011 November;62(11):1303–1309.[33]

In this study, 181 young people (69% female, mean age=15 years) who presented to the ED, experiencing suicidal ideation or following a suicide attempt, were randomly assigned to receive Family Intervention for Suicide Prevention (FISP) or enhanced standard ED care. FISP involves one family crisis therapy session, delivered by clinicians with didactic training. Its focuses are on framing the suicide attempt as a problem requiring action, educating caregivers on the importance of outpatient follow-up treatment, restricting access to means of suicide and developing a safety plan with the young person to use in future crises. FISP also works on strengthening family ties, by encouraging caregivers and young people to identify positive aspects of their family. Within 48 hours of discharge, family members were phoned to further support follow-up treatment. Standard ED care was enhanced through a one-off presentation to staff on the importance of linking suicidal patients with outpatient treatment services.

At the two month follow-up, young people who received FISP were more likely to have attended outpatient treatment than those who received enhanced standard ED care. There were no significant changes in suicide attempt or suicidal ideation in the group that received FISP compared to those who received enhanced standard ED care.

Wharff EA, Ginnis KB, Ross AM, et al. **Family-based crisis intervention with suicidal adolescents: a randomised clinical trial.** *Paediatric Emergency Care.* 2017 February.[34]

This study randomised 142 adolescents (72% female, mean age=16 years) who presented at the ED with suicide-related behaviour to receive Family-Based Crisis Intervention (FBCI) or treatment as usual (TAU). FBCI is a one-off, single session therapy for young people and their caregiver(s) presenting at an ED with suicide-related behaviour. It aims to stabilise the young person, facilitate family empowerment, and increase the family's capability of managing

at-risk young people at home. All participants first received a standard psychiatric evaluation, and those in the FBCI group then participated in a single 60–90 minute FBCI session. Follow-up telephone calls were made at one day, three days, one week, and one month after the ED visit.

At one-month follow-up, adolescents in both treatment groups showed equally significant decreases in suicidal thoughts and attempts. Adolescents who received FBCI were significantly less likely to have been psychiatrically hospitalised at one month follow-up compared to those who received TAU. Family members in the FBCI group also reported higher family empowerment than those whose children received TAU.

Outpatient interventions

Cottrell DJ, Wright-Hughes A, Collinson M, et al. **Effectiveness of systemic family therapy vs. treatment as usual for young people after self-harm: a pragmatic, phase 3, multi-centre, randomised controlled trial.** *Lancet Psychiatry.* 2018;5(3):203–21.[35]

This study involved 832 young people engaging in recurrent self-harm (89% female, mean age=14 years). They were randomised to receive either Self Harm Intervention: Family Therapy (SHIFT), developed by the Leeds Family Therapy Research Centre, [36] or treatment as usual (TAU). Family therapy involved 1.25 hour-long sessions, spread over six months at approximately one-month intervals, in which therapists worked with family members to understand current behaviours and beliefs within the family setting. Focus was also given to building coping mechanisms to help families in the face of future difficulties. TAU was unrestricted so may have involved individual or family therapy.

At 18 month follow-up, there was no significant difference in hospital attendance for repeat self-harm between the groups (28% in family therapy vs. 25% in TAU). Self-reported suicidal ideation was lower in participants receiving family therapy compared to TAU at 12 month follow-up, however these results were not sustained at 18 months. Participants receiving family therapy did, however, show greater improvement in behavioural outcomes and family functioning.

Asarnow JR, et al. **Cognitive behavioural family treatment for suicide attempt prevention: a randomised controlled trial.** *Journal of the American Academy of Child and Adolescent Psychiatry.* 2017;56(6):506–514.[37]

This small study involved 42 young people (88% female, mean age=15 years) who had attempted suicide in the past three months or had self-harm as a primary presenting issue. Participants were randomly assigned to either the Safe Alternatives for Teens and Youths (SAFETY) program or an enhanced treatment as usual intervention (E-TAU). The SAFETY program was a cognitive–behavioural, DBT-informed therapy delivered to each family by two therapists. Young people and their caregiver(s) attended separate sessions simultaneously with their own therapists. These were followed by a joint session with both the young person and their caregiver(s) to practice communication skills and identify problems. Participants received an average of 10 sessions each, with at least one session conducted during a home visit. The E-TAU intervention provided one in-clinic self-harm education session for parents, followed by at least three phone calls to encourage follow-up treatment.

SAFETY participants experienced less self-reported suicide attempts at the end of their treatment compared to those who received E-TAU. However, no significant difference in self-harm was observed between the two groups at three-month follow-up.

