BJPsych The British Journal of Psychiatry (2023)
223, A41. doi: 10.1192/bjp.2023.129

Highlights of this issue

Katherine Adlington

Reframing our approach to self-harm

'Cognitive reframing is a psychological technique that consists of identifying and then changing the way situations, experiences, events, ideas, and/or emotions are viewed.'[1] Before reframing became the tool of PR and political machines, it was a clinical tool: 'cognitive restructuring' was developed by Aaron Beck in the 1960s as part of cognitive therapy.

As clinicians, we benefit from reframing other aspects of our work too – be it diagnosis, treatment or patient interactions – as evidence and culture evolves. Two of this month's articles made me think about opportunities to reframe elements of our psychiatric practice.

In an editorial (pp. 499–500) summarising the new National Institute of Health and Care Excellence guidance *Self-Harm: Assessment, Management, and Preventing Recurrence*,[2] the multidisciplinary team of authors seek to highlight the key recommendations where they feel practice could be improved.

The first message encourages the need for empathy and kindness in the approach to people who self-harm – shocking (or perhaps not) that such things still need to be spelled out. Sadly, this is backed up by evidence that aversive treatments for self-harm, including criminal punishment as a deterrent, continue to occur in healthcare settings. For me, this demonstrates the importance of truly co-created guidelines so that the testimony of people who have experienced such treatment is an integral and living part of the guideline committee.

The guideline recommends a reframing of the previously popular risk assessment as a 'holistic risk formulation' that includes psychosocial assessment and focuses on 'the strengths and needs of the person' and 'should be conducted with hope and optimism'. Although hope and optimism are at times hard to come by in today's National Health Service (NHS), it is an important reminder of the benefits of maintaining these qualities in interactions with patients.

The guideline demonstrates that not all attempts to reframe our clinical practice are yet backed up by research – apparently there was not yet enough evidence to be able to make a recommendation about the use of safety plans or strategies for 'safer self-harm' – despite these already being introduced into clinical practice in some places.

Earlier use of repetitive transcranial magnetic stimulation (rTMS) in later-life depression?

A research paper by Wathra et al (pp. 504–506) could help to reframe the use of rTMS in treatment-resistant late-life depression. Using secondary analysis, the authors found that a lower level of treatment resistance was associated with better rTMS treatment outcomes in older people with depression, with both forms of rTMS (bilateral theta-burst stimulation or conventional bilateral rTMS) having similar clinical efficacy.

These results may lead us to ponder whether rTMS could be reframed as an earlier treatment of depression in older adults – perhaps even after just one failed medication trial – not just considered as a last resort approach to augmentation.

Expert by academia and by experience

Perhaps the most moving account that I have read in the *BJPsych* in recent years is the article by Professor Emerita Elizabeth Kuipers (pp. 507–508). It is a beautiful and honest account about her experiences of moving into the role of carer for her husband, who has developed dementia, from the unique perspective of a clinician and academic with a lifetime's experience as an observer in this area. She applies the evidence of which she is intimately aware to her new role as expert by experience, using very real and poignant personal examples from her journey and family life.

It is good to hear honestly about what more she would have hoped for from the NHS (yearly memory clinic follow-up, offers of respite) and her advice about the importance of maintaining your own life and interests and involving family, friends and the wider community where possible. Important advice comes from the unexpected source of 'Crocodile Dundee': 'when there is a problem – tell one person, soon everybody knows, and there is no longer a problem'.

COVID-19 inequalities

On the other end of the spectrum, carers and parents of young people may be interested by the research from Paterson et al (pp. 509–517). They used the only national population-wide registry of self-harm and suicidal ideation in the world to show that rates of these presentations in young people in Northern Ireland increased above expected levels during the pandemic – despite no elevation in other age groups. This chimes with other research showing particularly negative effects of the pandemic on child and adolescent mental health, including increased anxiety, depression and loneliness.

Research from Das-Munshi et al (pp. 518–525) is concerned with two other groups that have been disproportionately affected by the pandemic. They use Clinical Practice Research Datalink data from UK primary care to show that people living with severe mental illness (SMI) experienced an excess risk of death during the COVID-19 pandemic, continuing into the second wave despite the non-SMI population risk decreasing at this point. In keeping with previous research, Black Caribbean and Black African patients had a higher risk of death following COVID-19 infection, although the inequalities were similar across the SMI and non-SMI control groups – perhaps because it would be hard for existing inequalities in racially minoritised groups to get any higher (a 'ceiling effect', suggest the authors).

References

1 Robson Jr JP, Troutman-Jordan M. A concept analysis of cognitive reframing. *J Theory Constr Test* 2014; **18**(2): 55–9.

2 National Institute of Health and Care Excellence. *Self-Harm: Assessment, Management and Preventing Recurrence* [NG225]. NICE, 2022. Available from: https://www.nice.org.uk/guidance/ng225.