Suicidology Online 2010; **1**:95-108.

Suicidology Online
open access journal
www.suicidology-online.com

ISSN 2078-5488

Original Research

Brief intervention for deliberate self harm: an exploratory study

Vojna Tapolaa[1,2,✉], Raimo Lappalainen[1], Jarl Wahlström[1]

[1] University of Jyväskylä, Department of Psychology, Jyväskylä, Finland
[2] Lappeenranta University of Technology, Finnland

Submitted to SOL: 18th April 2010; accepted: 7th November 2010; published: 28th November 2010

***Abstract*:** Objective: To develop and explore the effectiveness of a 4-session intervention that combines elements of acceptance and commitment therapy (ACT) with elements of solution focused brief therapy (SFBT) to prevent deliberate self harm (DSH) in adults. Methods: An experimental pilot study with follow-up assessments at, 4-months, and 6-months after baseline was conducted using a random sample of 16 participants. Participants were consecutively assessed at the baseline and were assigned to a control group receiving treatment as usual (TAU) or an intervention group (ACT+SFBT+TAU) receiving the intervention in addition to treatment as usual. Results: On the 4- and the 6-month follow-up both groups evidenced significant changes over time in the incidence of DSH. The intervention group further evidenced significant changes over time in depression and emotional dysregulation. Conclusion: The 4-session student-delivered intervention may have positive effects on mechanisms associated with reduction of DSH, and produce additional positive effects as compared to treatment as usual. Practice implications: It is worthwhile in the future to study this type of intervention on larger scale.

Keywords: self harm, brief intervention, ACT, SFBT

Each year worldwide almost one million people die by suicide (World Health Organization, 2005). Prevention of suicide, as well as reduction of suicidal behavior, both fatal and non-fatal, is part of the Health for all targets of the World Health Organization (World Health Organization, 1992). One of the most important groups with a high risk of suicide consists of people who present to services following an episode of non-fatal self harm (Crawford, Thomas, Khan & Kulinskaya, 2007). High rates of suicide after deliberate self harm (DSH) have been reported throughout Europe (Hawton & Fagg, 1988; Suokas & Lönqvist, 1991) and in other parts of the world (Davis & Kosky, 1991). Indeed, it has been estimated that approximately 50% of all people who kill themselves have a history of deliberate self harm, an episode having occurred within a year before death in 20-25% (Hawton et al., 1998).

It has been suggested that enhanced treatment of those who self harm could help reduce the overall rate of suicide (Mann et al., 2005). However, there are few empirically supported treatments for self harm (Favazza, 1992; Walsh & Rosen, 1988). A systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition of deliberate self harm, concludes that there remains considerable uncertainty about which forms of psychosocial and physical treatments of patients who harm themselves are most effective (Hawton et al., 1998). However, the authors do report somewhat promising results for adapted forms of cognitive-behavioral therapy linked to problem solving. One such approach is Dialectic Behavior Therapy

✉ Vojna Tapolaa, DClinPsych
University of Jyväskylä, Department of Psychology, Jyväskylä
Lappeenranta University of Technology
Finnland
Tel: +358 50 512 4550
Fax: +358 5 621 7199
Email: vojna.tapola@jyu.fi

Suicidology Online
open access journal
www.suicidology-online.com
ISSN 2078-5488

(DBT) developed by Marsha Linehan (Linehan, 1993; Linehan et al., 2006). This approach combines the need for change in behavior with acceptance of negative feelings. Despite its efficacy, this treatment has been criticized as not being easily implemented in a traditional clinical setting in its full empirically supported package and also for its long term commitment (1 year), which may be difficult for some clients (Gratz & Gunderson, 2006). Therefore, additional interventions for self harm that are more economically and clinically feasible are needed.

In addition to being less costly than long term individual therapy, treatments utilizing a time limited format have also the potential to reach a large number of clients (Gunderson, 2001). However, in order to be effective, any time limited approach must have a specific and well-defined focus. Functional analytic approaches to psychopathology suggest that effective interventions address the function of maladaptive behaviors and symptom presentations (Gratz, 2003).

A review of the evidence on the functions of DSH concludes DSH to be serving an emotion-regulating function (Klonsky, 2007; Linehan, 1993; Gratz, 2003; Briere & Gil, 1998; Brown, Comtois & Linehan, 2002). It is thus reasonable for a time limited treatment designed to reduce DSH to address this particular function. For the purposes of our study, this function is conceptualized as involving the (a) awareness and understanding of emotions, (b) acceptance of emotions, (c) ability to control impulsive behaviors and behave in accordance with desired goals when experiencing negative emotions and (d) ability to use situation-appropriate emotion regulation strategies flexibly to modulate emotional responses as desired in order to meet individual goals and situational demands (Gratz & Roemer, 2004).

Another issue that such treatment needs to address is experiential avoidance since the empirical and theoretical literature suggests that the particular way in which self-harm operates to regulate emotions is through experiential avoidance i.e. attempts to avoid unwanted internal experiences (Hayes, Wilson, Gifford, Follette & Stroshal, 1996). We thus postulated that acceptance instead of avoidance of negative feelings would lead to a decrease in DSH and tailored our intervention along the lines of Acceptance and Commitment Therapy (ACT). Acceptance-based emotion regulation group intervention has already been shown to have positive effects on self harm (Gratz & Gunderson, 2006), and there is a growing body of evidence that ACT is an effective approach, covering areas such as psychosis (Bach & Hayes, 2002), addiction (Gifford et al., 2004), GAD (Evans et al., 2008), even clients seen in general outpatient practice (Stroshal, Hayes, Bergan & Romano, 1998).

The final ingredient of our current intervention was based on another issue implicated in the outcome following repetitive self harm, namely positive future thinking. It has been noted that the lack of future thinking is particularly associated with suicide risk (MacLeod, Pankhania, Lee & Mitchell, 1997; Hunter & O'Connor, 2003). A recent study into repetitive suicidal self harm shows that patients who reported high positive future thinking following a suicidal episode exhibited the best outcome in terms of hopelessness and suicidal thinking two months later (O'Connor, Fraser, Whyte, MacHale & Mastertone, 2008). The study suggests that the implementation and evaluation of rigorous interventions which attempt to modify positive future thinking is warranted, providing rationale for our intervention targeting not only emotional dysregulation but also positive future thinking among self harming individuals.

