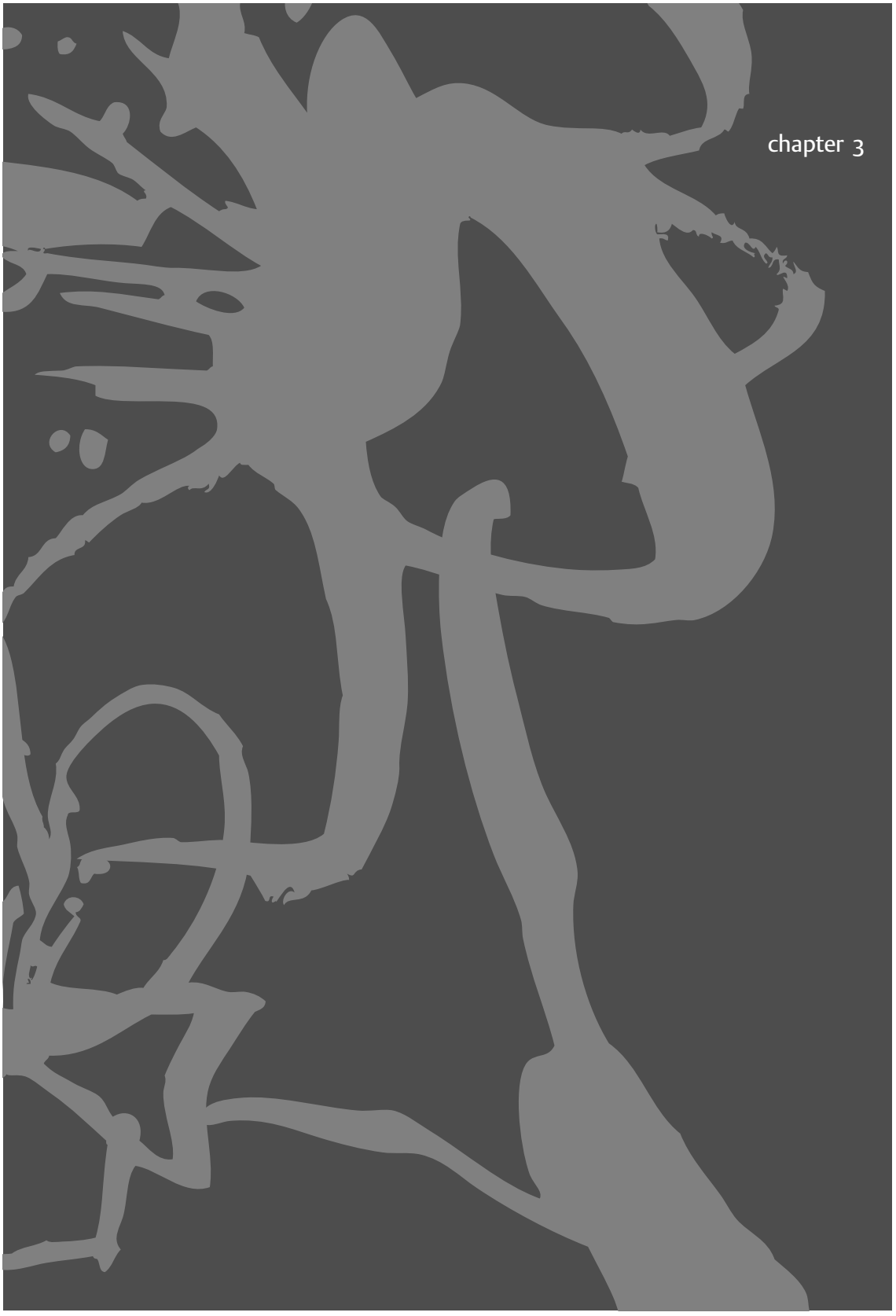
Cognitive-behavioural therapy for deliberate self-harm

Slee, N.


chapter 3

Treatment Protocol for Deliberate Self-Harm in Adolescents and Adults

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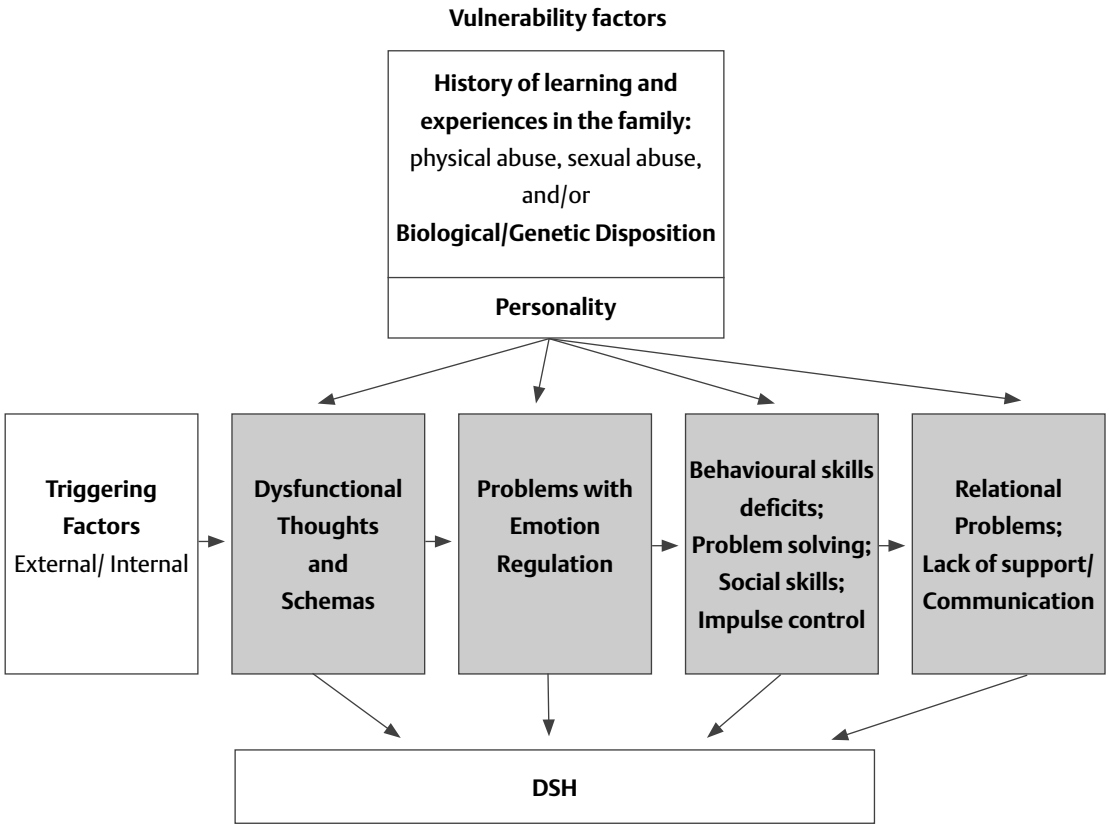
An adaptation of this chapter can be found in "Protocollaire Behandelingen bij Kinderen en Adolescenten" (eds. Caroline Braet en Susan Bögels), 2008, Uitgeverij Boom

