

This letter (doi: 10.1176/appi.ajp.2010.10101501) was accepted for publication in December 2010.

Response to Aubin et al. Letter

TO THE EDITOR: We are grateful to Dr. Aubin et al. for their comments. As with altitude, smoking also appears to be a risk factor for suicide, possibly by decreasing the availability of oxygen. In the United States, there is a negative correlation between altitude and smoking rates at the state level ($r=-0.36$, $p=0.01$). This relationship was assessed using state-level smoking data in the United States from the Indiana Tobacco Prevention and Cessation project (<http://www.tobaccofree-delawarecounty.org/documents/Smokingratesbystate2006.pdf>) and altitude data from U.S. Geological Survey data, as in our published paper. This association suggests that the relative hypoxia associated with altitude may be a deterrent to smoking. However, other conditions that have been linked to hypoxemia or hypoxia, such as sleep apnea, air pollution, and asthma, have also been reported to increase the risk for suicide. Further research will be needed to clarify the role that metabolic stress plays in rates of self-harm in vulnerable populations.

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Meta-Cognitive Therapy Without Metacognition: A Case of ADHD

TO THE EDITOR: In the August 2010 issue of the *Journal*, Mary V. Solanto, Ph.D., et al. (1) reported promising treatment effects for meta-cognitive therapy on adult attention deficit hyperactivity disorder (ADHD). This treatment combined traditional cognitive-behavioral therapy (CBT) with time management and organization skills training and warrants further evaluation. However, it is important to raise questions concerning the true nature of this treatment and its labeling as a meta-cognitive intervention.

The treatment does not directly attempt to modify meta-cognition, defined as thoughts or beliefs about cognition and the strategies used to control attention and thinking. It is therefore misleading to refer to this treatment as "meta-cognitive therapy."

Solanto and colleagues' approach was grounded in the cognitive rather than the meta-cognitive domain. This is because it consisted of enabling participants to break down tasks into manageable chunks (a cognitive skill) and to visualize long-term reward along with CBT for depressive and anxious thoughts (manipulating cognitive content).

A meta-cognitive approach to training executive control or attention skills would look very different. Meta-cognitive therapy for ADHD would challenge beliefs about attention, worry, and rumination and train individuals to disengage task-interfering cognitions and resist distraction. Attention skills might be directly facilitated by exercises in the flexible

control of attention by methods such as the attention training technique (2).

In contrast, Solanto et al. (1) modify the content of cognition (e.g., challenge negative thoughts and help individuals break tasks down). Although useful, cognition-focused interventions do not examine and directly change the metacognitions that control thinking and give rise to unhelpful patterns of attention. Some evidence exists that cognitive interventions do change metacognition (3), but they do not do this directly or optimally.

Why does any of this matter? Because there is well-defined meta-cognitive therapy (4–5) for psychological disorders that operates directly on metacognition. It has taken many years for the distinction between CBT and meta-cognitive therapy to be realized (6), and the mislabeling of treatments is a regressive step.

References

1. Solanto MV, Marks DJ, Wasserstein J, Mitchell K, Abikoff H, Alvir JM, Kofman MD: Efficacy of meta-cognitive therapy for adult ADHD. *Am J Psychiatry* 2010; 167:958–968
2. Wells A: Panic disorder in association with relaxation-induced anxiety: an attentional training approach to treatment. *Behaviour Therapy* 1990; 21:273–280
3. Solem S, Haland AT, Vogel PA, Hansen B, Wells A: Change in metacognitions predicts outcome in obsessive-compulsive disorder patients undergoing treatment with exposure and response prevention. *Behav Res Ther* 2010; 47:301–307
4. Wells A: Meta-cognition and worry: a cognitive model of generalized anxiety disorder. *Behav Cogn Psychother* 1995; 23:310–320
5. Wells A: *Metacognitive Therapy for Anxiety and Depression*. New York, Guilford, 2009
6. Fisher P, Wells A: *Metacognitive Therapy: Distinctive Features*. Hove, UK, Routledge, 2009

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Response to Wells and Fisher Letter

TO THE EDITOR: When we named our approach "meta-cognitive therapy" we were referring to the fact that our treatment aimed to help adults with ADHD develop a set of overarching or "meta" skills to guide their behavior with respect to time-management, organization, and planning (1, 2). These skills include cognitive and behavioral strategies to foster awareness of and appropriate allocation of time, initiate and sustain motivated behavior toward short- and long-term goals, and organize the physical environment so as to facilitate these objectives. The choice of this term was in keeping with a related "meta-awareness" approach to the treatment of ADHD, termed metacognitive remediation, previously used in the literature by one of the co-investigators in our group (3). We did not mean to imply that our treatment was related to the metacognitive therapy developed by Adrian Wells. We have since deleted this term from the descriptions of our work and from the title of our forthcoming treatment manual for

therapists, which will be published as *Cognitive-Behavioral Treatment for Adults With ADHD: Targeting Executive Dysfunction* by Guilford.

