3 Very brief psychotherapeutic interventions with deliberate self-harmers

Pauline Cowmeadow

There is a need for an effective treatment of patients who deliberately do themselves harm, whether through poisoning or injury, because of the frequent repetition of such acts and the increased risk of suicide. In the course of a controlled intervention study (Cowmeadow et al., in preparation) in which patients admitted to hospital after deliberate self-harm were allocated randomly to either eight sessions or a single session of psychotherapy (Cowmeadow, 1994), I gained experience of very brief interventions with this difficult group of patients. My interests were two-fold: firstly to explore the advantages of a psychotherapeutic approach, and secondly to assess the benefits of a single psychotherapeutic session, offered as soon as possible after the initial assessment. This chapter describes a model and some case studies, based on my work with deliberate self-harmers, in a single psychotherapeutic session. This model combines general psychodynamic elements with specific elements from the CAT approach.

Deliberate self-harm

Repetition of deliberate self-harm is common. A number of studies have shown that between 12% and 25% of patients treated for deliberate self-harm repeat within one year (Hawton and Catalan, 1982). Furthermore, there is an increased risk of suicide; in the year following an episode of self-harm the risk is 100 times higher than in the general population (Kreitman, 1989) and the overall lifetime risk is 27 times that of the general population (Hawton and

Cognitive Analytic Therapy: Developments in Theory and Practice, Edited by A. Ryle

Fagg, 1988). It has been noted that between a third and a half of all suicides are preceded by an episode of deliberate self-harm, often a comparatively short time before the fatal event and often treated by a professional (Kreitman, 1989). This represents a powerful argument for providing an effective intervention at the time of the self-harm episode, to prevent both repetition and suicide by severing the deliberate self-harm–suicide link.

Difficulties of providing effective treatment

The difficulties include the range of problems—emotional, personal and interpersonal—of these patients; the high proportion of patients with personality disorders; and the lack of any clear agreement about the best form of treatment, which is reflected in the wide variation in clinical practice (Hawton and Fagg, 1988). This patient group is characterised by very poor compliance with treatment; typically only 30% attend follow-up appointments after initial assessment (Moller, 1988). However, it has been noted that compliance may be improved by early intervention and continuity of care—that is, the same person doing both assessment and treatment (Moller, 1988). Another difficulty is that these patients often provoke rejecting and hostile attitudes in those who attempt to help them (Ramon, Bancroft and Skrimpshire, 1975). In addition, these patients are often very distressed and thus may cause high levels of anxiety in staff which may be difficult to contain.

Important treatment characteristics

The observations above suggest that an intervention most likely to be helpful should have the following features:

1. Treatment should take place early, as soon as possible after the episode of self-harm.
2. Treatment should be provided by the same person who did the assessment.
3. Treatment should be psychotherapeutic in approach, thus providing a framework within which the patient's distress may be taken seriously and his or her anxiety contained. Also, a psychotherapeutic approach addresses countertransference difficulties, in that reactions aroused in the therapist may be understood as enactments of the patient's interpersonal difficulties.
4. Treatment should include a problem-solving component which aims to help patients find alternative solutions to their difficulties so they do not need to resort to self-harm.

Before describing how I have combined these four elements in a single psychotherapeutic session, offered to patients shortly after assessment for a deliberate self-harm act, I shall review briefly the literature on single-session therapy.

Single-session psychotherapy

There have been many studies of brief psychotherapy, but reports of change occurring in five or fewer sessions are more rare (Barkham, 1989). Information about the potential usefulness of single-session psychotherapy comes from three areas: studies of 'dropouts' from therapy; follow-up studies of patients who received psychotherapy assessments but no treatment; and reports of planned brief interventions of between one and three sessions.

Several studies, mainly from the USA, have looked at the reasons given by patients for discontinuing therapy after a single session. These studies showed that, contrary to the therapists' assumptions, many patients failed to return because they felt they were satisfied with the help they had received (Talmon, 1990; Silverman and Beech, 1979). The author of one of these studies concludes that: 'Single-session encounters between mental health professionals and their clients are remarkably common. Not only is their frequency underestimated, but more importantly their therapeutic impact appears to be under-estimated as well' (Bloom, 1981, p. 180).

The second area of relevance is follow-up studies of patients assessed for psychotherapy who did not receive treatment. David Malan and others at the Tavistock Clinic (1975) followed up 45 patients two and eight years after the initial assessment. Twenty-three patients (51%) were judged to have improved symptomatically, and 11 (20%) showed evidence of psychodynamic change, as judged from therapists' reports of the first interview and from patients' comments about the interviews at follow-up. The psychodynamic changes were similar to those that might be expected from long-term psychotherapy. The authors concluded that 'Powerful therapeutic effects may follow from a single interview' (p. 121).