Introduction

Deliberate Self-Harm (DSH) involves deliberate injury inflicted by a person upon his or her own body, such as cutting, burning, scratching, head-banging, overdosing and taking toxic substances, regardless of the intention (Hawton, Zahl, & Weatherall, 2003). DSH is a serious clinical and public mental health problem among the younger age groups. Recent Dutch population-based studies show that DSH is reported by 4.3% of 15-20 year olds (de Wilde, 2005), by 2.6% of 18-24 year olds and by 2.9% of 25-34 year olds (Ten Have et al., 2006). These findings are similar to those of other western countries (Hawton & Van Heeringen, 2000; Skegg, 2005). However, DSH is not only a prevalent problem, repetition is also common (Hultén et al., 2004; Cedereke & Öjehagen, 2005; Kapur et al., 2005) and can occur quickly (Kapur et al., 2006). If no help is sought, DSH may increase in severity. Moreover, DSH is a strong indicator for suicide. The risk for suicide is at its highest during the first six months after an episode of DSH (Cooper et al., 2005), and suicide remains a significant risk for decades especially if the psychiatric and psychosocial problems of adolescents continue into adulthood (Harrington et al., 2005). As far as the severity and complexity of DSH is concerned, it is of great importance that therapists are capable of offering DSH patients appropriate treatment. This treatment protocol for DSH is intended to assist with this.

Research shows that DSH is often done on impulse (Rodham, Evans, & Hawton, 2004). It may be a reaction to an argument with parents, the end of a relationship, or problems at school or work (Miller, Rathus, & Linehan, 2007). In many cases DSH appears in the context of symptoms of depression, anxiety and behavioural problems (Burgess, Hawton, & Lovday, 1998; Kerfoot et al., 1996). Moreover, patients who harm themselves have frequently experienced traumatic events such as sexual abuse and physical maltreatment within the family (Evans, Hawton, & Rodham, 2005). Based on knowledge of psychological and psychosocial risk factors (see figure 1), we have developed a theoretical model, which describes the development and maintenance of DSH. It is a so called vulnerability-stress model. The model shows that the risk of DSH increases when a person with a specific vulnerability (e.g., a history of traumatic experiences and or biological traits) is subjected to stress. This could, for example, be an argument with a boyfriend or a girlfriend (an external trigger). The more often someone harms him or herself, the less the behaviour is linked to external events and the easier his/her own thoughts can become triggers of DSH (e.g., 'No one cares about me'). The model suggests that DSH is maintained through four aspects: dysfunctional thoughts, problems with emotion regulation, behavioural skills deficits and relational problems. These four aspects form the basis for change in DSH in the treatment protocol.

Figure 1. *Theoretical model of DSH*



2 What is known about the treatment of DSH and suicidal behaviour?

The treatment protocol for DSH combines elements from Cognitive Behaviour Therapy (CBT; Rudd, Joiner, & Rajab, 2001), Dialectical Behaviour Therapy (DBT; Linehan, 1993) and problem solving therapies (Nezu, Nezu, & Perri, 1989), since evidence for effectiveness of these treatments for DSH and suicidal behaviour is accumulating (Hawton et al., 1998). CBT reduces the tendency for suicide attempts much more so than regular treatments as is indicated by a recent randomized controlled trial (Randomized Controlled Trial: RCT) (Brown et al., 2005). DBT has also been studied in RCTs and these show that DBT has a visible effect on DSH (Linehan et al., 2006). The treatment has been adapted for adolescents, and the initial results are positive (Miller et al., 2007). In addition, problem solving therapies seem to have a positive effect on DSH and suicidal behaviour (Comtois & Linehan, 2006). Furthermore, the effectiveness of the treatment protocol for DSH has been evaluated in a RCT among adolescents and adults with DSH. After the treatment for DSH, adolescents and adults reported not only a reduction in DSH, but also a reduction in symptoms of depression, anxiety and suicidal thoughts. Moreover, they felt more confident and they were better able to cope with daily problems (Slee, Garnefski, van der Leeden, Arensman, & Spinhoven, 2008; see Chapter 4). These results confirm that DSH can be influenced by changes in dysfunctional thoughts, emotion regulation difficulties, behavioural skills deficits and relational problems.

3 Whom is the treatment intended for?

The treatment is intended for adolescents and adults who engage in DSH. The treatment is appropriate for people who seek help after an initial episode of DSH as well as for those who have been suffering from this behaviour for a longer period of time. The treatment is also applicable to people with varying diagnoses according to the DSM-IV, such as depression or borderline personality disorder. The target group comprises 15 to 35 year olds. The treatment is not suitable for people with serious cognitive limitations (an IQ score <70). When DSH is the result of psychotic experiences or is associated with drug and alcohol abuse, the treatment is not appropriate and specific treatments for these problems are recommended.

