QUESTION: In patients with deliberate self poisoning, does brief psychodynamic interpersonal therapy (PIT) reduce suicidal ideation, severity of depression, and further episodes of self harm and increase patient satisfaction?

Design
Randomised [allocation unconcealed†‡, blinded (outcome assessor)*], controlled trial with 6 months of follow up.

Setting
A university hospital emergency department in Manchester, UK.

Patients
119 adults who were 18–65 years of age (mean age 31 y, 55% women), presented with an episode of deliberate self poisoning, lived in the catchment area, were registered with a general practitioner, and did not need inpatient psychiatric treatment. 80% of patients completed 6 month assessments.

Intervention
After stratification by history of self harm, patients were allocated to 4 fifty minute sessions of PIT (n=58) or to usual care (n=61). PIT consisted of identifying and helping to resolve interpersonal difficulties that caused or exacerbated psychological distress. The therapy was described in a standardised manual.

Main outcome measures
Suicidal ideation (Beck Scale for Suicidal Ideation). Secondary outcomes were depression symptoms (Beck Depression Inventory), patient satisfaction (10 point scale; with higher scores indicating higher satisfaction), and further episodes of deliberate self harm.

Main results
Analysis was by intention to treat. After adjustment for baseline values, patients in the psychotherapy group had less suicidal ideation (p<0.005) and less severe depression (p=0.037) than patients in the usual care group (table). The difference in depression scores was no longer statistically significant after adjustment for marital status. Patient satisfaction was higher in the psychotherapy group than in the usual care group (p=0.009) (table). Unadjusted rates for repeated self harm were lower in the psychotherapy group than in the usual care group (p=0.15) (table).

Conclusion
In adults who have deliberately poisoned themselves, 4 sessions of psychodynamic interpersonal therapy reduced suicidal ideation and further episodes of deliberate self harm and increased patient satisfaction.

COMMENTARY
Rates of hospital attendance after self harm are about 400 in 100,000 per year in the UK, and in people who have committed suicide, 1 in 4 attended hospital after a non-fatal act in the previous year. Under the circumstances, the evidence for the effectiveness of interventions is disappointing. Guthrie et al struggled with some familiar problems, and despite their best efforts, many exclusions and refusals occurred; in the end they included only 25% of presenting patients. We cannot be sure how generalisable their findings are, although patient baseline characteristics were typical for the UK. Final numbers were respectable but were nonetheless relatively small, and possibilities exist for bias. For example, the treatment and control groups differed in marital status and past psychiatric history. The authors adjusted for some potential confounders in their analysis, but not all. The apparently large effect of psychological therapy on the repeated self harm rate needs to be viewed with caution.

The results of this trial are encouraging because they add to the evidence that brief psychological therapies improve outcomes after self harm. Those who are sympathetic will accept this as further evidence that patients with such a high burden of problems and risk of suicide should be offered treatment. Promising therapies (like the one evaluated here) are brief, have a strong focus on practical problem solving and interpersonal difficulties, and are delivered in a format that patients find acceptable.

For the sceptical, the evidence remains less than rock solid. For them, we still need large multicentre trials to test the real world effectiveness of psychological therapies before we can argue for their routine inclusion in clinical services.

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