The two therapeutic factors that were identified as being important in dynamic change were 'insight' and the patients being brought face to face with the necessity to take responsibility for their own lives. The authors commented that these patients, when seen at follow-up, showed a new ability to resolve a situation, first by self analysis and then by taking appropriate constructive action on the insight achieved. This resulted in a new way of handling emotional difficulties. Other changes included patients being able to work through feelings with other people involved and the breaking of vicious circles between patients and their environment. These changes appeared to have been facilitated by the single diagnostic interview, and the authors concluded:

'Clearly psychiatrists who undertake consultations should not automatically assign patients to long term psychotherapy or even to brief psychotherapy, but should be aware of the possibility that the single dynamic interview may be all that is needed' (p. 126).

The third area of information about single-session therapy comes from accounts of brief interventions of between one and three sessions. Freud described two cases of patients who were treated in a single session of psychoanalysis: Katharina (Breuer and Freud, 1893) and Gustav Mahler (Freud, 1960). More recently, Bloom (1981) has described a model for 'single-session focused therapy', the aim of which is to 'break through an impasse in the client's psychological life' (p. 182). Davanloo (1980) has given accounts of planned two-session dynamic psychotherapy, and Talmon (1990) has described an approach to single-session therapy in terms of 'maximising the effect of the first (and only) therapeutic encounter'. He emphasises flexibility of technique and an active approach. Barkham has described a model of 'Two Plus One Therapy', in which patients are seen for two sessions one week apart, followed by a third session three months later.

Common themes from studies in all three areas are, firstly, that the therapeutic impact of single psychotherapeutic sessions may be under-estimated; secondly, that the therapeutic power of single sessions may be maximised by active interventions by the therapist; and lastly that these interventions should aim at increasing the patient's insight into his or her difficulties so as to discover new ways of handling emotional difficulties.

Single-session therapy and deliberate self-harm

Various studies of psychodynamic psychotherapy with deliberate self-harm patients have described the difficulties and general issues that may arise in working with these patients (Tabachnick, 1961; Birtchnell, 1983; Campbell and Hale, 1991; McGinley and Rimmer, 1992). There are, however, no reports of single psychotherapeutic sessions with this group of patients. One of my research interests was to explore the potential therapeutic value of the single psychotherapeutic session, which I thought might be especially relevant in the treatment of deliberate self-harmers because they frequently do not return for treatment after initial assessment.

Practical details

All patients received a full clinical assessment as soon as possible after their admission, before the psychotherapy session. Patients needing antidepressants

or inpatient treatment were excluded from the project. During the assessment, particular emphasis was placed on a detailed reconstruction of the events, including the patient's states of mind and emotions, leading up to the self-harm act. Typical patterns in relationships and in reactions to important figures in the patient's life were identified. In this way, information was gained about problem behaviours or feelings which would be the focus for the single psychotherapy session. After assessment, the patient was given a copy of the Psychotherapy File (see Appendix 2.1 in Chapter 2), and asked to read it before the psychotherapeutic session, which usually took place about one or two hours later.

The patients were told that the aim of the session was to look in more detail at some of the problems that had emerged in the assessment interview, with a view to clarifying the cause of these difficulties and identifying alternatives to self-harming behaviour. Patients were also told that they would be asked to attend follow-up appointments in three months and one year but they could request a further session at any time.

A model for single-session psychotherapy with deliberate self-harmers

My starting point for doing psychotherapy with patients who have harmed themselves deliberately is Neil Kessel's (1965) description of the predicament of patients who have taken overdoses:

> Distress drives people to self poisoning acts: distress and despair, unhappiness and desperation. . . . Nobody takes poison a little or a lot, to live or to die, unless at that moment he is distressed beyond what he can bear and so desperate that he cannot see a more rational solution. He does not think that no solution exists, but he cannot himself find it. The suicide says, in effect 'There is no way out', but people who poison themselves are saying 'I cannot see a way out'. They find themselves trapped. They are desperate; and their distress drives them to an action that is both stupid and, at the same time, a blow for liberation, to an action that is both senseless and purposeful (p. 1336).