4 How does the treatment work?

The therapist explains the treatment by using an example of the patient's daily life.

Therapist: If you harm yourself it is important to get help, because it is very difficult to get better on your own. In order to get an idea of how the treatment works, we can look at the example which you just talked about of a difficult situation last weekend. What exactly happened?

Christy (17): When I went to my parents' home last weekend, my father, mother and sister

were washing the car. Total chaos entered my head and I didn't know anymore what to do. I cut myself with a kitchen knife to stop the chaos. I don't understand myself, because there really wasn't anything going on that was a problem.
Therapist: In order to gain an insight into the chaos it can be very helpful to look closely at what was happening, what you were thinking, what you were feeling, what you were doing and how your parents and sister reacted. Do you remember what you were thinking when you arrived and saw your parents and sister washing the car?
Christy: My sister still lives at home and I just came by and then I wound up hanging around.
Therapist: What did you feel then?
Christy: Lonely, sad, and also tense; it just started to get worse. Thoughts raced through my head - total chaos.
Therapist: Do you remember what you were thinking?
Christy: My parents don't care about me. Nobody cares about me...Nobody cares...I felt so sad and lonely...
Therapist: Yes, the more negative thoughts you have, the lonelier, sadder and more tense you will start to feel. See how your thoughts and feelings amplify one another?
Christy: It feels good to talk about this, because I find it really strange and scary, as if cutting just happens for no reason at all.
Therapist: The feeling of chaos does not just appear from nowhere. Nor does the cutting. When you start to become aware of your thoughts, feelings and behaviour in difficult situations, you can gradually learn how to stop the cutting behaviour. This is the main objective of the treatment. During the treatment you will learn to recognize negative thoughts and how to challenge them. You will learn to bear and accept negative feelings. You will also learn how to deal with problems and gain self confidence.

5 The treatment protocol for DSH

This chapter describes a time limited CBT (12 sessions of 45 minutes) for DSH. The treatment consists of three phases. During the early phase (sessions 1 and 2) the significance of DSH is discussed, goals are set and the therapist and patient come to a set of agreements. During the middle phase of the treatment (sessions 3 through 10), the focus will be on cognitive, emotional, behavioural and relational problems which maintain DSH. Session 3 and 4 form the basis for session 5 through 10. During the last phase of the treatment (sessions 11 and 12) the focus is on relapse prevention.

5.1 Early phase of the treatment (sessions 1 and 2)

Structure of sessions 1 and 2

- The significance of DSH; asking about important details of the most recent Episode(s), mental health, social circumstances, future
- Giving an explanation of the treatment
- Making practical agreements
- Formulating goals
- Making a help chart
- Filling in the agreements on the chart

5.1.1 The significance of DSH

During the first phase of the treatment, it is the therapist's task to come to a shared understanding of what DSH means experientially. The therapist invites the patient to talk about the last episode of DSH. This enhances the patient's insight as well as giving him/her the feeling that he/she is being heard. An additional advantage of the information given by the patient is that this is an initial indicator for the functional analysis of DSH. A functional analysis describes how DSH is maintained. The questioning of antecedents and consequences of self-harm gives insight into the function of the behaviour, for example, the rejection by a boyfriend (antecedent) and the extra attention of the parents which follows DSH (consequence which reinforces the behaviour). In order to gain insight into DSH, the therapist will ask about: *The significant details of the most recent episode* (or the episode which is best remembered): (1) events preceding DSH, (2) circumstances (if the patient was alone, if others were aware of it), (3) motives and intent, especially suicidal intent, (4) thoughts and emotion which preceded DSH (5) lethality of the chosen method (and the attitude the patient exhibits), (6) thoughts and emotions that followed DSH (7) reactions of others toward DSH and (8) other consequences (for example medical care of the injuries or a hospital admittance) The *mental health* of the patient: (1) earlier episodes of DSH or suicidal behaviour, (2) psychiatric diagnoses, (3) personality problems, (4) substance abuse, and (5) psychosocial problems. S*ocial circumstances*: (1) lifestyle conditions, (2) support from family, friends, partner and other important persons and (3) coping strategies. *The future*: (1) how the patient perceives help, (2) inventory of thoughts of hopelessness, (3) the risk of repetition of DSH. The therapist needs to take into account any earlier treatments as well as treatment successes and treatment failures. In addition, it is important to get familiar with the life history of the patient. The therapist develops a

holistic theory, which describes how earlier experiences of, for example, sexual abuse or being bullied at school, have contributed to dysfunctional cognitions, emotion regulation difficulties, behavioural skills deficits and relational problems which the patient exhibits. In addition to the patient, the partner and family are also an important source of information. The functional analysis is not limited to the first session, but can be expanded with information obtained in later sessions. The therapist asks Amy (24) what DSH means to her. *'I am usually busy with work and sports. When I am not busy, I start to think about things that happened in the past. I can't stop these thoughts. They only stop when I start to cut myself. That brings relief. The cutting hurts, but the tension before the cutting is worse. Just like long ago when my mother would hit me; the moments before the hitting were the worst. I would be relieved once it was over...'*

5.1.2 Explanation of administering treatment and making practical agreements

During the first session the therapist explains the treatment; how thoughts, feelings, behaviour and reactions of others are coherent and maintain DSH. The therapists also discusses the practical points pertaining to the sessions; the duration and frequency of the sessions and the availability of the therapist outside the sessions. Finally, the therapist asks the patient to acquire a nice book with blank pages or a notebook and to take this along to session 3.