In designing the current intervention to reduce DSH we utilized the ACT to target emotional dysregulation. We also benefited from Solution focused brief therapy (SFBT) and its ties to positive psychology (Lethem, 2002) in tackling positive future thinking. SFBT in fact has already shown promising results in the treatment of DSH (Lamprecht et al., 2007) as well as in specific other areas (Bravesmith, 2004). We thus tailored a time limited approach to reducing DSH according to that which has so far been found efficient with respect to this particular aim. Our intervention for reducing self harm therefore targets emotion dysregulation using elements of ACT as well as positive future thinking benefiting the SFBT. The purpose of this pilot study was to investigate, using a randomized controlled procedure, efficacy of this brief ACT-SFBT derived four session psychological treatment combined with treatment as usual, and compared with treatment as usual only.

Methods

Participants

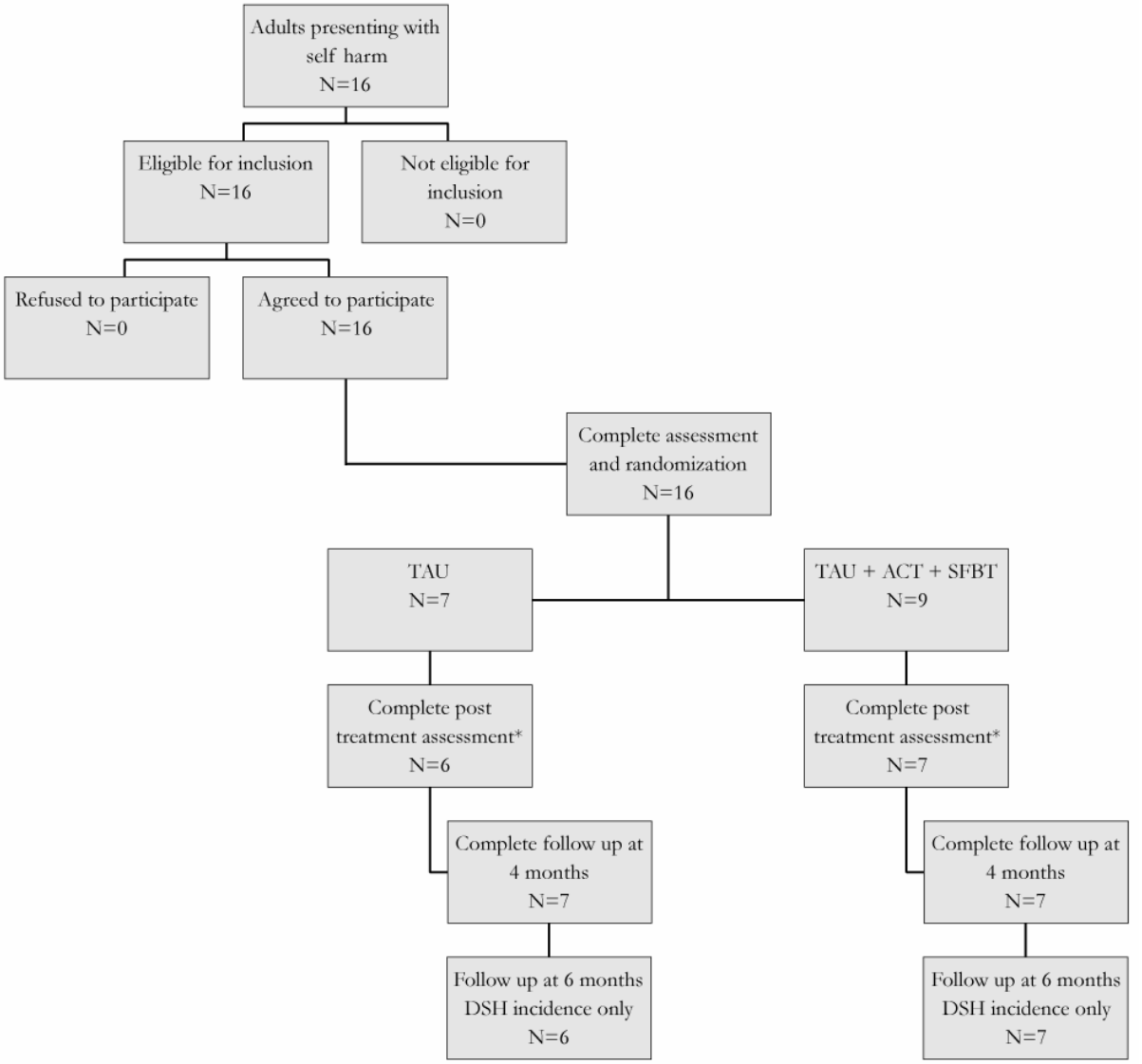
Participants were 16 patients who presented with an episode of self harm during the time period of the data collection, which began in February 2008 and ended in February 2009. Participants had to be of age range 18-65, they had to be able to read and write Finnish and be living within the catchment area of the Central Finland Community General Hospital.

Procedure

On visiting the emergency department at the Central Finland Community General Hospital, individuals who had recently engaged in DSH received a leaflet with a complete description of the study. In this leaflet it was announced that the person interested in participating may voluntarily contact the member of the research team, who

Suicidology Online
open access journal
www.suicidology-online.com
ISSN 2078-5488

Figure 1. All adults presenting with DSH volunteering for the study.



* Data not included in this study

would provide further information on the study. Informed consent was obtained from all participants. After participants had given written consent they were assessed at the premises of the Psychotherapy Training and Research Center at the University of Jyväskylä. All individuals who volunteered to participate were found eligible for the study and were, following the baseline assessment, randomly assigned to 4 sessions of ACT+SFBT in addition to TAU (intervention group), or to TAU only (control group). See Figure 1 for all adults presenting with self harm volunteering for the study.