There is wide variation in what may be achieved in a single psychotherapeutic session, depending on the intensity and nature of the patient's distress and how well motivated he or she is to understand the internal causes of the problems, rather than attributing everything to external events. Despite this variation, it is possible to describe a number of therapeutic factors and aims that are involved in a single psychotherapeutic session:

1. Restate the problem in terms of specific emotions and anxieties, such as rage, despair, guilt, fear of rejection.
2. Encourage the expression of emotions and provide containment.

3. Identify problem feelings and behaviours, such as angry outbursts.
4. Describe procedures that reinforce problem feelings and behaviours, especially those linked with actual or perceived rejection from others.
5. Link problem procedures with past experiences.
6. Discuss alternative procedures.
7. Provide a brief reformulation, which may be in prose or diagrammatic.

The self-harm act is often presented by the patient as a reaction to external events but always represents powerful internal states or conflicts which must be addressed therapeutically if repetition and future suicide are to be prevented. When the emotions underlying the distress have been acknowledged, these may be linked to maladaptive procedures which will be seen to be derived from early experience. Alternative strategies will be discussed, and a brief reformulation may be drawn up with the patient.

In summary, the single psychotherapeutic session responds to the predicament of the self-harmer, as described by Kessel, by combining a therapeutic understanding of the patient's distress with a problem-solving approach. I will now illustrate the use of this model with some case examples.

CASE 1

Mr J was Italian, aged 22. He had recently come out of prison and was trying to find work and somewhere to live. He had lost a job as a waiter and was having arguments with the friend in whose council flat he was staying. He felt guilty about imposing on his friend's hospitality but felt exploited by her because she expected him to do baby-sitting and housework. His guilt was compounded when his friend received a bill from the council for £1000 for the rent. Feeling increasingly depressed and anxious, he asked his GP for help but felt fobbed off with a prescription for diazepam with which he overdosed three days later.

Mr J expressed feelings of anger and despair, initially towards the council who were refusing to help him find a flat. He described his feelings before he took the overdose as: 'I felt fed up, couldn't handle any more, and wanted to block everything out. I felt everyone was looking down on me, despising me. I felt I wasn't going to get anywhere on my own and that no-one would help me. I felt desperate and hopeless.' He strongly identified with the description of the Placation Trap in the Psychotherapy File, recognising that behaving in this way often caused him to feel taken advantage of and furious.

The focus of the psychotherapeutic session was his sense of worthlessness and his placatory behaviour within relationships. He attempted to improve his self-esteem by trying to please others and this often led to his feeling exploited, resentful and guilty. This cycle was described to him in the form of a diagram (Figure 3.1). This linked his childhood experience of having been threatened and beaten by a very critical stepfather to internalised self-critical and blaming attitudes which reinforced his feelings of worthlessness.

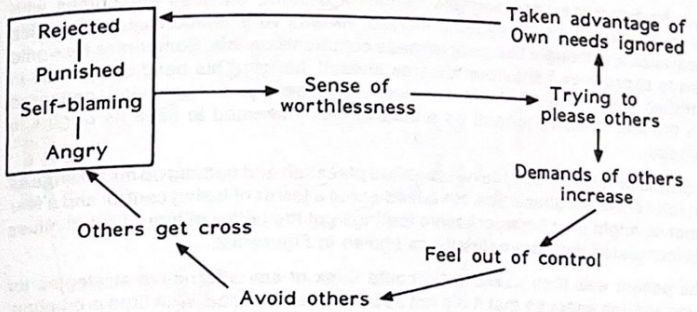

Figure 3.1: Diagrammatic reformulation for 'J'

Mr J found this a helpful description of his difficulties. He became less angry and described how in some situations he had been able to set limits on the demands of others and that this had resulted in an increased sense of his own worth. Mr J was given a copy of the diagram, but was lost to follow-up because he moved out of the area.

CASE 2

Mr B was a 24-year-old unemployed man who took an overdose after a violent argument with his girlfriend during which he smashed up their flat. The argument was precipitated by her threatening to leave, because of his mounting aggressive behaviour. He described himself as feeling increasingly depressed, tense and 'on a short fuse' for three months since he had lost his job. This occurred after he was accused of threatening behaviour towards his workmates.

He was the only child of his parents but was brought up with step-siblings who were the children of each parent's previous marriages. He was envied by his step-siblings, who regarded him as spoilt and fortunate in having two parents living together. He described himself as 'idolised' by his mother, who had high expectations of him. This put him under considerable pressure to succeed. He said he did not want to be 'special' but just to be 'normal'. He dropped out of school and ran away from home. His father was a physically intimidating man who had the potential to be violent. Although he was never violent towards Mr B, he often felt frightened of and intimidated by him. He described how frightening it was when his father beat up a young man who had insulted his wife.