5.1.3 Formulating goals

On basis of the functional analysis and holistic theory, the therapist and the patient formulate treatment goals. The goals pertain to the factors that maintain DSH: dysfunctional cognitions, emotion regulation difficulties, behavioural skills deficits and relational problems. The more precise treatment goals are formulated, the more effective treatment likely is. Moreover, it is important that treatment goals are realistic. *Amy (24), discussed previously, appears to avoid experiencing emotions by cutting herself or staying busy. The therapist is of the opinion that Amy can benefit from expanding her emotion regulation skills. During the sessions she can learn to experience her feelings of tension in a safe manner, and outside the sessions she can in the first instance benefit from activities which offer her solace. Processing the earlier traumatic life events does not fit within the short term treatment, but could be a subject for follow up treatment. Amy, together with her therapist, formulates the following goals: She wants to reduce stress and learn alternatives to take the place of cutting herself.*

5.1.4 Making a help chart

In addition to these goals, the therapist and Amy formulate concrete steps for Amy to take, if she starts to feel tense. These steps are written down on a card, the so called help chart.

Amy's help chart

When I feel tense, I will choose one or more of the following:

1 *Play music*

2 *Take a shower*

3 *Call my friend Susan*

The chart can be extended after a while and if needed adjusted. In case the urge to self harm becomes very strong, it helps to select activities which do not enable DSH to take place. Some examples include going for a walk or visiting someone.

5.1.5 Filling in the agreement card

During session 2, the therapist introduces the so called agreement card, which describes the responsibility of the patient during the therapy, such as presence and participation during the sessions and use of the help chart. The responsibilities of the therapist are also listed on the card, such as the therapist's availability and input. Since responsibilities on both sides have been made explicit, ambivalent feelings about use of the help chart can be discussed immediately. However, the tendency to DSH can never be forbidden, since the therapy is intended to address that. Patients also do not have to promise that they will not harm themselves anymore. In this manner, the agreement card differs from a treatment contract which forbids DSH. It is preferred to use such an agreement card rather than a treatment contract, since the card emphasizes desired behaviour rather than undesired behaviour (Rudd et al., 2001). If patients do not use the help chart, the therapist will discuss this: 'What stops you from using the chart? What does it mean to you that you don't use the chart? What needs to change in order for you to use this chart?' It may be necessary in the beginning of the treatment to adjust the chart. It could be that the functional analysis was not complete and that some essentials were left out. Moreover, during the introduction of the help chart, an explanation is given what will happen if the

patient does not make use of the chart. If necessary, a discussion will take place to see if the offered form of help is appropriate or if it would be better to discontinue treatment.

The agreement card of Amy is mostly aimed on self-injury, since Amy has no suicidal thoughts or plans. In case of suicidal thoughts or plans, the card can be adjusted.

Amy's agreement card

Amy
I will be present at every session and if I am detained, I will call the therapist.
I will make an effort during the sessions. Outside the sessions I will practice the new skills. If I feel the urge to harm myself, I will use the help chart.

My most important goals:

1 *Practice the alternatives for DSH (using the help chart)*

2 *Reduce tension (using the help chart)*

Date	Signature
.....	.....

Therapist
I promise to give my full effort to help you reach your goals. Outside the sessions you can reach me at XXX-XXXXXXX (during office hours). Outside of office hours, you can contact X at XXX-XXXXXXX.

Date	Signature
.....	.....

5.2 Middle phase of the treatment: sessions 3 and 4

The middle phase of the treatment is directed toward factors that maintain DSH; cognitive problems, emotion regulation difficulties, behavioural skills deficits and relational problems. Sessions 3 and 4 form the basis for sessions 5 through 10.

Structure of sessions 3 and 4

- Evaluating the current mood
- Evaluating the DSH and/or suicidal behaviour during the past week.
- Introducing the diary pertaining to problem situations
- Evaluating the skills, talents and resilience of patient, partner and family

5.2.1 Evaluating the current mood and DSH during the past week

At the beginning of each session, the therapist asks about feelings of sadness, tension and thoughts of DSH and suicide. This systematic approach helps to prevent intense emotions and suicidal thoughts from being missed. If a patient reports suicidal thoughts, it is important to ask about the nature of those thoughts: 'How frequently do you think about it? Have you already made a plan? What prevents you from doing it?' These questions give the therapist insight into the severity of the suicidal tendency and help patients to put their thoughts into order. Moreover, an open conversation breaks open the isolation. Van Heeringen and Kerkhof (2000) and Shea (2002) offer practical suggestions for the evaluation of suicidal tendencies and for taking protective measures.

Once the therapist has asked the patient about current mood and thoughts of DSH and suicidal behaviour, he/she will ask about the number of episodes of DSH and suicidal behaviour during the last week and these will be recorded in detail.

5.2.2 Introducing the diary for problem situations

During session 3, patients are asked to bring a notebook with blank pages in which to write down their problem situations. The therapist explains that during each session they will discuss problem situations, especially situations in which they have harmed themselves or when the urge to do so was very strong. The focus each time will be on the following questions. 'What happened? What were you thinking? What were you feeling? What did you do?' The answers to these questions are then noted down in the diary. This gives insight into cognitive, emotional, behavioural and relational problems which should be addressed. Other important questions are: 'How often does this problem happen? What would the patient want to see changed?'

A question from Lauren's (22) diary:
Event: I call my boyfriend but he doesn't answer.
What I thought: He doesn't care about me anymore. He wants to break up.
What I felt: (intensity 0-100): fear (90), anger (90) and sadness (90)
What I did: I kept calling him every minute for an entire 15 minutes and when he finally answered, I yelled at him.

The diary provides clear insight into Lauren's interpretation of a seemingly neutral event. It also provides an image of the intensity of her feelings and the way in which she deals with the event. After a while the diary reveals themes such as fear of abandonment. The diary can also reveal specific problems with emotion regulation and specific skills deficits. The therapist explains that keeping a diary provides material to practice during and outside sessions.

5.2.3 Skills, talent and resilience

Due to the focus on problems, strengths of the patient, partner and family can easily remain under-exposed. However, they are an important counter-balance for DSH. These strengths could be coping skills, talent, resilience, fun activities and social support.