Spirito A, et al. **Concurrent treatment for adolescent and parent depressed mood and suicidality: feasibility, acceptability, and preliminary findings.** *Journal of Child and Adolescent Psychopharmacology.* 2015;25(2):131–139.[32]

This small study compared simultaneous parent–adolescent CBT (PA-CBT) with adolescent-only CBT (AO-CBT) in 24 adolescent and parent pairs (adolescent mean age=14 years, 83% female), in which adolescents had a current major depressive episode (MDE) and parents had current or past MDE. Parents and adolescents in the PA-CBT intervention completed weekly CBT sessions with their own separate therapists for 12 weeks, followed by sessions every two weeks for a following 12 weeks. Sessions focused on developing safety plans, problem solving, cognitive restructuring, and regulating affect. Individual sessions ended with a joint meeting between parent and adolescent to address family

communication and problems. Adolescents in the AO-CBT intervention received the same individual CBT as those in the PA-CBT intervention, and parents were only involved in end-of-session check-ins regarding their child's progress.

Adolescents in both groups improved equally in suicidality over the treatment period, with reductions sustained at the 48-week follow-up. Parents and adolescents in the PA-CBT intervention experienced greater reductions in depressed mood over the course of the treatment compared to those in AO-CBT, however group differences were not sustained at the 48-week follow-up.

Mehlum L, et al. **Dialectical behaviour therapy for adolescents with repeated suicidal and self-harming behaviour: a randomised trial.** *Journal of the American Academy of Child and Adolescent Psychiatry.* 2014;53(10):1082–1091.[31]

In this study 77 adolescents (88% female, mean age=16 years) with recent and repetitive self-harm were randomly assigned to receive dialectical behavioural therapy for adolescents (DBT-A) or enhanced usual care (EUC). DBT aims to reinforce adaptive behaviours and coping skills via mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness, and promotes normative emotional expression.[38] DBT-A was delivered over 19 weeks and involved an hour of individual therapy and a two hour multi-family training skills session each week. Additional family therapy and phone coaching was provided when appropriate. EUC involved weekly CBT or psychodynamic therapy, with an average of no less than one session per week for 19 weeks.

Young people who received DBT-A experienced larger reductions in frequency of self-harm and severity of suicidal ideation over the 19-week treatment period. Suicidal ideation continued to improve throughout the study for DBT-A adolescents, whereas improvements levelled out for EUC participants after 15 weeks. Self-reported depressive symptoms decreased significantly in both treatment groups, but only DBT-A participants experienced a significant reduction in clinician-rated depression.

Rossouw TI and Fonagy P. **Mentalisation-based treatment for self-harm in adolescents: a randomised controlled trial.** *Journal of the American Academy of Child and Adolescent Psychiatry.* 2012 December;51(12):1304–1313.[30]

This study explored the effectiveness of a year-long mentalisation-based therapy program (MBT-A) in reducing self-harm in 80 adolescents (mean age = 15 years, 85% female). Participants were outpatients with at least one episode of self-harm in the past month, and were randomly allocated to receive either MBT-A or TAU. MBT-A was delivered through weekly, 50 minute individual therapy sessions and monthly mentalisation-based family sessions. The aim of these family sessions was to improve each member's ability to mentalise and regulate affect, especially during family conflict. TAU involved routine care provided by community adolescent mental health services, which mainly involved individual therapy. However, 33% of TAU participants received some form of family-based intervention, compared to 63% in the MBT-A intervention.

Adolescents receiving MBT-A experienced significantly larger reductions in self-harm and depression compared to those receiving TAU at the end of the 12-month treatment.

Table 2. Summary of trials included in this research bulletin

Study	Intervention	Setting	Results
Asarnow et al. (2011)	Family intervention for suicide prevention (FISP)	Emergency Department	No statistically significant impact on suicide attempts or suicidal ideation
Wharff et al. (2017)	Family-based crisis intervention	Emergency Department	No significant differences in suicidal thoughts and attempts between treatment and control group
Cottrell et al. (2018)	Self-harm intervention: family therapy (SHIFT)	Outpatient Clinic	No significant difference in hospital attendance for repeat self-harm between treatment and control
Asarnow et al. (2017)	Cognitive behavioural therapy	Outpatient Clinic with at least one home visit	Less self-reported suicide attempts in the treatment compared with the control group. No significant change in self-harm frequency
Spirito et al. (2015)	Cognitive behavioural therapy	Outpatient clinic	No significant differences in suicidality between treatment and control group
Mehlum et al. (2014)	Dialectical behavioural therapy	Outpatient clinic	Intervention was superior in reducing self-harm and suicidal ideation compared to control
Rossouw et al. (2012)	Mentalisation-based therapy	Outpatient clinic	Intervention was more effective in reducing self-harm compared to control

Where to from here?