In the psychotherapeutic session, Mr B was very tense and angry, demanding: 'What's the point of all this?' I asked him what he thought his main problem was. He replied: 'my violent tendencies'. I then explained that the purpose of the session was to try to understand this problem in more depth and if possible to find some solutions. He then calmed down considerably and talked about how his aggressive feelings were affecting his life in all areas; not only at work and with his girlfriend

whom he felt made unreasonable demands on him, but also sometimes with strangers by whom he easily felt criticised. He was very self-conscious about his appearance and thought that people made comments on this. Sometimes he would resort to aggressive behaviour towards himself, banging his head on the wall in frustration. Underlying much of these aggressive feelings and behaviour appeared to be the fear of being judged as a failure, which seemed to have its origins in childhood.

From the psychotherapy file he identified placation and bottling up his feelings as most relevant to his difficulties. He talked about a terror of losing control and a fear of what he might do if his aggressive feelings got the better of him. His difficulties were formulated diagrammatically as shown in Figure 3.2.

The patient was then asked if he could think of any alternative strategies for dealing with his anger so that it did not escalate into violence. With little prompting, he made seven suggestions. These included: drinking less; taking more physical exercise and seeking mental stimulation; avoiding situations in which he anticipated being exploited; remembering the positive aspects of his relationship with his girlfriend; when he felt himself getting wound up, talking to a helpful friend or getting out of the situation to give himself time to think.

When Mr B was seen for follow-up four months later, he reported considerable improvement. He had had only one further violent outburst, had been getting on better with his girlfriend and had started on a training course. He felt less depressed, more relaxed and had remembered all seven alternative strategies and was putting most of them into practice.

Thus the single psychotherapeutic session appeared to have helped Mr B mobilise his own resources for dealing with increasingly difficult aggressive feelings that were having a destructive effect on all areas of his life.

CASE 3

Miss C was an 18-year-old college student living with her mother and younger sister. She took an overdose after an argument with her mother in which she felt treated unfairly. The background to this was that, due to her mother's intending remarriage, there had been increasing arguments between her sister and her mother. Miss C was very worried that her mother's marriage would result in the breakup of the family. Despite her own anxiety at losing a close relationship with her mother and having to move to a different house, in which she feared her stepfather would 'make all the rules', she suppressed these feelings in trying to help her younger sister come to terms with the situation. 'I've been feeling so upset but couldn't talk about it. . . . No-one seemed to understand how I was feeling, but all the time I was trying to understand how they were feeling, trying to sort it all out. . . . I just got too much.' She expressed anger because she felt that everyone expected her to be 'solid and coping and not in need of support'. Even her boyfriend seemed unaware of her feelings.

Her parents had divorced when she was eight; her father had left home which upset her greatly because she was very attached to him. She remembers feeling insecure, fearing that he was dead and that the house might be broken into by a man who would attack her, her mother and her sister. Despite these anxieties she

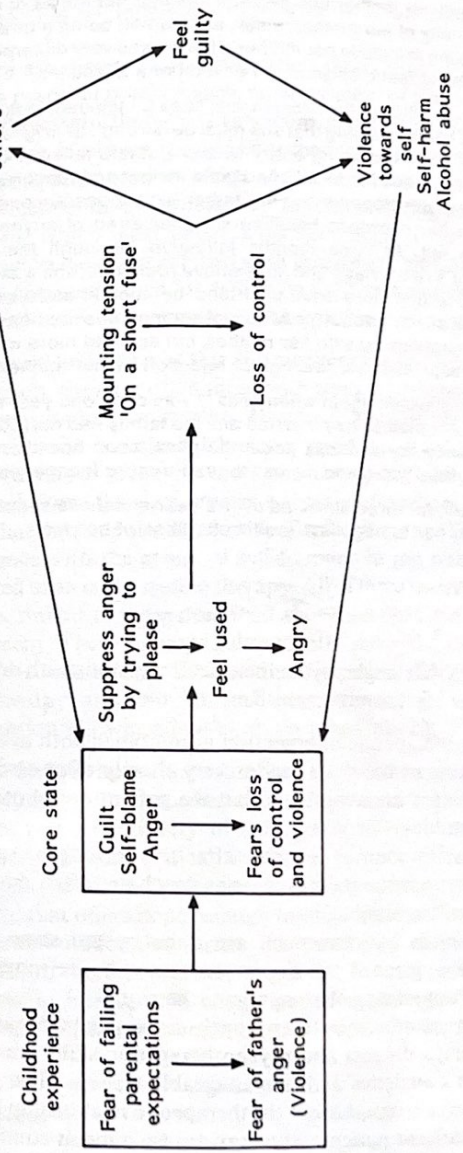

Figure 3.2: Diagrammatic reformulation for 'B'

remembered thinking that she had to be 'strong', that it was up to her to take her father's place and protect her mother and sister. It seemed her sense of security was based on the continuity of her mother, sister and herself being a threesome, and that the threat of having to include her mother's fiancé was very disturbing, and perhaps also caused her to feel displaced in her mother's affections.

