Two clinical vignettes introduce us to two patients presenting with a history of self-harm and their entrance into psychosocial therapies to reduce the repetition of these behaviours. We follow them into the early stages of therapy, accompanying the vignettes with self-test questions, to illustrate the approaches taken in manual-assisted cognitive behavioural therapy (MACT) and dialectical behaviour therapy (DBT). These clinical vignettes complement the theoretical framework and evidence base outlined in *The psychosocial management of self-harm: Part 1* and illustrate the use of psychosocial interventions in practice.

Clinical vignette 1: Manual-assisted CBT for self-harm

- There are potential problems that might influence a doctor’s assessment of a self-harming patient including:
  - possible intoxication, which clouds diagnostic specificity
  - possible histrionic personality traits (e.g. inappropriately seductive behaviour)
  - possible borderline personality traits (recurrent threats or acts of self-harm)
  - possible minimising of symptoms to expedite discharge and avoid engagement
  - poor therapeutic alliance due to features of the patient, the doctor, the environment, the long wait for assessment, and the antisocial hour of the assessment
  - poor therapeutic alliance due to the patient’s earlier interactions with emergency department staff.

- The psychiatrist should also be aware of the possible dynamics affecting the assessment:
  - idealisation
  - negative transference
  - negative counter-transference
  - projective identification
  - denigration
  - acting out.

- Factors most predictive of outcome are:
  - therapeutic alliance
  - therapist training, competence
  - patient expectations about the therapeutic modality offered
  - personality traits
  - non-specific factors relating to patient, therapist or environment
  - theoretical allegiance of the investigators.

- Other interventions to consider might be:
  - psychoanalytic psychotherapy
  - interpersonal psychotherapy
  - group cognitive behavioural therapy
  - group analytic psychotherapy
  - dialectical behaviour therapy (DBT)
  - supportive psychotherapy
  - acceptance and commitment therapy (ACT)
  - cognitive analytic therapy (CAT)
  - social problem-solving therapy
  - allocation to a CPN
  - out-patient psychiatric review to consider pharmacological management of chronic dysphoria and impulsive aggression.

- If a diagnosis of borderline personality disorder (BPD) is confirmed the following may be indicated:
  - dialectical behaviour treatment (DBT)
  - mentalisation-based treatment (MBT)
  - transference-focused therapy
  - Interpersonal psychotherapy (IPT) – but only in the treatment of associated depression.
Some ways to improve manual-assisted therapies could be:
- Regular audit of the department’s service resulting in the updating of manuals where indicated
- Ensuring that any manual-based treatments considered for implementation are empirically supported (the basis of evidence-based policy)
- Incorporating training in the use of manual-based treatments into the department’s academic programme
- Ensuring a system of adequate supervision of trainees
- Devising criteria for combining, sequencing or switching between such therapies according to patient response.

Clinical vignette 2: DBT for the reduction of self-harming behaviour

- Dialectical behaviour therapy (DBT) was introduced and developed by Dr Marsha Linehan, Clinical Psychologist at the University of Washington in Seattle. DBT is based on a biosocial theory of borderline personality disorder which views early childhood development in an ‘invalidating environment’ as responsible for difficulties in recognising and regulating emotions.

- The components of DBT are:
  - Individual therapy
  - Skills training group
  - Out-of-hours telephone contact
  - Weekly consultation group for therapists.

- A DBT team would consist of:
  - The individual therapist
  - Skills trainers
  - A psychiatrist
  - Other staff, who may be peripherally involved according to characteristics of the patient’s behaviour.

- A number of sessions is used to establish commitment to treatment. The stages of DBT are:
  - Pre-treatment: this concentrates on assessment, commitment and orientation to therapy.
  - Stage 1: this explores suicidal behaviours, therapy-interfering behaviours and quality-of-life-interfering behaviours, and looks at the skills needed to resolve these problems.
  - Stage 2: this explores post-traumatic stress related problems.
  - Stage 3: this focuses on self-esteem and individual treatment goals.

- Problems in implementing DBT services might be:
  - Unwillingness to fund DBT services due to the comparative expense
  - Perceived expense and lack of evidence of cost-effectiveness
  - Patients often viewed as a marginalised group
  - Lack of staff trained in DBT
  - Difficulties and expense in accessing DBT training
  - Local infrastructure – facilities to provide individual sessions, group sessions and telephone rota
  - Real or feared therapist burn-out
  - Service cuts and rapid reform threatening the longevity of DBT services.

Further reading