

Correspondence

EDITED BY LOUISE HOWARD

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Crisis telephone consultation for deliberate self-harm patients

With reference to Evans *et al* (1999), it is not clear from the paper whether the 'green card' treatment group really received a different treatment from the control group. Did the control group receive advice concerning methods of accessing mental health services in the future (e.g. the general practitioner, crisis centre, ward, community psychiatric nurses, Samaritans)? This is particularly relevant as approximately 50% of each group were referred on to mental health services. This would have negated the effect of the green card as a valid different treatment intervention.

It would be helpful to know how many patients used the telephone support service after having been given the green card. It is possible that a poor telephone support service could have caused the apparent lack of positive outcome in the study. One wonders about the availability of on-call psychiatric trainees and their level of expertise in giving telephone counselling; additional information about this in the paper would have been appreciated.

The patients who had a history of repeated deliberate self-harm, probably represent a more vulnerable group, as stated in the paper, but they may also be a group who habitually use deliberate self-harm as a method of communication. Therefore, paying increased attention (in the form of the green card) to this dysfunctional behaviour may have exacerbated the behaviour.

Evans, M. O., Morgan, H. G., Hayward, A., *et al* (1999) Crisis telephone consultation for deliberate self-harm patients: effects on repetition. *British Journal of Psychiatry*, 175, 23–27.

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Author's reply: I wish to clarify some of the points raised by Dr Darely. First, it is

important to remember that both groups in our study received 'treatment as usual', while those subjects randomised to receive a green card also had the facility to access emergency telephone consultation. We know from our data that there were no significant differences between groups with respect to their management following deliberate self-harm (DSH) assessment, and it is important to remember that the management plan was presented to patients before randomisation to avoid any subsequent bias in the treatment offered. We did not document other advice given over and above the main management plan but this is likely in both groups to have included advice to consult with the patient's general practitioner or psychiatric keyworker (if applicable).

Details of how the telephone support system was used, together with its effects on patients' uptake of other routine medical and psychiatric services, are soon to be published in a separate paper (further details available upon request). Speculation about why the green card appears to have a detrimental effect in DSH patients with a previous history of self-harm and a positive effect in 'first-timers' must remain tentative as these were secondary subgroup findings. Further research, in the form of a large multicentre trial, is needed to clarify the effects of the green card on patients presenting with DSH for the first time.

The mechanisms for such effects of the green card are even more speculative at this stage. For first-timers (only a minority of whom will use the card) it is not clear whether knowledge that the card is there to be used should a crisis ensue (the 'safety net' hypothesis) is the most important ingredient or whether the consultation itself makes the difference. Further qualitative work in this area utilising patient interviews would be welcome. For some patients with a history of repeated DSH, it could be suggested that the green card may heighten their experience of gratification resulting

from a use of self-harm as an albeit distorted form of communication. Another hypothesis might be that a brief, focused telephone consultation from a psychiatrist in training is not containing enough and actually increases self-harming behaviour in such individuals. It seems unlikely that this apparent paradox will be explored further in view of ethical considerations when proposing research methodology. However, it may well be a pertinent issue given the projected prominence of 'NHS Direct'.

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Suicide attempts v. deliberate self-harm: a response

Ogundipe (1999), citing Hawton *et al* (1997), states that deliberate self-harm is more common in females than males, although the difference is narrowing. In reply, Isometsä & Lönnqvist (1999) write that Finland is the only country in Europe where males seem to have a slightly higher incidence of parasuicide than females. In Ireland, the National Suicide Research Foundation monitors hospital-treated parasuicide in one-quarter of the country. Forty-seven per cent of those treated are male and the male : female ratio is even closer to parity in urban areas. It is somewhat surprising to find that the Irish situation corresponds more closely to that in Finland as opposed to our British neighbours.

Both the Irish and Finnish data originate from centres of the WHO/EURO Multicentre Study of Parasuicide. The following standardised definition of parasuicide is utilised in all centres participating in this study. "An act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage and which is aimed at realising changes which the subject desired via the actual or expected physical consequences" (Kerkhof *et al*, 1994). It is noteworthy that suicidal intent is not referred to in this definition. However, Isometsä & Lönnqvist indicated that some degree of suicidal intent was required in their study. It is possible for Finnish males to have a slightly higher incidence of parasuicide, as defined by the WHO/EURO Study, and