Problem procedures identified in the session with Miss C included: looking after others at the expense of herself; feeling that she must be 'strong', thus ignoring her own needs and feelings, then becoming angry because others failed to offer her support when she felt she needed it. Miss C had good insight and recognised how this pattern of coping had developed since her father's disappearance, and also how this contributed to her overdose because she despaired of anyone being interested in how she felt. At three months follow-up, although the difficult situation with her mother's remarriage and housemove remained, she was bottling up her feelings less and talking more to her boyfriend, her mother and also friends at college. She remained anxious about the effects of her mother's relationship with her fiance on her own relationship with her mother, but seemed more tolerant of him and better able to cope with her feelings of rejection by her mother.

These themes were discussed again when Miss C was seen one year after her overdose. By this time, her mother had married and the family had moved outside London. Miss C expressed her sadness about the changes in her life, but also acknowledged that the time had come for her to lead a more independent life.

Miss C was seen, in all, for three sessions over a year and these seemed to be very helpful in assisting her to negotiate a difficult phase of her life.

Conclusions

My experience suggests that single psychotherapeutic sessions with deliberate self-harmers may have several important benefits:

1. Because the psychotherapeutic intervention is combined with assessment and often takes place on the same day or very shortly after assessment, problems of compliance are avoided in that the patient does not need to return for treatment.
2. Providing treatment as soon as possible after the episode of self-harm makes it more likely that the painful feelings which are often relevant to core anxieties are still accessible.
3. Becuase the assessment and treatment are done by the same person, relevant information gleaned at assessment may be reframed in a psychotherapeutic way during the therapeutic session.
4. A psychodynamic psychotherapeutic approach ensures that close attention is paid to the patient's distress and psychotherapeutic skills are used to contain the patient's anxieties and unmanageable feelings. The psychotherapeutic approach also emphasises the therapeutic relationship which is particularly important for patients who may arouse difficult countertransference reactions and who often feel very alienated, and anticipate rejection and criticism.

5. The problem-solving component helps to alleviate distress and despair by suggesting the possibility of alternative solutions.

There are, however, two important limitations of single-session therapy. From a practical point of view, an assessment of a self-harm patient followed by single-session therapy is time-consuming, usually taking a minimum of three hours. However, it could be argued that a thorough assessment followed by a therapeutic session which aims to prevent repetition of self-harm is a more effective use of professional time than giving appointments for future treatment which most patients do not attend. I believe that a therapeutic intervention closely combined with assessment should be provided for every patient who is admitted for deliberate self-harm, and that this may represent a potentially effective approach to the problem of repetition and suicide.

A second limitation of this approach is that some patients need more than one session; they are often those with serious personality difficulties or those with longstanding depression. However, a single psychotherapeutic session combined with assessment forms a good basis for further psychotherapy. Provided this is done by the same therapist, taking a psychotherapeutic approach from the start creates a therapeutic alliance which makes it more likely that the patient will return for further therapy. This was borne out by my experience with the group of self-harmers in my research project who were allocated to an eight-session therapy. All of these received a first psychotherapy session, similar to those described above, on the same day or a few days after assessment. These patients subsequently showed a much higher compliance than expected, in that 50% of them attended all eight sessions, completing their therapy, and four-fifths of them attended at least once after the initial intervention (Cowmeadow et al., in preparation).

This finding appears to confirm the effectiveness of the single psychotherapeutic session described above. In summary, the crucial elements of this approach are: continuity of care; early intervention; a psychotherapeutic approach that aims to make emotional contact with the patient and help him or her feel that the difficulties are being taken seriously; and a problem-solving element, that offers hope because taking a different perspective on apparently insuperable difficulties carries the possibility of finding new solutions. In conclusion, there is a strong argument for providing this type of psychotherapeutic intervention to all patients who present with an episode of deliberate self-harm, no matter how trivial this may initially appear to be.