References

1. Solanto MV, Marks DJ, Mitchell K, Wasserstein J, Kofman MD: Development of a new psychosocial treatment for adults with AD/HD. *J Atten Disord* 2008; 11:728–736
2. Solanto MV, Marks DJ, Wasserstein J, Mitchell K, Abikoff H, Alvir MJ, Kofman MD: Efficacy of meta-cognitive therapy for adult ADHD. *Am J Psychiatry* 2010; 167:958–968
3. Wasserstein J, Lynn A: Metacognitive remediation in adult ADHD: treating executive function deficits via executive functions. *Ann N Y Acad Sci* 2001; 931:376–384

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Study Limitations in Report of Suicidal Behavior Among Women With Co-occurring PTSD and Borderline Personality Disorder

TO THE EDITOR: In the October 2010 issue of the *Journal*, Melanie S. Harned, Ph.D., et al. (1) reported on an important study examining the relationship between posttraumatic stress disorder (PTSD) and borderline personality disorder. This is an important area of inquiry, and the authors have done an admirable job in comprehensively assessing their sample. However, the study has several limitations, and the conclusions are not consistent with recent studies that were not cited.

As stated by Harned et al. (1) themselves, we want to underscore the fact that the small size and select nature of their study (94 women) make it difficult to draw conclusions. They conducted numerous comparisons across variables without any adjustment for multiple comparisons. Furthermore, they have not cited recent large epidemiologic studies examining the association between PTSD, borderline personality disorder, and suicide attempts (2–4).

Harned and colleagues' conclusion that frequency, intent, and lethality of suicide attempts are the same for individuals with borderline personality disorder with and without PTSD is inconsistent with recent work. Cogle et al. (2), using the U.S. National Comorbidity Survey Replication data (N=5,692), demonstrated that PTSD is associated with suicide attempts, even after adjusting for the effects of borderline personality disorder. We extended these findings using the National Epidemiologic Survey on Alcohol and Related Conditions (N=34,653), by showing that PTSD is associated with suicide attempts after adjustment for all sociodemographic factors and axis I disorders (3). Pagura et al. (4) were the first to examine comorbidity of PTSD and borderline personality disorder in a large nationally representative sample by comparing individuals with PTSD alone (N=1,820), borderline personality disorder alone (N=1,290), and comorbid PTSD and borderline personality disorder (N=643). This study found that individu-

als with comorbid PTSD and borderline personality disorder had greater odds of lifetime suicide attempt compared to individuals with either condition alone (4).

We have shown that individuals with co-occurring PTSD and borderline personality disorder have higher odds of having a suicide attempt than either disorder alone (3, 4). These findings are in contrast to the findings of Harned and colleagues' study (1). We believe the discrepancy between the epidemiologic studies and the Harned et al. study is due to the differences in sample size. We note that epidemiologic studies cited above are limited by lack of assessment of lethality of suicide attempts, a strength of Harned and colleagues' study. We suggest that future clinical studies need to gather a larger sample and include a comparison group of women with PTSD.

References

1. Harned MS, Rizvi SL, Linehan MM: Impact of co-occurring post-traumatic stress disorder on suicidal women with borderline personality disorder. *Am J Psychiatry* 2010; 167:1210–1217
2. Cogle JR, Keough ME, Riccardi CJ, Sachs-Ericsson N: Anxiety disorders and suicidality in the National Comorbidity Survey-Replication. *J Psychiatr Res* 2009; 43:825–829
3. Nepon J, Belik S, Bolton J, Sareen J: The relationship between anxiety disorders and suicide attempts: findings from the National Epidemiologic Survey on Alcohol and Related Conditions. *Depress Anxiety* 2010; 27:791–798
4. Pagura J, Stein MB, Bolton JM, Cox BJ, Grant B, Sareen J: Comorbidity of borderline personality disorder and posttraumatic stress disorder in the US population. *J Psychiatr Res* 2010; 44:1190–1198

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Response to Nepon et al. Letter

TO THE EDITOR: We appreciate the thoughtful comments made by Dr. Nepon and his colleagues. Our recent study found that borderline personality disorder patients with and without PTSD did not significantly differ in the frequency, intent, and lethality of suicide attempts (1). Nepon et al. point out that this is inconsistent with the results of several recent epidemiologic studies (2–4). These studies, all published since our manuscript was originally submitted and thus not cited in our article, are to be commended for their use of large-scale, nationally representative samples. As Nepon et al. describe, these epidemiologic studies found that PTSD is associated with a greater risk of suicide attempt after controlling for the effects of borderline personality disorder (2, 3) and that individuals with both borderline personality disorder and PTSD had a higher rate of lifetime suicide attempt compared to individuals with either disorder alone (4). Nepon et al. suggest that the discrepant findings between these epidemiologic studies and our study are due to differences in sample size, as our study used a markedly smaller sample.