The intervention took place at the premises of Psychotherapy Training and Research Center at the University of Jyväskylä and was conducted by advanced level psychology students who received 36 hours of training in the treatment in question. All intervention was supervised by a qualified psychotherapist. To insure the treatments integrity, all sessions were videotaped with the permission of the participants. All participants were invited for subsequent complete follow-up assessment at 4 weeks and 4 months following the baseline assessment. The 6-month follow-up assessment of incidence of DSH only was conducted by telephone. The assessor was not blind to conditions; however, all outcome measures were self-reported, and there was limited interaction between participants and the assessor. The medical ethics committee of the Central Finland Community General approved all procedures.

Design

All 16 individuals who contacted the research team with an intention to participate were included in the study. Participants were randomly assigned to 4 sessions intervention group (n=9) or to control group (n=7). The assessments were conducted by a member of the research team who was not the participant's therapist.

Suicidology Online
open access journal
www.suicidology-online.com
ISSN 2078-5488

Table 1. Demographic characteristics of participants

	ACT + SFBT	TAU
Age (years)	31	36
Sex		
Female	100%	100%
Male	0%	0%
Functioning ability		
Able to work (n)	11% (1)	14% (1)
Somewhat impaired (n)	56% (5)	43% (3)
Totally unable (n)	33% (3)	43% (3)
Medication (n)	100% (9)	100% (7)
Motivation readiness* (mean)	8.0	8.7
Financial situation** (mean)	2.4	2.5
No suicide in family (n)	78% (7)	85% (6)
No suicide attempts in family (n)	67% (6)	71% (5)
DSH incidence 4-month prior to baseline (mean)	2.29	2.71

* Motivation readiness was measured using a 0-10 scale, 0 = not at all, 10 = as ready as possible.
** Financial situation was measured on a 1-4 point scale, 1=good, 2=moderate, 3=rather bad, 4=very bad.

Primary outcome: assessment of DSH

The primary outcome measure of the study was the number of episodes of self harm at follow-up. The number of episodes in the past 4 months was assessed using Suicide Attempt Self-Injury Interview (SASII) (Linehan, Comtois, Brown, Heard & Wagner, 2006), which for the purposes of this study was translated into Finnish, with the permission of the author, and backtranslated. The authors found SASII to have very good interrater reliability and adequate validity. This instrument was designed to assess the factors involved in nonfatal suicide attempts and intentional self harm. However, for the purposes of this analysis, only the data on the actual number of DSH episodes obtained using this instrument was used.

DSH was defined as including both deliberate self-poisoning (overdose) and self-injury. Patients were also asked about incidents of self-injury, which was defined as intentional irrespective of the apparent purpose of the act, and included cutting, scratching, punching, hanging, stepping into the traffic. Thus, all behavior that was self-initiated with the intent to harm the body (regardless of intent to die) was included.

Secondary outcomes

Depression

Depression was measured with the Beck Depression Inventory BDI (Beck, Ward, Mendelson, Mock & Erbaugh, 1961). The BDI is a 21 item self-report inventory that evaluates the level of depression. The subject is asked to rate each item on a 3-point scale of severity. A total score is determined by aggregating the item responses and may range from 0 to 63 (normal-severe). BDI scores above the 9 cutoff may indicate the presence of depression. The test has high internal consistency, with $\alpha = .91$.

Anxiety

Anxiety was measured using the Beck Anxiety Inventory BAI (Beck & Steer, 1993). On the BAI, the examinee is asked to rate 21 symptoms of anxiety on a 4-point Likert scale.

Quality of life

Health-related quality of life (HRQoL) was measured by the 15D (Sintonen, 2001). A 15D is a 15dimensional, standardized generic instrument. Its 15 dimensions are moving, seeing, hearing, breathing, sleeping, eating, speech, elimination, usual activities, mental function, discomfort and symptoms, depression, distress, vitality and sexual activity. Each dimension is divided into levels. The respondent is asked to indicate the level that best describes his or her present health status on each dimension at that particular time (first level = no problems, fifth level = worst condition). On the basis of repeated measurements, the 15D has demonstrated good reliability, validity and sensitivity. A difference of larger or equal to .03 in the 15D score is clinically important in the sense that people can on average feel the difference (Sintonen, 1995).

Avoidance of internal experiences

Action and Acceptance Questionnaire AAQ (Hayes et al., 2004) is a 9-item measure of experiential avoidance. Although the AAQ was developed as a measure of the tendency to avoid internal experiences in general, many items focus on the avoidance of emotions. Example items include, "I try hard to avoid feeling depressed and anxious" and "anxiety is bad." The AAQ has been found to have adequate internal consistency ($\alpha = .70$), as well as adequate convergent, discriminant, and concurrent validity (Hayes et al., 2004). Items were recorded so that higher scores indicated greater experiential avoidance, and a sum was calculated.

Emotional regulation

The Difficulties in Emotion Regulation Scale DERS (Gratz & Roemer, 2004) was used to assess self-reported emotion regulation difficulties. Six subscale scores can be computed from the 36 items, namely nonacceptance of emotions (6 items; e.g., "When I'm upset, I feel guilty for feeling that way"), difficulties engaging in goal-directed behavior when distressed (5 items; e.g., "When I'm upset I have difficulty concentrating"), impulse control difficulties (6 items; e.g., "When I'm upset, I become out of control"), lack of emotional awareness (6 items; e.g., "I pay attention to how I feel"), limited access to emotion regulation

Suicidology Online
open access journal
www.suicidology-online.com
ISSN 2078-5488

Table 2. Change in the primary outcome variable - Deliberate self harm (DSH)

	Pre	4-month	With-in effect	6-month	With-in effect
ACT+SFBT+TAU (n=6)	2.29 (1.25)	0.17 (0.41)	Z=-2.06, p=0.03	0.43 (0.54)	Z=-2.23, p=0.02
TAU N=(7)	2.71 (0.76)	0.86 (1.46)	Z=-1.88, p=0.04	1.00 (0.89)	Z=-2.04, p=0.03

Means, standard deviations in brackets.

strategies (8 items; e.g., "When I'm upset, it takes me a long time to feel better"), and lack of emotional clarity (5 items; e.g., "I am confused about how I feel"). Participants rate each item on a scale from '1' (almost never, 0-10%) to '5' (almost always, 91100%). Items were recorded so that higher scores indicated greater emotion dysregulation, and a sum was calculated.