References

Barkham, M. (1989). Exploratory therapy in 2–1 sessions. I: Rationale for a brief psychotherapy model, *British Journal of Psychotherapy*, **6** (1), 82–88.

Birtchnell, J. (1983). Psychotherapeutic considerations in the management of the suicidal patient, *American Journal of Psychotherapy*, **37**, 24–36.
Bloom, B.L. (1981). Focused single-session therapy: initial development and evaluation. In: Budman, S.H. (Ed), *Forms of Brief Therapy*, pp. 167–216, New York, Guilford Press.
Breuer, J. and Freud, S. (1893). Studies in hysteria. Republished 1944 in J. Strachey (ed), *The Complete Psychological Works of Sigmund Freud*, Vol. 2. London, Hogarth Press.
Campbell, D. and Hale, R. (1991). Suicidal acts. In: Holmes, J. (Ed), *Textbook of Psychotherapy in Psychiatric Practice*. Edinburgh, Churchill Livingstone.
Cowmeadow, P. (1994). Deliberate self-harm and cognitive–analytic therapy, *International Journal of Brief Therapy*, **9**, 135–150.
Cowmeadow, P., Ryle, A., Watson, J. and Savournin, R. (in preparation). An intervention study using brief psychotherapy with deliberate self-harmers.
Davanloo, H. (Ed) (1980). *Short-term Dynamic Psychotherapy*. New York, Jason Aronson.
Freud, A. (ed.) (1960). *Letters of Sigmund Freud*. New York, Basic Books.
Hawton, K. and Catalan, J. (1982). *Attempted Suicide*. Oxford, Oxford University Press.
Hawton, K. and Fagg, J. (1988). Suicide and other causes of death following attempted suicide, *British Journal of Psychiatry*, **152**, 359–366.
Kessel, N. (1965). Self poisoning, *British Medical Journal*, 1265–1270 and 1336–1340.
Kreitman, N. (Ed) (1989). *Para-suicide*. Chichester, John Wiley.
Malan, D.H., Heath, E.S., Bacal, H.A. and Balfour, F.H.G. (1975). Psychodynamic changes in untreated neurotic patients. II: Apparently genuine improvements. *Archives of General Psychiatry*, **32**, 110–126.
McGinley, E. and Rimmer, J. (1992). The trauma of attempted suicide, *Psychoanalytic Psychotherapy*, **7** (1), 58–68.
Moller, H.J. (1988). Compliance. In: Platt, S.P. and Kreitman, N. (Eds), *Current Research on Suicide and Para-suicide: Selected Proceedings of the Second European Symposium on Suicidal Behaviour*. Edinburgh, Edinburgh University Press, pp. 164–172.
Ramon, S., Bancroft, J.H.J. and Skrimpshire, A.M. (1975). Attitudes towards self-poisoning among physicians and nurses in a general hospital, *British Journal of Psychiatry*, **127**, 257–264.
Silverman, W.H. and Beech, R.P. (1979). Are drop-outs, drop-outs? *Journal of Community Psychology*, **7**, 236–242.
Tabachnick, N. (1961). Countertransference crisis in suicidal attempts, *Archives of General Psychiatry*, **4**, 64–71.
Talmon, M. (1990). *Single Session Therapy*. Oxford, Jossey-Bass.

4 Treating eating disorders using CAT: two case examples

Francesca Denman

This chapter recounts the experiences of a group of therapists at a major psychiatric hospital who have been treating patients presenting with severe eating disorders, using Cognitive Analytic Therapy (CAT). Two patients who had different presentations and underlying target problem procedures (TPPs) are discussed. The cases illustrate the range of difficulties encountered by CAT therapists in managing the different presentations.

Background

Eating disorders are now a relatively common problem in psychotherapeutic practice, but no approach to treatment has gained clear pre-eminence. These patients can be among the most challenging to treat and their symptoms can be of life-threatening proportions. CAT was thought a possible approach to try because, while both psychodynamic and cognitive–behavioural approaches appear to have something to offer, they also both present distinctive difficulties. CAT, insofar as it integrates both these approaches, might be able to offset the weaknesses of one approach against the strengths of the other.

Cognitive–behavioural treatments seemed to be good at achieving symptomatic improvements in some patients but frequently appeared to leave emotional issues untouched. Furthermore, things could go wrong in these treatments because the therapist could be seen by patients as a coercive parent and was, in consequence, liable to reproduce some common aspects of their

Cognitive Analytic Therapy: Developments in Theory and Practice, Edited by A. Ryle