When Jade (19) is asked about her strengths, she reveals that she can dance well and that she is rather social.

Fun activities can be implemented as part of the therapy.

Initially, Helen (23) is not able to name any activities which she enjoys. As therapy progresses, it appears that she enjoys watching old movies. She will reward her self by watching a movie after coming home from a long day at work.

The partner or parents can encourage patients to partake in fun activities. Joint fun activities can be expanded. These can also be placed on the help chart.

5.3 Middle phase of treatment (continued): sessions 5 through 10

Session 5 through 10 build on session 3 and 4. The structure of sessions 5 through 10 remains the same; evaluating the current mood and DSH and suicidal behaviour, discussing problem situations and evaluating cognitive, emotional, behavioural or relational problems. Once it is clear what the specific problems are and how frequently they surface, therapeutic interventions can be selected which address the specific cognitive, emotional, behavioural or relational problems of the patient.

Structure of sessions 5 through 10
- Evaluating the current mood (see § 5.2.1)
- Evaluating DSH and/or suicidal behaviour during the past week (see § 5.2.1)
- Evaluating actual problem situations (especially those related to DSH/suicidal behaviour) (see § 5.2.2)
- Evaluating the use of the help chart; adjust if needed (see § 5.1.4)
- Patients select the most important problem situation and based on that focus on dysfunctional cognitions, emotion regulation difficulties, behavioural skills deficits and relational problems (see § 5.2.2)
- Select relevant therapeutic technique; interventions with dysfunctional cognitions, emotional problems, behavioural problems or relational problems
- Practice with cognitive problems (dysfunctional thoughts or schemas), emotion regulation difficulties (avoiding emotions or excessive emotion), behavioural problems (lack of skills and self-defeating behaviour) or relational problems (improving communication and expanding social support)
- When needed incur support of partner or parents, especially if problems with the partner or parents seem to maintain DSH

5.3.1 Possible interventions for cognitive problems

Below is a chart of the cognitive interventions therapists can select to target cognitive problems associated with DSH.

Overview of interventions for dysfunctional cognitions and schemas:
- Identifying dysfunctional cognitions and suicidal thoughts
- Recognizing negative thoughts, challenging them and distancing oneself
- Identifying dysfunctional schemas (sessions 8 through 12)
- Creating a behavioural experiment

• *Identifying dysfunctional cognitions and suicidal thoughts*

Patients who harm themselves think more negatively about themselves, others and the world than patients who do not harm themselves (Slee, Garnefski, Spinhoven, & Arensman, 2008). This ranges from mild self criticism ('Feeling sad is a sign of weakness')

to suicidal thoughts ('The world is better off without me'). Suicidal thoughts demand special attention, in particular those thoughts that pertain to being a burden to others ('I am a burden to my family'), thoughts of helplessness ('No one can help me to solve my problems'), thoughts pertaining to being unworthy of love ('I am not worthy of love') and thoughts of not being able to bear painful feelings ('My feelings are unbearable'). These thoughts have in common that they suppress a feeling of hopelessness and they are important triggers for DSH and suicidal behaviour (Rudd et al., 2001; Slee, Garnefski, et al., 2008). During treatment, patients learn how to recognize these thoughts, challenge them and distance themselves from them.

- *Recognizing, challenging and distancing from negative thoughts*

The diary provides insight into the connection between negative thoughts and negative feelings. It also provides an insight into the specific content of the thoughts. A broad spectrum of interventions is available to challenge negative thoughts (see for example Beck, Freeman et al., 1990 and Rudd et al., 2001**)**. A much used intervention is collecting pros and cons of a specific thought. Another technique is to take on a new perspective. This technique is illustrated in the example below.

Grace (17): I have been depressed for a year and it is just getting worse. It is really hard on my parents. Sometimes I think that it would be better for everyone if I were dead.
Therapist: What would you think if your parents were depressed and needed care?
Grace: Well, if they were depressed, I would also want to take care of them.
Therapist: Also?
Grace (smiles): Yes, when I think of it, my parents want to take care of me because they love me.
Therapist: How do you feel when you think like that?
Grace: This thought makes me feel better.

- *Identifying dysfunctional schemas*

By looking more closely at dysfunctional and suicidal thoughts, the underlying dysfunctional schemas become visible. The Socratic dialogue, metaphors, and many other techniques can produce schema change (see for an overview Beck et al., 1990). Below is an example of a technique called 'extreme contradictions'.

Emily (22) refers to herself as 'bad'.
Therapist: I was wondering if you know of anyone who is a good example of 'bad'; someone you know personally or someone you have read about in the newspaper or know about from TV.
Emily: Well murderers, psychopaths, parents who abuse their children, people who abuse animals.

Therapist: If you compare yourself with them, how much badness do you show?
Emily: ...Well, not that much.
Therapist: Is it then correct when you say that you are bad?
Emily: No, not really, I think.

- *Setting up a behavioural experiment*

A different way to challenge negative thoughts is a behavioural experiment.
Jasmine (23) lives in student housing with six others. There is always someone who would like to do something with one or more of the group.
Jasmine: Sometimes I long to be alone for just a little while. I could just scream. I then go to my room to cut myself in order to feel some peace. I know I can't go on like this, but I am afraid to say no if they ask me for something. I am afraid that they will then start to ignore me.
Therapist: How do you know that they will ignore you if you choose to say no for a change?
Jasmine: Well, that's just what I think.
Therapist: How could you find out if this is really true?
Jasmine: I could ask my best friends what they would think if I said 'no'.
Therapist: Wonderful. In order for it to be a real test, it is important that you write down what you think they will say, so that we can compare it with that what your friends are going to say.

5.3.2 Possible interventions with emotional problems

Below is a chart of the emotional interventions therapists can select to target emotional problems associated with DSH.

