Brief psychodynamic interpersonal treatment after deliberate self poisoning reduced suicidal ideation and deliberate self harm


QUESTION: In patients who have deliberately poisoned themselves, does brief psychodynamic interpersonal treatment (PIT) reduce suicidal ideation, severity of depression, and further episodes of self harm, and increase patient satisfaction?

Design
Randomised (allocation unsealed†), 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 to 65 years of age (mean age 31 y, 55% women), presented with an episode of deliberate self poisoning, were registered with a general practitioner and did not need inpatient psychiatric treatment. Follow up was 80%.

Intervention
After stratification by history of self harm, patients were allocated to four 50 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 treatment 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, higher scores indicate higher satisfaction), and further episodes of deliberate self harm.

Main results
Analysis was by intention to treat. After adjustment for baseline values, psychotherapy led to less suicidal ideation (p < 0.005) and less severe depression (p=0.057) than did usual care (table). The difference in depression scores was no longer statistically significant after adjustment for marital status. Patient satisfaction was higher for psychotherapy than for usual care (p=0.015) (table). Unadjusted rates for repeated self harm were lower for psychotherapy than for usual care (p=0.009) (table).

Conclusion
In adults who have deliberately poisoned themselves, 4 sessions of psychodynamic interpersonal treatment reduced suicidal ideation and 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 the hospital after a non-fatal act in the previous year. Under the circumstances, the evidence for the effectiveness of interventions is disappointing.1 Guthrie et al struggled with some familiar problems and, despite their best efforts, many exclusions and refusals of patients occurred; in the end, they included only 23% 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 previous psychiatric history. The authors adjusted for some potential confounders in their analysis but not for all. The apparently large effect of psychological treatment 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 treatments improve outcomes after self harm.2 Those who are sympathetic will accept the study findings as further evidence that patients with such a high burden of problems and risk for suicide should be offered treatment. Promising treatments (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. We still need large multicentre trials to test the real-world effectiveness of psychological treatments before we can argue for their routine inclusion in clinical services.

Allan House, DM
University of Leeds
Leeds, UK