

## CORRESPONDENCE

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To the Editor:

Unfortunately, not all alternative explanations were considered by Tyrer and colleagues (2003*a*) when the findings of the POPMACT study were published. The study consisted of a randomized controlled trial, comparing a brief cognitive behaviour therapy with treatment as usual in a sample of deliberate self-harm (DSH) patients.

In our opinion, the study has raised unnecessary concern among those working with DSH patients using interventions based on a cognitive behaviour approach, which has become apparent from the considerable number of reactions we received from clinicians in the past months.

An important advantage of the RCT by Tyrer *et al.*, compared to most previous RCTs in this area (Hawton *et al.* 1998; Hawton & Sinclair, 2003) is that this is the first multi-centre trial, enabling them to include a large sample and to reach sufficient power to test the efficacy of the experimental treatment intervention: A brief Manual Assisted Cognitive Behaviour Therapy (MACT). However, taking into consideration the inclusion criteria that were applied, as well as the eventual profile of the DSH patients, the outcomes are not surprising. First of all, the criterion to only include DSH patients who were repeaters at the time of the index episode of DSH in combination with the fact that nearly half (42%) of the sample had a personality disorder (Tyrer *et al.* 2003*a, b*), is usually an indication for a long-term rather than a short-term treatment (Bornstein *et al.* 1988; Linehan *et al.* 1991; Johnson *et al.* 1999). Compared to first-ever DSH patients, those who repeatedly harm themselves appear to be more strongly sensitized for suicide-related thoughts and behaviours under the influence of previous suicidal experiences. Consequently, repeated episodes of DSH appear to be primarily elicited by a wide range of intra-psychic and external stimuli, and not by

specific negative events. In contrast, first-ever DSH patients more often report specific negative events to be primarily associated with the intensity of the suicidal crisis at the time of the first episode (Joiner & Rudd, 2000). Considering the fact that this sensitization process is associated with persistent states of distress and lack of responsiveness to external events (Joiner & Rudd, 2000), efforts to change this process are likely to involve more time and effort from a therapist than a maximum number of five-plus-two booster sessions, including reading a treatment manual (Tyrer *et al.* 2003*a, b*). Although the active treatment MACT was intended to combine bibliotherapy and treatment sessions of cognitive-behavioural therapy, more than one third (38%,  $n=90$ ) attended no treatment sessions, and their treatment involved the treatment booklet alone, while an additional five patients had no record of receiving the booklet. The authors compared repetition rates of the non-attenders with those who received a minimum of one session of therapy. This would probably underestimate the effect of the therapy sessions. Therefore, it would have been worthwhile if the authors had compared the repetition rates of those who attended a maximum of only two therapy sessions with those who attended three or more sessions.

The treatment rationale behind the use of a 70-page self-help manual for DSH patients with repeated episodes is questionable given that this patient population's problem-solving approach has been associated with passivity and an inability to actively solve problems (McAuliffe *et al.* 2002), which has also been underlined by Hawton & Sinclair (2003). Pollock & Williams (2001) further demonstrated that DSH patients who were more over-general in memory, have difficulties in remembering and analysing specific situations, making them less able to perform manual-based self-assessments.

From our experience with ongoing randomized treatment trials including cognitive behavioural interventions, a consistent observation is

that DSH patients are not likely to be compliant in reading a manual individually and they have great difficulty in independently carrying out exercises aimed at changing their negative cognitions and associated emotions and behaviours.

The authors correctly state that in some centres treatment as usual (TAU) might have been of value, and thereby might have reduced the effects seen in the trial. The therapy on offer as TAU differed by centre but there were no statistically significant differences in the estimated effect of MACT when examined by centre. This rules out the type of TAU therapy as the reason for the lack of a significant reduction in repetition. However, as the authors state, 'in many cases the amount of therapeutic time given in TAU exceeded that of MACT considerably' (Tyrer *et al.* 2003a, p. 974), which is not surprising given that 38% in the experimental group received no therapeutic time at all. It also suggests that TAU achieved better uptake of therapy and better retention of patients in therapy. Such aspects of treatment should have been systematically recorded. If this was done, a comparison of the therapy duration in both arms of the study should have been provided. Furthermore, and possibly as a secondary analysis, the treatment effect of MACT could have been adjusted for treatment duration. This more equitable assessment of effect may have led to a positive finding.

Although we agree with Byford and colleagues (2003) that cost-effectiveness is an important issue in relation to the management of suicidal behaviour, in particular the costs involved in the treatment of patients who engage in repeated DSH, a cost-effectiveness analysis seems to be premature until all possible explanations for the lack of a significant positive treatment effect have been explored.

## DECLARATION OF INTEREST

None.