Overview of interventions for emotional problems:
- Observing emotions
- Breaking through emotional avoidance with experiential exercises
- Breaking through emotional avoidance with mindfulness exercises
- Learning to recognize emotions in a timely manner
- Differentiating and naming emotions
- Regulating intense emotion: diverting and finding solace

- *Enhancing mood toleranceLearning to observe emotions*

Some patients tell their psychotherapist that they do not feel anything anymore. DSH can take on the function to break through the lack of feeling and to regain contact with their bodies.

Julia (16) experiences flat affect to the point that she is unable to indicate what she felt in various situations during the past week. 'Nothing', she says, 'but when I burn myself, I at least feel something'.

Audrey (25) relates in a monotonous tone how one of her neighbours humiliated her. When questioned, she said she did not feel anything when talking about it.

It is important to find out whether patients are aware of the flat affect. Furthermore, it is important to examine what causes them to feel so threatened by their feelings. Patients can be afraid of becoming completely overwhelmed. *'If I begin to cry, I'll never stop', says Audrey.* Assuming an indifferent attitude can also be a form of self protection, as is the case with Julia. *'If I keep people at a distance, they can't touch me.'* If patients practice observing their feelings, they often become aware that they avoid certain feelings. This insight can be the beginning of breaking through avoidance. With some patients it is important that this happens in stages, otherwise they would be overwhelmed by emotions.

- *Breaking through emotional avoidance with the use of experiential exercises*

When patients are afraid of emotions, this fear promotes the intensity of the emotions. During the session, experiential exercises can be used in order to test or challenge catastrophic thoughts about emotions.

Therapist: The tension that you just spoke of, where is it located?

Amy (24): In my stomach, it feels tight because of the tension.

Therapist: Okay. Can you place your attention on that area of your stomach, right there where the tension is?

Amy: Yes... it is getting worse. I now also feel pressure on my chest.Therapist: Okay, the tension in your stomach, the pressure on your chest, just let it be. Amy is able to experience it for several minutes.

Therapist: Well done. What did you notice when you observed the tension?

Amy: Well, that it first got worse and then it became less intense. I didn t think I would be able to keep it up.

This technique provides a new look at how emotions change and how patients can bear them. Even the strongest emotions will reduce in intensity after a while. Patients who harm themselves are not usually aware of this since they do not wait for the moment of the reduction in intensity of the emotion; by then they will already have harmed themselves. Moreover, some patients want to simply rid themselves of the intense emotion. One of

the goals of treatment is to have them experience that emotions are a valuable aspect of the human experience. Dialectical Behaviour Therapy emphasizes in this context that wisdom develops from the integration of feeling and thinking (Linehan, 1993).

- *Breaking through emotional avoidance using mindfulness exercises*

In order to break through the pattern of emotional avoidance, mindfulness exercises can also be used. These exercises focus on sensory awareness in the present moment, for example, the eating of chocolate or listening to music, without judging it to being 'pleasant' or 'unpleasant'. They are based on eastern psychological approaches, as well as western ways of non-reinforcing exposure. They are also used as methods to eliminate the automatic avoidance of fear responses (Linehan, 1993). It has been our experience that patients enjoy these exercises, which can be performed during the session. The exercises can also be placed on the help chart to be applied at home during moments when they feel stressed, sad or angry. The heightened attention placed on the here–and-now, which these exercises demand, stops impulsive behaviour and proves useful in breaking through dissociation.

Lilian (28) puts her cat on her lap and pays attention to all sensory perceptions while she pets the cat; the soft fur, the warmth of the cat's body, the purring, how the cat slowly opens and closes its eyes, the patterns of the brown and black stripes of the fur. She discovers that this calms her and that it prevents her from dissociating.

- *Learning to recognize emotions in a timely manner*

When patients are blocked off from their emotions, they will only begin to notice them once the emotions have become very intense, which increases the risk of escaping into self-harm in order to stop the painful experience.

Rachel (15) is not aware of her feelings of fear and dissociates when she watches TV programs that remind her of sexual abuse. She describes how she takes all the medication she can find, as if she were 'in a daze'. During the session Rachel becomes aware of light feelings of fear and she is able to apply techniques to calm herself (for example, drawing, colouring, reading a book in a rocking chair).

- *Learning to differentiate emotions and name them*

Patients can experience difficulty differentiating and naming emotions.

Kevin (19) divides emotions into two categories: 'chill' and 'not-chill'.

Since Kevin has difficulty differentiating emotions, he is not able to see the effect of his thoughts on his emotions. The result is that he does not understand the goal of cognitive interventions. The therapist encourages him to observe bodily sensations and emotions

more closely, and helps him to put his experiences into words. The better he learns to differentiate his emotions, the more he discovers the connections between his thoughts and his emotions and the more he understands the objective of cognitive interventions.

- *Regulating intense emotions: finding diversion and solace.*

Whereas some patients avoid feelings, for others it is important not to remain for too long in the feelings they experience. This can be accomplished by, for example, shifting the attention to something else, or by conjuring up a contrasting feeling. Combining activities of finding diversion with those of finding solace can be very effective.
Rachel (15) discovers that lounging around in a rocking chair with a cup of tea and a children s book, can be more effective than each one of these activities alone. On the help chart patients note down those diversion activities, which turn out to be effective. We have found that the effect of these diversion activities is greater if they are done mindfully.
Jessica (26) notices that taking a walk has a positive impact on her mood if she is mindful of her surroundings.

5.3.3 Possible interventions with behavioural problems

Below is a chart of the behavioural interventions therapists can select to target behavioural problems associated with DSH

Overview of interventions for behavioural problems:
- Observing problems and setting priorities
- Reinforcing existing problem solving skills
- Implementing a step plan for dealing with problems
- Reducing self-defeating behaviour
- Acceptance of living circumstances which cannot be changed

- *Observing problems and setting priorities*

Patients who harm themselves experience more stressful events in comparison to other patients (de Wilde, 2000). They react also more passively to problems and tend to avoid them more often (Evans, Hawton, & Rodham, 2005), which causes problems to accumulate. The more problems accumulate, the greater the risk of self harm. When patients report a variety of problems, it is necessary to set priorities and to first deal with the problems which are connected most strongly with self harm. The therapist completes an inventory

of the patient's coping skills and how they apply these to problem situations.

