



The psychosocial management of DSH: Part 2

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Assessment of self-harming patients

Some reasons why people attempt to harm themselves are:

- to gain control over life;
- to reach out to others or to signal that they need help;
- to cope with feeling overwhelmed;
- to release tension or experience emotion;
- a wish to successfully complete suicide;
- a 'cry of pain' rather than a 'cry for help'.

There are potential problems that might influence a doctor's assessment of a self-harming patient including:

- possible intoxication;
- poor therapeutic alliance due to features of the patient, the doctor, the environment, the long wait for assessment, and the antisocial hour of the assessment;
- possible histrionic personality traits (e.g. inappropriately seductive behaviour);
- possible borderline personality traits (recurrent threats or acts of self-harm);
- possible minimising of symptoms to expedite discharge and avoid engagement.

The psychiatrist should also be aware of the possible dynamics affecting the assessment:

- **idealisation**
- **negative transference**
- **negative counter-transference**
- **projective identification**

- **denigration** – where the patient feels let down at the point of discharge;
- **acting out** – where the therapist or patient enacts elements of the patient's internal object relations in order to remove the anxiety and threat that is felt.

Upon initial contact with a patient, the psychiatrist might:

- take the patient to a private room to perform a confidential assessment;
- take as full a history as possible, conduct a mental state examination and risk assessment as recommended by NICE guidelines (NICE 2004);
- be aware of any powerful negative feelings in the counter-transference - malignant alienation is a particular issue in patients with multiple admissions for self-harm (Watts & Morgan 1994);
- offer an evidence-based intervention to reduce repetition of self-harm.

Risk assessment

Factors in a patient's history that suggest a high risk of repeated self-harm are:

- use of alcohol
- poor social support.

Factors that have been shown to predict the risk of self-harm in those with substance misuse disorders are:

- a history of prior acts of self-harm
- severity of addiction
- difficulty in controlling violent behaviour (Tiet 2006).

Recently released prisoners and newly-discharged psychiatric patients have a similar risk of suicide.

- One 2006 study found an eight-fold increase in suicide risk amongst newly-released male prisoners and a 36 times higher risk for females (Pratt et al 2006).
- This approaches the risk seen in patients recently discharged from psychiatric units.
- Explanatory (or confounding factors) in released prisoners include mental illness, poverty, poor housing, unemployment, and fractured family and social networks.

NB: When treating a newly-released prisoner or psychiatric in-patient, it would be good practice to inform the following agencies that the therapy is to take place, with the patient's consent, and to request feedback if there is any evidence of clinical deterioration or of illicit drug use:

- social worker

- drug and alcohol key worker
- general practitioner
- liaison psychiatry team.

Providing an outline of what the therapy involves and what the patient has committed to also helps clarify the boundaries of treatment.

Factors most predictive of outcome

Factors most predictive of outcome are:

- **therapeutic alliance** – a meta-analysis in 2000 has shown that the overall relationship between therapeutic alliance and outcome is moderate, but consistent (Martin et al 2000);
- **therapist competence** (Davidson et al 2004, Shaw et al 1999);
- **patient expectations about the therapeutic modality offered** - this is often hard to extricate from therapeutic alliance because this alliance may develop as a consequence of the patient's optimistic expectations (Meyer et al 2002);
- **personality traits** - these have been shown to predict outcome when patients with non-psychotic major depression are treated with interpersonal psychotherapy but not when they are treated with CBT (Joyce et al 2007);
- **non-specific factors relating to patient, therapist or environment** - these are hard to evaluate and consequently remain theoretical due to the lack of an evidence base. Factors suggested include patient and therapist motivation, and the atmosphere in the department where therapy is delivered.
- **theoretical allegiance of the investigators** - this has also been shown to have an impact on the evaluation of outcomes in psychotherapy research (Luborsky et al 1999).