The authors describe good psychometric properties for all subscales, e.g. adequate to good internal consistencies (αs larger than .80) and stabilities (φs larger than .69) and significant correlations with other emotion regulation measures (Gratz & Roemer, 2004). The DERS was translated into Finnish with the permission of the author and back-translated in order to establish equivalence of the English and Finnish language versions. Significant correlations between the Finnish DERS version and similar measures of emotional regulation were found when validating the DERS in a sample of 50 clinical and non-clinical participants (Tapola, in preparation).

Other measures

Demographic information was obtained, as well as the information on patient satisfaction with treatment. This was measured using 5 point scale responses ranging from 1=very dissatisfied, to 5=very satisfied.

Treatment as usual

For ethical purposes participants in both study conditions were free to pursue any form of usual treatment they deemed warranted. We recorded three forms of TAU: psychotropic medication, psychiatric hospitalization, and outpatient sessions with a mental health worker (not a qualified psychotherapist). No treatment specific to self harm was recorded.

Intervention

The intervention was implemented by advanced level psychology students, under intense supervision of a qualified psychotherapist. Student-therapists underwent 36 hours of training in the manual based ACT+SFBT. To facilitate treatment fidelity, the ACT+SFBT manual was structured and contains in-session exercises for participants. All sessions were videotaped and treatment fidelity was rated on all sessions. The intervention is outlined in more detail in Tables 4a-d.

Statistical analysis

Analyses were performed with SPSS 15 for windows Vista. Because of the low number of subjects, non-parametric methods were used. Chi-Square Tests and Mann-Whitney U-Tests were conducted on demographic characteristics to determine equivalence across conditions. To determine change over time (pre-treatment, 4-month and 6-month follow-ups) within each group Wilcoxon signed ranks tests were used.

Results

There was no significant difference between the intervention group (n=9) and the control group (n=7) on any of the demographic characteristics including gender, age, educational level, functioning ability, use of medication, or motivation for change. In addition, no significant difference was found with regard to presence of suicide in the family, presence of suicide attempts in the family, and the history of self harm in the past 4 months.

On the 4-month and 6-month follow-up both groups evidenced significant changes over time on the main outcome measure -deliberate self harm. Thus, self harm episodes decreased in both groups

At the 4-month follow-up the results show that the intervention group evidenced significant changes on secondary outcome measures of depression as well as on difficulties in emotion regulation (DERS). Looking more closely at the DERS subscales we see that for the intervention group significant changes occurred on subscales of impulse dyscontrol and lack of clarity, with goal directed difficulties subscale showing a trend too. A further trend in intervention group was noted on measure for quality of life and emotional non-acceptance. On the other hand, no changes for any of the outcome measures were detected in the control group. Furthermore, when examining closely the DERS subscales it is noted that a significant change for the worse occurred on subscale of emotion clarity.

In addition, all participants who returned the treatment satisfaction form (n=7) would

Suicidology Online
open access journal
www.suicidology-online.com
ISSN 2078-5488

recommend the treatment to others. The treatment satisfaction score itself was 4.6 (measured on a 5 point scale from very dissatisfied to very satisfied).

Discussion

When drawing conclusions from this study, it must be remembered that there are several limitations mainly due to low number of subjects. However, it must also be emphasized that this study indicates low cost brief interventions may have additional positive effects on regular treatment for deliberate self harm. This study also presents an example of how a brief intervention for deliberate self harm could be conducted.

The results indicate that changes over time for the intervention group were significant on primary outcome measure, as well as on several secondary outcome measures. Primary outcome measure, DSH, was reduced significantly for both groups on 4-month follow-up. With respect to change over time on secondary outcome variables at 4-month follow-up the intervention group fares significantly better compared to control group.. Health related quality of life reached marginally significant change for the intervention group, but not for the control group. The change over time in emotional dysregulation was also significant for the intervention group only. Looking more closely at the DERS subscales we saw that for intervention group significant changes over time occurred on subscales of impulse dyscontrol and lack of clarity, with emotional nonacceptance and goal directed difficulties subscale showing a similar trend too.

This indicates that on 4-month follow-up the intervention group participants were clearer about their emotions, i.e. better able to identify, label, and differentiate between emotional states. They were also better able to control their impulsive behaviors and behave in accordance with desired goals when experiencing negative emotions. The control group participants however showed a significant change on the DERS subscale of clarity, only in the direction for the worse. In other words, on 4-month follow-up these participants were even more cloudy about their emotional states than they were at the outset of the study. In addition to the changes in quality of life, and emotional dysregulation, in the treatment group a significant change was noted also for yet another secondary variable, namely depression. We expected there to be a change in depression as a consequence of our attempts to increase positive future thinking, another mechanism of change we proposed at the outset. It could well be that the depression for the participants of the intervention group was reduced beyond the extent the trend indicates, especially when we take into account low reactivity of this particular measure (Minami & Kircher, 2007). In each case, no such trend was evident for the control group. The results thus show potential utility of adding this short-term intervention to existing treatment as usual. Furthermore, this study indicates that time-limited training in the intervention (36 hours) combined with qualified supervision brings about good enough proficiency in intervention implementation. Students with no prior clinical experience and with limited hours of training were well able to implement the intervention under the supervision of a qualified psychotherapist and all intervention group participants were satisfied with the intervention and would recommend it.

The results must be evaluated the light of the study's limitations. Most notably, this study involved a small and homogenous sample of participants, limiting both generalizability and statistical conclusion validity of the results. The reliance on self-report measures of emotional responding and symptom severity may result in biased data. Furthermore, although the effects of positive thinking may here be indirectly reflected in measures on depression and goal clarity, to establish the potential effect of positive future thinking a more direct measure of the phenomenon, such as Future Thinking Task (MacLeod et al., 1997) would need to be used.