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The Authors reply:

Dr Arensman and her colleagues raise several issues about our paper (Tyrer *et al.* 2003a) that can be summarized under four headings:

- (a) the appropriateness of a brief intervention for a population with complex problems;
- (b) the value of bibliotherapy;

(c) the value of individual elements of treatment as usual (TAU);

(d) the relevance of cost effectiveness.

Dr Arensman and colleagues question the appropriateness of testing a brief CBT intervention in DSH repeaters, many of whom also had personality disorder. With the wisdom of hindsight we agree that a longer intervention delivered by more highly trained therapists might have been more efficacious in reducing rates of repetition. However, we wanted to develop and test an intervention that might have broad applicability to A&E settings across the UK. Moreover, in our pilot study conducted in a very high-risk sample of DSH repeaters with borderline personality disturbance and with a previous episode within the past year, brief manual-assisted cognitive therapy (MACT) was effective (Evans *et al.* 1999). Lastly, by targeting a group that was liable to repeat at some stage we were more likely to have a sample that was sufficiently large to test the main hypothesis; that the proportion repeating self-harm over a one-year period would be less in those treated with MACT. This approach is consistent with initially targeting public health preventive strategies at those of higher risk (Rose, 1993).

Dr Arensman and colleagues also question the rationale behind the inclusion of a patient workbook in our intervention. Most cognitive behavioural interventions use patient worksheets on a regular basis, for within or between session use. We went beyond this and wrote a patient manual which contains case stories and worksheets, precisely because we were aware that DSH patients have impairments in interpersonal problem-solving based on their difficulties in generating specific autobiographical memories. The workbook was to be used collaboratively during and between sessions. The idea was that the case examples and written exercises would foster the development of more specific memories and of problem solving, which could be added to over time and which, importantly, the patient could keep for reference beyond the end of therapy. Our intention was that the patient manual would be integrated into therapy and that it would help therapists focus therapy on relevant areas. The 'bibliotherapy' component of the study was not examined specifically in the project as the MACT intervention consisted of the booklet together with face-to-face

cognitive-behaviour therapy. In retrospect, it would have been desirable to assess whether the degree of usage of the manual and/or the completion of therapeutic worksheets predicted outcome. In our previous study (Evans *et al.* 1999) the bibliotherapy element was judged to be of value by users and the booklet has been embraced with enthusiasm by many other investigators in the field. It has now been developed into book form (Schmidt & Davidson, 2004) and there is no evidence that its effects run counter to those of active face-to-face therapy.

Of more relevance is the competence of the therapists in administering the cognitive behaviour treatment. The POPMACT study reflected ordinary practice so treatment was given by NHS clinicians as part of their routine work. Our therapists were not expert CBT therapists, and only received brief training in MACT. Lengthier training or more specialist CBT practitioners might have produced different results. Comparison of those who were judged competent at giving treatment on the basis of randomly selected, blind taped assessments, showed that competent therapists had a better symptomatic outcome than less competent ones (although this did not extend to the proportion who repeated self-harm) (Davidson *et al.* in press).

The treatment as usual (TAU) in the centres involved in the study reflected variation that occurs nationally and these differences were identified at the beginning of the trial (Tyrer *et al.* 2003*b*). In the absence of clear evidence of efficacy for any specific treatment each service tends to adopt different approaches to the treatment of self-harm. However, most of the TAU interventions in the study were psychosocial in nature (mainly problem-solving approaches) and recent reviews have shown that these are efficacious (e.g. Hawton *et al.* 1998).

It is important to emphasize that the POPMACT trial was a large pragmatic trial with a single primary outcome planned in advance. Pragmatic trials should reflect actual practice as much as possible and so we tried to emulate this in our design. Apart from excluding those who had self-harmed for the first time we tried to include most of those who present commonly with self-harm, recognizing that many have co-morbid conditions. There were some secondary issues, such as the frequency of self-harm

and relationship between self-harm, specific personality abnormality and cost, which showed differences between MACT and TAU (Tyrer *et al.* 2004) but these were not linked to the main hypothesis. Clearly there could have been ways of maximizing uptake of MACT (e.g. by going to see patients at their homes if they failed to keep appointments) but these would have deviated from the pragmatic approach in reflecting what was feasible in ordinary clinical practice.

It is the pragmatic nature of this trial that also made it an ideal candidate for assessment of cost-effectiveness. Economic evaluations are best conducted within well-designed, pragmatic trials comparing a new treatment with the existing treatment that it is most likely to replace (Drummond, 1994). The POPMACT trial fulfilled all of these criteria and, in addition, benefited from pilot study evidence suggesting that MACT was both more effective and less costly for this patient group. Thus we cannot agree that a cost-effectiveness analysis was premature.

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