Manual assisted cognitive-behaviour therapy

Some ways to improve manual-assisted therapies could be:

- regular audit of the department's service resulting in the updating of manuals where indicated;
- ensuring that any manual-based treatments considered for implementation are empirically supported (the basis of evidence-based policy);
- incorporating training in the use of manual-based treatments into the department's academic programme;
- ensuring a system of adequate supervision of trainees;
- devising criteria for combining, sequencing or switching between such therapies according to patient response (Craighead & Craighead 1998).

Dialectical behaviour therapy

Dialectical behaviour therapy (DBT) was introduced and developed by Dr Marsha Linehan, Clinical Psychologist at the University of Washington in Seattle. Her randomised controlled trials evaluated the use of cognitive-behavioural therapy in chronically parasuicidal patients with borderline personality disorder, including those with substance misuse problems (Linehan et al 2001).

DBT is based on a biosocial theory of borderline personality disorder which views early childhood development in an 'invalidating environment' as responsible for difficulties in recognising and regulating emotions.

The components of DBT are:

- individual therapy
- skills training group
- out-of-hours telephone contact
- weekly consultation group for therapists (Palmer 2002).

A DBT team would consist of:

- the individual therapist (who takes responsibility for overseeing the patient's treatment);
- skills trainers (ideally the trainers should not also be a patient's individual therapist but this may not always be feasible);
- a psychiatrist (if medication is needed for treatment of depression, substance misuse problems or brief psychosis);
- other staff, who may be peripherally involved according to characteristics of the patient's behaviour. Therapists are sometimes contacted by A&E staff in the event of any self-harming behaviour but try to encourage the patient to take the lead in advising A&E staff on how best to manage them.

A number of sessions is used to establish commitment to treatment because:

- patients with borderline personality disorder usually have experiences of being let down, both by other people and by ineffective treatments;
- they may have some trepidation about being offered a new treatment and if not adequately prepared may find the process too challenging. In dropping out of treatment they then reinforce their sense of being let down. Several sessions may be used to establish the commitments involved and this applies to both patient and therapist;
- whilst the patient commits to stay in therapy for an agreed period, attend regularly and work on self-harming or therapy-interfering behaviour, the therapist commits to be available as agreed, to maintain confidentiality, and to conduct themselves competently and professionally;

- the patient is reminded of their commitment throughout the therapy in order to re-establish this, particularly at difficult stages.

Stages of DBT

- **Pre-treatment:** this concentrates on assessment, commitment and orientation to therapy.
- **Stage 1:** this explores suicidal behaviours, therapy-interfering behaviours and quality-of-life-interfering behaviours, and looks at the skills needed to resolve these problems.
- **Stage 2:** this explores post-traumatic stress related problems.
- **Stage 3:** this focuses on self-esteem and individual treatment goals.

Problems in implementing DBT services might be:

- unwillingness to fund DBT services due to the comparative expense;
- relative lack of evidence of effectiveness or cost-effectiveness;
- patients often viewed as a marginalised group;
- lack of staff trained in DBT;
- difficulties and expense in accessing DBT training;
- local infrastructure – facilities to provide individual sessions, group sessions and telephone rota;
- real or feared therapist burn-out.

Other interventions

If the patient refuses any follow-up, they can be given an emergency crisis card. If the patient is a first-ever self-harmer there is very weak (non-significant) evidence that 24-hour telephone access to psychiatric help may be associated with a reduction in self-harm for the six months after the episode (Evans et al, 1999).

Other interventions might be:

- psychoanalytic psychotherapy;
- interpersonal psychotherapy;
- group therapy;
- supportive psychotherapy;
- allocation to a CPN;
- out-patient psychiatric review to consider pharmacological management of chronic dysphoria and impulsive aggression;

- partial hospitalisation - a psychoanalytically-orientated treatment offered in conjunction with partial hospitalisation and delivered over 18 months. When evaluated, this resulted in a statistically significant decrease in frequency of suicide attempts and acts of self-harm, the number and duration of in-patient admissions, the use of psychotropic medication, and self-reported measures of depression, anxiety, general symptom distress, interpersonal function, and social adjustment (Bateman & Fonagy 1999, 2001).