- *Reinforcing existing problem solving skills*

One of the therapeutic goals is to reinforce existing problem solving skills, in order for patients to be better equipped to cope with difficult situations.

Mariah (27): The girls I work with are just straight up rude. They are always talking about the way I dress. They are also saying I am fat and other ignorant stuff like if we were in high school. I am really getting frustrated with them and my patience is running low…
Therapist: I am very sorry to hear about your situation…it seems like little bits and pieces of high school will follow us for the rest of our lives.
Mariah: Yes, I had rude people too when I was in high school but just ignored them because if they see that you are not getting upset then they will get bored with bugging you.
Therapist: Could that be helpful in this situation too?
Mariah: Yes, now that I think of it, ignoring them seems the best thing to do.
Therapist: What else did you find helpful back then?
Mariah: Well, I could try to focus on the girls I like to hang out with and not so much on the others. I could also respond playfully, with a joke…that might surprise them!
Therapist: Wonderful how you use your imagination to deal with this situation.

- *Implementing a stepped approach for dealing with problems*

Patients learn how to deal with problems step by step: (1) putting the problem into words, (2) brainstorming solutions, (3) choosing a solution, (4) implementing the solution and (5) evaluating the solution (Nezu, Nezu, & Perri, 1989). The therapist practices with patients the appropriate skills that are needed to arrive at a practical solution.

- *Reducing self-defeating behaviour*

In addition to expanding problem solving skills, it is important to reduce self-defeating behaviour, since this increases the risk of self harm.

Zoe (20) tells that she has a knife hidden beneath her bed. The therapist reminds her of the goals she has set.
Therapist: you want to stop cutting yourself, yet you have a knife within reach. When things become hard for you, you can just reach for it. How do you see this?
Zoe: The knife makes me feel safe; when I feel awful I can do something about it.
Therapist: Exactly, you are used to reverting to cutting yourself when you feel bad. You have just started to deal in a different manner with your feeling of pain, such as using the help chart. I wonder if you get the chance to practice this new skill when the knife is in reach…
Zoe: Hmm…, yes, the knife beneath the bed does make it more difficult, and it doesn't really fit with what I want to change…

Other examples of behaviours which increase the risk of self-harm are the use of alcohol and drugs, mixing with friends or acquaintances who self-harm (also on the internet), or exposure to people who tend to bully or humiliate.

- *Acceptance of living circumstances which cannot be changed*

Patients who harm themselves, often find themselves in difficult life circumstances. Some difficulties cannot be changed.

Michael (18): I regret that I started using drugs. I lost a lot of friends because of it.
Olivia (28): My grandfather molested me when I was seven. Nothing can change that.
Ethan (20): It is so hard to be depressed for so long and not knowing when I'll feel better.

Acceptance in some situations is the only realistic possibility.

5.3.4 Possible relational interventions

Self-harm is often the result of relationship problems with others such as the partner, family and friends. The next paragraph covers relational problems and possible interventions.

Overview of interventions for relational problems:
- Improving communication
- Expanding social support
- Creating a safe therapeutic relationship

- *Improving communication*

The communication within the partner and family is usually severely disrupted at the time of seeking help. There are many varying communication skills that might be helpful to the patient and their family. However, the emphasis within this particular treatment protocol is on assertion, listening intently, and responding towards others. Communication skills can be practiced in individual sessions, but also during family sessions, when the therapist can guide the communication between the family and the patient right then and there.

Almost all patients who harm themselves find it difficult to express their feelings, since they have learned to keep these to themselves (Linehan, 1993). The focus of *assertion* is on expressing thoughts, feelings and needs in an adequate yet not aggressive manner such as 'I think/feel…' and ' I would like…', instead of 'You are…' or 'You should…' If there is someone with whom the patient feels safe, such as a partner, parent or a friend, the

therapist will encourage the patient to tell this person how he/she feels, thinks, or needs.

The focus of *listening intently* is on the thoughts, feelings and needs of others without passing judgement ('You are stupid' or 'Well, this isn't going anywhere!' or nonverbal judgements such as rolling with the eyes or sighing disapprovingly).

The focus of *responding to feelings and thoughts of others* is on empathy, by which both patient and partner or family place themselves in the role of the other, thinking about what the other has experienced and currently experiences and learning how to reflect that they understand what the other person feels or thinks ('I understand that you are disappointed'). Part of this is also accepting that there is justification in varying points of view ('I understand how you see this, even though I do think differently').

- *Expanding social support*

Patients need the support of others in order to overcome self-harm and suicidal behaviour. Through help and advice from the therapist, the patient creates an as large as possible network of support consisting of the partner, family, friends, General Practitioner, home room teacher and other important people (Leenaars, 2004). If patients find it difficult to ask for support, it is important to find out what prevents them from doing so. It could be thoughts of helplessness ('No one can help me') or distrust ('If I show others how I feel, they will hurt me') or shame ('I don't want my parents to know that I am doing so badly').

- *Creating a safe relationship with the therapist*

An important aspect of therapy for patients who harm themselves is creating a safe therapeutic relationship. The therapist should expresses empathy and not judge (Ellis, 2001), conveying to the patient that he/she is valued regardless of his or her behaviour. The therapeutic relationship is one of the most effective reinforcers. Conveying warmth, interest and concern enables the therapist to reinforce desired behaviour. Maintaining clear boundaries is an effective strategy to eradicate undesired behaviour. Limits put a sense of organization into the patient's life, giving the patient clear boundaries regarding what is and what is not acceptable behaviour. Therapists may ask themselves: What limits do I need to set for the patient's safety? What limits must I set to teach the patient socially appropriate behaviour?

