Specific psychological treatment versus treatment as usual in adolescents with self-harm: systematic review and meta-analysis

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CRD summary

This review concluded that there was no evidence that specific psychological treatments were superior to treatment as usual in improving engagement with therapy in young people who have self harmed. Due to concerns with the dichotomisation of the data and clinical heterogeneity between studies it is not clear how reliable this conclusion is.

Authors' objectives

To investigate whether offering specific psychological treatment to adolescents who have self harmed results in better engagement with therapy than offering treatment as usual.

Searching

PsycINFO, EMBASE and PubMed were searched up to December 2009. References of identified studies were checked as were those of cited articles. Experts were contacted in order to identify unpublished studies. No language restrictions were applied. Some search terms were reported.

Study selection

Randomised controlled trials (RCTs) that compared a specific psychological treatment to treatment as usual in adolescent patients (aged up to 18) who have self harmed at least once were eligible for inclusion. Studies were required to evaluate participant engagement with therapy; engagement was defined as attending at least four sessions of a psychotherapeutic intervention. Specific psychological treatments were defined as theoretically coherent non-pharmacological interventions which were replicable. Self-harm was defined as self-poisoning or self-injury irrespective of intent. Studies in which adolescents with self-harm were a minority were excluded as were studies which contained any type of pharmacological intervention.

A range of specific psychological treatments were included; these utilised different therapeutic approaches, such as cognitive, behavioural and psychodynamic methods. Delivery of interventions was group-based, individual or family-based. Maximum and minimum age range of participants was 12 to 18 years, where reported. Participants included teenagers who had attempted suicide, self-poisoned or repeatedly self-harmed and those diagnosed with a borderline personality disorder.

Two reviewers independently assessed the studies for inclusion.

Assessment of study quality

The studies were given a score for allocation concealment of between one (adequate) and three (inadequate). The Jadad score which awards up to five points for the criteria of randomisation, blinding and treatment of withdrawals and drop-outs was also calculated.

The authors did not state how many reviewers performed the validity assessment.

Data extraction

Data were extracted on the mean number of sessions attended. These data were dichotomised to calculate the number attending at least four treatment sessions and the number attending fewer than four sessions and used to calculate risk ratios (RR) with 95% confidence intervals (CI).

The authors did not state how many reviewers performed the data extraction.

Methods of synthesis

Pooled risk ratios with 95% confidence intervals were calculated for engagement using a DerSimonian and Laird random-effects model. Heterogeneity was assessed using I^2.

Results of the review

Seven RCTs were included in the review (787 participants), six of which were included in the meta-analysis (498 participants). Sample sizes ranged from 39 to 289. Study quality was variable; four studies had adequate allocation concealment but it was unclear in three. The six studies included in the meta-analysis all had Jadad score of three points; the remaining trial scored two. Follow-up ranged from three to 24 months.

There was no statistically significant difference in the number of participants who attended at least four sessions between specific psychological treatments (72.3%) and treatment as usual (56.7%). The pooled risk ratio for non-attendance at four sessions was 0.71 (95% CI 0.49 to 1.05) in favour of specific psychological therapies. There was substantial heterogeneity between studies (I^2=50%). The only study to show a statistically significant benefit of the specific psychological intervention was one employing a home-based family therapy delivered by social workers; all except one of the other studies showed a non-significant benefit of specific psychological therapy.

Authors' conclusions

There was no available evidence that specific psychological treatments were superior to treatment as usual in improving engagement with therapy in young people who have self harmed.

CRD commentary

The review question and inclusion criteria were clear and the search was adequate. The authors reported using methods designed to reduce reviewer error and bias for the selection of studies but not at other stages of the review process.

The authors carried out a quality assessment of included studies, but the use of summary scores without information on individual aspects of study design was not the most informative way to present assessment results. The authors accepted that the cut-off point selected to dichotomise engagement and non-engagement with therapy was arbitrary. The pooled effect size calculated was sensitive to the cut-off selected and this should be considered. The considerable clinical heterogeneity between the interventions included should also be considered; this was reflected in statistical heterogeneity and reduced the information value of the pooled estimate.

Therefore, the reliability of the authors' conclusions is unclear.

Implications of the review for practice and research

Practice: The authors stated that offering treatment at home might improve engagement with therapy. Tackling service and family barriers to treatment and using the first contact with young people therapeutically may also help.

Research: The authors stated that future research could focus on developing interventions that take a range of factors influencing engagement into account.

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