The evidence for family-based interventions in reducing suicide-related behaviour in young people is growing, however as the studies reviewed here demonstrate, there is not yet compelling evidence that these interventions reduce suicide-related outcomes. While some studies suggest more promising results for family-based interventions, at present, there is not enough evidence to say which type of family-based therapeutic approach is most effective.

It should be noted that the length of the intervention and the degree of ongoing family involvement appear to be important factors in influencing outcomes. Family engagement and support may increase adherence to follow-up treatment, however, further studies are required to confirm this. Although the largest trial of family-based therapy showed no effect in terms of repetition of self-harm, there were positive benefits on levels of suicidal ideation and family functioning.[35] When considering the 'effectiveness' of different approaches, it is important to look at a variety of outcomes that are likely to be affecting a young person's quality of life. Research shows that treatments that involve family skills training and parent education, which are delivered over longer periods of time, appear to be most successful.[39, 40, 41]

What does this mean for clinical practice?

Clinicians should continue to refer to the National Institute for Health and Care Excellence (NICE) clinical guidelines, which state that: 'Subject to the person's consent and right to confidentiality, encourage the family, carers or significant others to be involved where appropriate'.[27] Caregivers can be a valuable source of support for their child, and family-based interventions present an important opportunity to enhance support for young people, whilst potentially providing psychoeducation and support to the caregiver(s) themselves. The decision to involve a young person's family in therapy is also likely to be influenced by the skills and experience of the treating clinician.

Despite the promising role of family-based interventions in preventing and managing suicide-related behaviour in young people, there remain a number of practical barriers to families being involved in therapy. Finding an appropriate time for both parent and young person to attend, and/or parents opting not to be involved in therapy for fear of being blamed or judged by therapists present potential barriers.[42, 43] Obstacles pertaining to the therapies themselves may also arise. For example, whilst intensive interventions, such as DBT-A, are promising it is unclear how feasible it is to deliver such an intensive intervention in non-intensive clinical services that are restricted by session numbers.

Services should ensure that family-inclusive practice is supported and encouraged at an organisational level. It is also important that clinicians and services be aware of self-stigma, that may be experienced by parents and/or caregivers, and how this can deter help-seeking behaviours.[44] Clinicians who engage with families in an active, non-blaming way that minimises shame may help to address some of these barriers to care. For more practical information on how to support parents of young people who self-harm, please see Orygen's free clinical practice point *'Supporting clinicians to work with parents of young people who self-harm'*.

Questions for future research

- What are the most effective types of family-based treatments, and what are the common core components contained across them?
- What approaches are most effective for young people from separated families?
- Is family-based therapy more effective for younger vs. older adolescents?
- Can key elements of effective therapy be delivered via online methods? A recent study has assessed the feasibility of using an app-based safety plan with a platform for both young people and their parents.[45]
- The majority of young people included in the studies so far have been female, and it is unclear whether there are differences in treatment effectiveness for males.
- How do cultural factors influence family involvement in care?

The practicalities of generating evidence in this area

Family-based therapies can be difficult to implement and evaluate, with some of the barriers including: [46]

- Highly-skilled staff are often needed to deliver the intervention, and staff often need to be based within already established services.
- Balance between amount of data collected and the burden this presents for the family must be considered, taking into account the chance of drop-out.
- Family therapies cannot be delivered uniformly, as each family is different, with unique needs and parent/caregiver dynamics.

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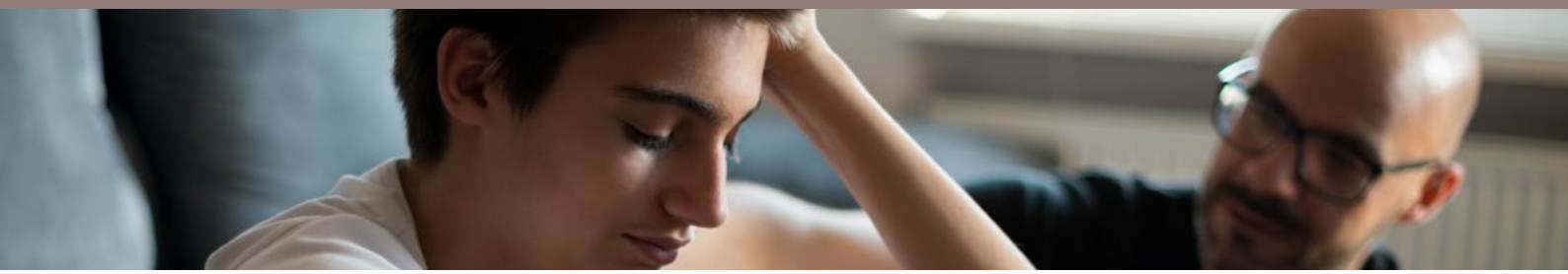

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