Further research on a large-scale is needed to evaluate this intervention. Further research is also needed to evaluate whether the emotional dysregulation and positive future thinking are indeed the potential mechanisms of change, as the results of this study indicate. Moreover, further research is needed to evaluate yet another such potential mechanism suggested to us in the spontaneous feedback of the current study participants – namely the positive attitudes of staff working with individuals who self harm. In their feedback the participants of the current study expressed satisfaction with the nonjudgmental and positive attitude of the assessor and their therapists. The literature suggests that clinical staff of the accident and emergency departments, which are often the first point for people who self harm, may be critical in addressing the needs of this vulnerable group (Mackay & Barrowclough, 2005). It is further suggested that nursing responses tend to be uniform and inflexible (McAllister, 2001) and that in general people who harm themselves are not popular with health services staff (Alston & Robinson, 1992). The clinical profession, in particular nurses and doctors in the accident and emergency are reported to be unsympathetic towards individuals who self harm (Pierce, 1986; Treloar & Pinford, 1993). These clinicians often perceive DSH as manipulative and attention

Suicidology Online
open access journal
www.suicidology-online.com
ISSN 2078-5488

Table 4. Change in secondary outcome parameters

	ACT+SFBT+TAU (n=6)			TAU (n=7)		
	Pre	**4-month**	**With-in effect**	**Pre**	**4-month**	**With-in effect**
15D - Health Quality	28.67 (4.97)	24.67 (5.85)	Z=-1.83, p=0.06*	30.00 (6.53)	27.57 (4.58)	Z=-1.06,p=0.16
DERS	104.00 (20.56)	90.00 (18.49)	Z=-2.20, p=0.02**	96.14 (24.55)	91.00 (20.83)	Z=-0.68, p=0.27
Emotion non-acceptance	21.00 (4.78)	18.00 (5.51)	Z=-1.83, p=0.06*	21.00 (7.23)	18.00 (4.20)	Z=-1.36, p=0.10
Impulse dyscontrol	15.83 (4.83)	12.67 (3.88)	Z=-2.02, p=0.03**	14.14 (4.86)	14.57 (5.65)	Z=-0.42, p=0.39
Goal-directed difficulties	15.00 (3.85)	12.67 (3.67)	Z=-1.84, p=0.06*	14.43 (3.78)	13.29 (3.99)	Z=-1.06, p=0.20
Emotion non-awareness	13.33 (3.88)	13.17 (3.55)	Z= -0.28, p=0.50	14.14 (4.29)	11.43 (4.16)	Z=-1.10, p=0.16
Lack of ER strategies	23.67 (4.03)	22.33 (4.80)	Z=-0.81, p=0.25	21.57 (4.79)	20.14 (4.34)	Z=-0.59, p=0.31
Lack of clarity	15.17 (3.77)	11.17 (2.04)	Z=-2.02, p=0.03**	11.00 (4.08)	13.57 (4.24)	Z=-2.21, p=0.02**
AAQ	31.17 (12.73)	36.00 (12.33)	Z=-1.26, p=0.16	29.14 (9.10)	32.86 (8.26)	Z=-1.19, p=0.15
BDI	31.33 (9.93)	25.00 (13.57)	Z=-2.02, p=0.03**	25.43 (10.50)	24.71 (11.87)	Z=-0.09, p=0.49
BAI	23.00 (13.07)	20.00 (14.33)	Z=-0.95, p=0.20	23.29 (16.57)	22.14 (14.99)	Z=-0.42, p=0.36

Means, standard deviations in brackets.
*marginally significant p<0.07; ** p<0.05 (Wilcoxon Signed Ranks Test, 1-tailed)

seeking behavior (Warm, Murray & Fox, 2002). Perhaps the attitudes had also a role to play in the fact that only 16 individuals were referred to the current study, when it was clearly and repetitively outlined that all individuals engaging in self harm are to be given information on the research, and the number of all individuals presenting to Central Finland Community General Hospital for DSH during the year 2008 approached 200 (personal correspondence). There thus arises need for the future research to also investigate more closely motivational factors for seeking and accepting treatment among clients with DSH. In fact, in this study we used almost 12 months for the recruitment process, and were able to study treatment effects on a small number of participants. This indicates that there can be considerable difficulties in carrying out large scale clinical effectiveness trials.

Conclusions

The 4-session student-delivered intervention combined with the treatment as usual had broader effects on reduction of DSH than did treatment as usual only. Positive effects were also noted for the brief intervention on depression and emotional regulation strategies. In addition, trained and supervised student therapists with no prior clinical experience were found to deliver satisfactory intervention.

Practice implications

To achieve enhanced service provision it is worthwhile in the future, provided further studies confirm the preliminary findings here, to add this intervention as a permanent part of TAU when dealing with DSH. Work also needs to be done on clinical staff' education and training in brief interventions in general and their attitudes and behavior in particular in order to improve the outcome of treatment for individuals engaging in DSH. A training approach such as that used in this study with a focus on strengths, acceptance and positive future thinking, along with a shift in philosophy towards "the client as able and cooperative" may have a place in forming attitudes that contribute to improving outcome after DSH.

Suicidology Online 2010; **1**:95-108.

Suicidology Online
open access journal
www.suicidology-online.com
ISSN 2078-5488

Table 4a. Interventions - Session 1

Task	Means	Example
Task 1 Creating an initial therapeutic reality	brief introduction of how the intervention works, Paying attention, being genuinely interested, complimenting on coming to treatment , emphasizing collaboration	"We will meet 4 times, one time per week for about 45 minutes, during which time we will work on issues you fins important" "Most people wait until their cutting is very well established and frequent to seek help. How did you decide to come in while you have just started cutting"
Task 2 Ask for goals/rehearse preferred future	miracle method	The precise language of the intervention may vary, but the basic wording is: *I am going to ask you a rather strange question [pause]. The strange question is this: [pause] After we talk, you will go back to your work (home, school) and you will do whatever you need to do the rest of today, such as taking care of the children, cooking dinner, watching TV, giving the children a bath, and so on. It will become time to go to bed. Everybody in your household is quiet, and you are sleeping in peace. In the middle of the night, a miracle happens and the problem that prompted you to talk to me today is solved! But because this happens while you are sleeping, you have no way of knowing that there was an overnight miracle that solved the problem. [pause] So, when you wake up tomorrow morning, what might be the small change that will make you say to yourself, "Wow, something must have happened—the problem is gone!"* In the Miracle Method then the barriers to reaching the goal are eliminated by a miracle while everyone is sleeping. The participants are then asked what things would be happening once the miracle had occurred. This does not involve hoping for the miracle, but freeing imagination and action from unnecessary limitations.
Task 3 getting in touch with one's own experience moment to moment in a defused and accepting way.	5-minute mindfulness exercise : just breathing	There is neither a right nor a wrong way to be mindful. Simply be who you directly experience yourself to be in the moment. If thoughts or emotions show up then observe them but do not believe or disbelieve them. As you practice, allow yourself to become more and more mindful of the sensations, thoughts, and feelings that are happening for you. Follow your breath. Simply watch your breath come in and go out of your body. This happens naturally. Feel the breath come in, feel the breath go out. Allow it to happen without getting in the way. If you want to, you can count your breaths, from one to ten. Once you have reached ten, go back to one. Just keep watching your breath. All kinds of content will come up when you sit. Your anger, depression, anxiety, low self-esteem – all these may surface. Just watch them come in and go out. As they appear, treat them with kindness, the way you would pat a visiting child on the head in acknowledgement of his presence.
Task 4 Homework – 5-minute breathing exercise	Recommend homework	"In between now and when we meet again, I would like you to practice the breathing exercise we just practised here together"