5.3.5 The role of the partner, family and important others

The treatment is first and foremost an individual one. However, the involvement of the partner or the (non-abusive) parent(s) in the therapeutic process is of great importance, since paying attention and showing sincere interest significantly counterbalances self-harm. During the course of treatment, the partner or parents learn how to pay attention and show empathy, as well as how to encourage desired behaviour and ignore undesired behaviour.

Family sessions can be planned depending on the needs of patients and parents.

Partner, parents and others who care about the patient, often have difficulty refraining from expressing feelings of powerlessness and anger when the patient harms him or herself. For them it may seem that they are doing it all wrong, no matter how hard they try. If they take away sharp objects, the patients may become angry ('They don't understand at all'). If they do nothing at all, anger may be invoked as well ('My mother just let's me do it'!). Partner and parents can learn to start up a discussion about the meaning of self-harm. This diverts the attention from forbidding the self-harm to sharing the feelings, and indirectly the risk of self-harm reduces. If patients learn to talk about their feelings, this will create room for the partner or parents to express their concern. Partner and parents can then make clear that they do not feel disgust or fear of the patient, but that they are merely overwhelmed by the injuries and the pain they must feel that drives them to self-harm.

5.3.6 Evaluating the effects of treatment

The therapist notes during each session the number of episodes of DSH and suicidal behaviour that occurred during the past week, in order to monitor the changes which occur due to the influence of the therapy. In addition the therapist checks to see if the nature of the self-harm changes. How intrusive are the thoughts of self-harm or suicide? How severe are the injuries? Is the patient able to stop the self-harm once he or she started it? To what degree does the patient exercise control over self-harm? To what extent have the cognitive, emotional, behavioural and relational problems which maintained the behaviour been reduced?

5.4 Last phase of the treatment (sessions 11 and 12)

Structure of sessions 11 and 12:

- Consolidating therapeutic changes
- Preventing relapse
- Checking which elements of the treatment the patient has found useful

Session 11 occurs one month after session 10, and session 12 occurs two months after session 11. In the final sessions, the emphasis lies on relapse prevention and the role which negative thoughts and negative feelings play. In accordance with Mindfulness-Based Cognitive Therapy, the emphasis is on early recognition of signs of relapse (Segal,

Williams, & Teasdale, 2004). The therapist and patient brainstorm on future situations, which hold risk of relapse. By imagining these situations as much as possible and going through those scenarios (how would the patient feel/think/do?), it becomes clear whether they have been sufficiently equipped to deal with future difficulties. The therapy will be brought to a completion once the patient has confidence in being able to cope with all aspects of the situation. During the last session, there will be a reflection on the treatment: What was most useful? What do you want to remember to apply when facing difficulties? Patients will make a card which contains the most valuable insights and the most effective techniques. They can carry this card with them and pull it out at moments when they experience difficulties.

6 Traps and solutions

In general, the therapist sees self-harm as a problem that needs to be dealt with, while patients see it as a solution to their problems. In our experience, we find that it is helpful to allow both visions to co-exist and to search for a shared understanding of self-harm, by, for example, looking at it as an effective short term solution for unbearable pain. From this shared vision, both therapist and patients can search for alternatives to self-harm.

Another important characteristic of the treatment is a non-judgemental attitude towards patients, their partner and their family. Patients and their partner and parents usually find themselves stuck in negative judgements about themselves ('It's all my fault') and each other ('She is the cause of the problems in our family'). During the course of treatments patients and their partner and parents learn to relate differently to negative feelings and thoughts. They learn to recognize negative feelings and thoughts at an early stage and look at them with a friendly, mild and accepting attitude. The therapist can only teach this new attitude if he or she approaches his or her own feelings and thoughts in the same non-judgemental way. This can be challenging, since the behaviour of patients and their family can sometimes evoke strong negative feelings. By recognizing these feelings without judging them, the therapist creates space to consider how he or she wants to respond.

Therapists want to reduce the risk of suicide as much as possible. For this reason, therapists sometimes use so called no-suicide contracts. However, the effectiveness of these contracts has never been demonstrated (Rudd, Mandrusiak & Joiner, 2006). An alternative is the agreement card as described in paragraph 5.1.5. The agreement card emphasizes desired behaviour, including help seeking behaviour which prevents suicide. It is our experience that the use of an agreement card has a positive impact on the therapeutic relationship.

Another major point is that the treatment manual assumes availability (by phone) of the therapist during office hours. However, Dialectical Behaviour Therapy offers the

possibility of contact outside office hours (Linehan, 1993; Miller et al., 2007). The choice for this is determined by the needs of the patient, the partner, the family, and the personal boundaries of the therapist. The question the therapist can ask is: to what extend am I prepared to help this patient before I start to feel uncomfortable? Do I feel good about expanding the availability for a clearly defined period of time (e.g., for the duration of the crisis)?

Another point concerns what therapists can do once their personal boundaries are reached or breached. For example, when patients or their partner or parents call several times a day, or when patients or their family yell, threaten or physically attack the therapist. In all these cases it is important that the therapist sets clear boundaries ('You may express anger, but I want you to stop calling me names'). The therapist needs to apply natural consequences once the boundary has been crossed ('If you don't stop yelling, I want you to go out in the hall to cool off. You can come back when you are able to sit here without yelling at me').

These examples concerning setting boundaries show that the therapeutic relationship can demand a great deal of the therapist. Patients who harm themselves can evoke strong conflicting feelings, such as anger, disgust, or concern. Therapists can also feel the tendency to give up, just as their patients may have. Supervision and peer supervision (preferably twice a month) offer therapists the opportunity to share their experiences and to notice conflicting feelings in time. Supervision and peer supervision are important, especially when working with patients who exhibit complex problems.