Suicidology Online 2010; **1**:95-108.

Suicidology Online
open access journal
www.suicidology-online.com
ISSN 2078-5488

Table 4b. Interventions - Session 2

Task	Means	Example
Task 1 getting in touch with one's own experience moment to moment in a defused and accepting way.	5-minute mindfulness exercise : just breathing	Same as in session 1
Task 2 working on goals and rehearsing preferred future		
a: Scaling back client's grand ideas about their goals or progress into more achievable goals	Smaller step questions	"That sounds like a big goal and dream. What kinds of things would be happening in the next week if you were headed in the direction of those big goals?"; "What is the smallest thing you can do now that will help you in the direction of the big goal?"
b: Elicit descriptions of times when things went differently from the usual problem situation	Exceptions questions	"Can you recall a time when you felt anxious and you thought you would cut, but instead you resisted the urge?"
c: Obtain continual feedback from the client and get them realize changes or gray areas in the problem situation	Scaling questions	"On a scale from one to 100, 100 being the most self harming and one being no self harming, where have you been in the past week?"
d: Highlight differences and get the person to compare and contrast things about exceptions or solutions	Difference questions	"What was different now from the way you usually handle the overdose?"
e: Create positive expectancies	Positive expectancy questions	"Before you reduce or stop harming yourself let's talk about how well you are coping with it now"; "After you reduce or stop harming yourself what else will change in your life?"

Suicidology Online 2010; **1**:95-108.

Suicidology Online
open access journal
www.suicidology-online.com
ISSN 2078-5488

Table 4b. Interventions - Session 2 (continued)

Task	Means	Example
Task 3 expanding participants' tools for handling acute negative arousal, tolerating frustration, learning to be aware of emotions and the antecedents of emotions (sensations, cognitions, motivational impulses), labelling emotions without judgement and without giving into emotion-induced action tendencies, becoming aware of one's capacity to tolerate negative emotions, realizing that emotions are not permanent.	Low frustration tolerance exercise (LFT)	FT exercise (A six part loop): being mindful of bodily sensations A six part loop (1,2,3,4,5,6,1,2,3,etc.). *1.'Tell me a frustration you could bear' (this question alone should expose the client to mental and somatic events associated with the LFT, particularly when asked repetitively).* *2.'How does that frustration seem to you now?'* *3.'Tell me a frustration you would rather not bear?'* *4.'How would that frustration feel in your body?' (introceptive awareness)* *5.'What part of that frustration might you be able to bear?' This question gently eases the client into imagining himself tolerating part of a frustration he feels he doesn't want to tolerate. There is usually some part of the frustration that is tolerable. If there is not, that is fine too.* *6.'How does that frustration seem to you now?' Continue to Q1.* In this exercise it is important to acknowledge, to act predictably, and to avoid anything that could be perceived as judgement. The repetition gives the client much opportunity to exercise his perceptions; the constant movement brought about by repetition also promotes letting go attitude and foster detachment from the thoughts and sensations. It also increases opportunities for a client to experience both emotional and cognitive flexibility.
Task 4 Homework	Recommend homework: 5-minute breathing exercise and increase in goal directed behaviour	"In between now and when we meet again I would like you to do more of the things that we discussed today and you found working well for you"

Suicidology Online 2010; **1**:95-108.

Suicidology Online
open access journal
www.suicidology-online.com
ISSN 2078-5488

Table 4c. Interventions - Session 3

Task	Means	Example
Task 1 same as in session 2 ***Task 2*** same as in session 2		
Task 3 assimilating statements that are positive, experiencing directly having different identities, noticing how different self-related content tends to produce different reactions	Pick an identity metaphor	*"I want you to play a game with me. It's called the Pick an identity Exercise. Your job is to reach into that box over there and pull out one slip of paper at a time. On each slip of paper I have written down an identity statement. Some of these statements are things that you have told me here. Some of the things describe general characteristics of people. Your job is to pick any four slips of paper, and then I want you to try as hard as you can to imagine that you are the person described in those four slips of paper. Some of the slips will have messages on them that you have told yourself, or seem true of you, and you may see some slips of paper that have messages that you have not thought of. Your job is to take both kinds of messages and try as hard as you can to be that person, right here in the room with me, right now. I'm not trying to change what you believe about yourself. So this is not designed to make you stop believing in any of your ideas about who you are. I'm just interested in seeing what it feels like to actually imagine that you can become that person described by the identity statements, OK?"* The therapist's job is to help the client construct the reality of being this person. Then, the therapist can ask questions like 'What does this person think about his or her career, relationships, and family upbringing?', or 'How does this person feel in intimate situations?'. Once this has been done and the therapist is satisfied that the person has really taken on the imaginary identity, the therapist may ask 'And who is noticing all these thoughts and feelings right now?' The exercise may be repeated three or four times in a session. If the client makes remarks about feeling different under different identity formations

Suicidology Online
open access journal
www.suicidology-online.com
ISSN 2078-5488

Table 4d. Interventions - Session 4

Task	Means	Example
Task 1 same as sessions 2/3 ***Task 2*** same as sessions 2/3		
Task 3 clarify the relationship between avoidance and action quite clearly.	physical metaphor –Take your keys with you	*Ask whether the client carries keys and whether you can borrow them. Put the keys on the table and say, 'OK, suppose these represent the things you've been avoiding. See this key here? That is your anxiety. See this key, that is your anger at your mother.' (continue fitting major issues to the client's keys) The keys are then placed in front of the client, and the client is asked, 'What are you going to do with the keys?' If the client says 'Leave them behind', say, 'Except that two things happen. First, you find that instead of leaving them behind, you keep coming back to make sure they are left behind, so then you can't go. And second, it's hard to live life without your keys. Some doors won't open without them. So what are you going to do with your keys?' The process continues, waiting for the client to do something. Most clients are a bit uncomfortable about actually picking them up. For one thing, it seems silly (which in itself is another 'key'), and for another, the keys are symbols of 'bad' things. In that context actually picking them up is a step forward, and the therapist should keep presenting the keys until they are picked up, without ordering them to be picked up. If the client says 'I would feel silly picking them up,' or 'What do I need to do?' point out to a key and say 'That feeling? That's this one here. So what are you going to do with the keys?' When they are finally picked up, say something like, 'OK. Now the question is, where will you go? And notice there isn't anywhere you can't go with them.' Also note that other keys will keep showing up – that is, answering the question affirmatively now does not mean that the same questions won't be asked over and over again by life. The client should also be asked in the natural environment to think about letting go of avoidance of difficult emotions, thoughts, and so on, every time he or she touches, carries, or uses the keys. Suggest that when the keys are used that the client also affirmatively choose to carry his or her experiential 'keys'.* According to Hayes et al [41], in the metaphor, keys on the client's ring are said to represent different difficult emotions, memories, thoughts, and reactions. The metaphor highlights two important aspects of these keys. First, picking up the keys and carrying them does not keep us from going anywhere, and second, the keys actually open doors that might otherwise be locked to us without them. Doing the exercise with actual keys the client uses also gives the client a physical touchstone, or reminder of his or her goals (where the client is going), the means of going (willingness), and what the client must carry with him or her to move (the client's history and reactions it may produce). Because we use our keys many times in a day, this metaphor plants a seed that can be contacted frequently outside therapy sessions.
Task 4 review positive effects of treatment	Direct questions	"what are the things you found most useful and you feel you will be using in the future on your own "
Task 5 give credit for participation	Compliment	"In a treatment as demanding as this has been, it would have been normal to reconsider the participation, but you persisted and attended all fours sessions. How did you do that!"
Task 6 motivate further change	Motivation questions	"How have you benefited now that you harm yourself less?" "What positive effects has this

Suicidology Online
open access journal
www.suicidology-online.com
ISSN 2078-5488

References:

Alston M.H. & Robinson B.H. (1992) Nurses' attitudes towards suicide. *Omega, 25*, 205-215.

Bach P.B. & Hayes S.C. (2002). The use of acceptance and commitment therapy to prevent the rehospitalisation of psychotic patients: a randomized controlled trial. *Journal of Consulting and Clinical Psychology, 70*, 1129-1139.

Beck A.T., Ward C.H., Mendelson M., Mock J. & Erbaugh J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 38*, 764-768.

Beck A.T. & Steer R.A. (1993). *Manual for the Beck Anxiety Inventory*. San Antonio, TX: Psychological Corporation.

Berg I.K. & Dolan Y. (2001). *Tales of solutions: A collection of hope-inspiring stories*. New York, NY: Norton.

Bravesmith A. (2004). Brief Therapy in Primary Care: The Setting, the Discipline and the Borderline Patient. *British journal of Psychotherapy, 21*, 37-48.

Briere J. & Gil E. (1998). Self mutilation in clinical and general population samples: Prevalence, correlates and functions. *American Journal of Orthopsychiatry, 68*, 609-620.

Brown M.Z., Comtois K.A. & Linehan M.M. (2002). Reasons for suicide attempts and non-suicidal self injury in women with borderline personality disorder. *Journal of abnormal Psychology, 111*, 198-202.

Crawford M.J., Thomas O., Khan N. & Kulinskaya E. (2007). Psychosocial interventions following self-harm. *British Journal of Psychiatry, 190*, 11-17.

Davis A.T. & Kosky R.J. (1991). Attempted suicide in Adelaide and Perth: changing rates for males and females, 1971-1087. *Med J Aust, 154*, 666-670.

De Shazer S. (1985). *Keys to solution in brief therapy*. New York, NY: Norton.

Evans S., Ferrando S., Findler M., Stowell C., Smart C. & Haglin D. (2008). Mindfulness-based cognitive therapy for generalized anxiety disorder. *Journal of Anxiety Disorders, 22*, 716-721.

Favazza A.R. (1992). Repetitive Self-mutilation. *Psychiatric annals, 22*, 60-63.

Gifford E.V., more authors (2004). Acceptance theory based treatment for smoking cessation: an initial trial of acceptance and commitment therapy. *Behaviour Therapy, 35*, 689-706.

Gratz, K.L. (2003). Risk factors for and functions of deliberate self-harm: An empirical and conceptual review. *Clinical Psychology: Science and Practice, 10*, 192-205.

Gratz K.L. & Gunderson J.G. (2006). Preliminary data on an acceptance-based emotion regulation group intervention for deliberate self-harm among women with borderline personality disorder. *Behavior Therapy, 37*, 25-35.

Gratz K.L. & Roemer L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26*, 41-54.

Gunderson J.G. (2001). *Borderline personality disorder: A clinical guide*. Washington, DC: American Psychiatric Press.

Hawton K., Arensman E., Townsend E., Bremmer S., Feldman E., Goldney R., Gunnel D., Hazell P., van Heeringen K., House A., Owens D., Sakinofsky I. & Träskman-Bendz L. (1998). Deliberate self harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. *British Medical Journal, 317*, 441-447.

Hawton K. & Fagg J. (1988). Suicide, and other causes of death, following attempted suicide. *Br J Psychiatry, 152*, 751-761.

Hayes S.C. & Smith S. (2005). *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger Publications.

Hayes S.C., Stroshal K.D. & Wilson K.G. (1999). *Acceptance and Commitment Therapy: An Experiential Approach To Behavior Change.* New York, NY: The Guilford Press.

Hayes S.C., Strosahl K.D., Wilson K.G., Bissett R.T., Pistorello J., Toarmino D., Polusny M.A., Dykstra T.A., Batten S.V., Bergan J., Stewart S.H., Zvolensky M.J., Eifert G.H., Bond F.W., Forsyth J.P., Karekla M. & McCurry S.M. (2004). Measuring experiential avoidance: A preliminary test of a working model. *The Psychological record, 54,* 553-578.

Hayes S.C., Wilson K.G., Gifford E.V.,Follette V.M. & Strosahl K. (1996). Experiential avoidance and behavioural disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64*, 1152-1168.

Hunter E.C. & O'Connor R.C. (2003). Hopelessness and future thinking in parasuicide: the role of perfectionism. *Brit.J.Clin.Psychol., 42*, 355-365.

Kapur N., Murphy E., Cooper J., Bergen H., Hawton K., Simkin S., Casey D., Horrocks

Suicidology Online
open access journal
www.suicidology-online.com
ISSN 2078-5488

J., Lilley R., Noble R. & Owens D. (2008). Psychosocial assessment following self-harm: Results from the Multi-Centre Monitoring of Self-Harm Project. *Journal of affective disorders, 106*, 285-293.

Klonsky E.D. (2007). The functions of deliberate self-injury. A review of the evidence. *Clinical Psychology Review, 27*, 226-239.

Lamprecht H., Laydon C., Mcquillan C., Wiseman S., Williams L., Gash A. & Reilly J. (2007). Single-session solution-focused brief therapy and self-harm: A pilot study. *Journal of Psychiatric and Mental Health Nursing, 14*, 601-602.

Lethem J. (2002). Brief Solution focused Therapy. *Child and Adolescent Mental Health, 7*, 189-192.

Linehan M.M. (1993). *Cognitive–behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.

Linehan M.M., Comtois K.A., Brown M.Z., Heard H.L. & Wagner A. (2006). Suicide Attempt Self-Injury Interview (SASII): Development, Reliability, and Validity of a Scale To Assess Suicide Attempts And Intentional Self-Injury. *Psychological Assessment, 18(3),* 303-312.

Linehan M.M., Comtois K.A., Murray A.M., Brown M.Z., Gallop R.J., Heard H.L. et al. (2006). Two-year randomized control trial and follow-up of dialectical behavior therapy vs. therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry, 63*, 757-766.

Mackay N. & Barrowclough C. (2005). Accident and emergency staff's perceptions of deliberate self-harm: Attributions, emotions and willingness to help. *British Journal of Clinical Psychology, 44*, 255-267.

MacLeod A.K., Pankhania B., Lee M. & Mitchell D. (1997). Parasuicide, depression and anticipation of positive and negative future experiences. *Psychol. Med., 27*, 973-977.

Mann J.J., Apter A., Bertolote J. et al. (2005). Suicide prevention strategies: a systematic review. *JAMA, 294*, 2064-2074.

McAllister M.M. (2001). In harm's way: A postmodern narrative enquiry. *Journal of Psychiatric and Mental Health nursing, 8*, 391-397.

Minami T. & Kircher J.C. (2007). Benchmarks for Psychotherapy Efficacy in Adult Major Depression. *Journal of Consulting and clinical Psychology, 75(2)*, 232-243.

O'Connor R.C., Fraser L., Whyte M., MacHale S. & Mastertone G. (2008). A comparison of specific positive future expectancies and global hopelessness as predictors of suicidal ideation in a prospective study of repeat self-harmers. *Journal of Affective disorders, 110*, 207-214.

Pierce D. (1986). Deliberate self-harm: How do patients view their treatment? *British journal of Psychiatry, 149*, 624-626.

Stroshal K.D., Hayes S.C., Bergan J. & Romano P. (1998). Assessing the field effectiveness of acceptance and commitment therapy: An example of the manipulated training research method. *Behaviour Therapy, 29*, 35-63.

Suokas J. & Lönqvist J. (1991). Outcome of attempted suicide and psychiatric consultation: risk factors and suicide during a five year follow-up. *Acta Psychiatr Scand, 84*, 545-549.

Sintonen H. (1995). The 15 D measure of health-related quality of life. II feasibility, reliability and validity of its valuation system. *Centre for Health Program Evaluation. Working Paper 42*. Retrieved from: http://www.buseco.monash.edu.au/centres/che/che-publications.html.

Sintonen H. (2001). The 15 D instrument of health related-quality of life: properties and applications. *Ann Med, 33*, 328-36.

Treloar A.J. & Pinford T.J. (1993). Deliberate self-harm: An assessment of patients' attitudes to the care they receive. *Crisis, 14*, 83-89.

Walsh B.W. & Rosen P.M. (1988). *Self-Mutilation: Theory, research, and treatment*. New York, NY: Guilford Press.

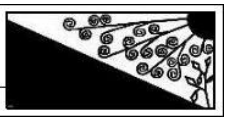
Warm A., Murray C. & Fox J. (2002). Who helps? Supporting people who self-harm. *Journal of Mental Health, 11(2)*, 121-130.

Whitfield H.J. (2006). Towards case-specific applications of mindfulness-based cognitive-behavioural therapies: A Mindfulness-Based Rational Emotive Behaviour Therapy. *Counselling psychology, 19(2)*, 205.

World Health Organization. (2005). *Suicide Huge but Preventable Public Health Problem.* http: // www.who.int./mediacentre/news/releases/2004/pr61/en/

World Health Organization. (1992). *Health-for-all targets. The health policy for Europe. Summary of the updated edition.* Copenhagen, Denmark: World Health Organization (EUR ICP HSC 013).

Suicidology Online
open access journal
www.suicidology-online.com



ISSN 2078-5488

Editorial Office
Dr. Nestor Kapusta
Medical University of Vienna
Department of Psychoanalysis and Psychotherapy
Waehringer Guertel 18-20
1090 Vienna, Austria
office@suicidology-online.com
http://www.suicidology-online.com