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Original Research Article

An acceptance and commitment therapy based protocol for the management of acute self-harm and violence in severe mental illness

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Abstract

Though only engaged in by a minority of sufferers, self-harm and violence can nevertheless occur within the context of a variety of mental illnesses, from personality disorder to affective disorders, to schizophrenia and other psychoses. Violence to the self (both with and without suicidal intent) and others are not uncommon occurrences on psychiatric wards. This paper explores the utilisation of a new mindfulness centred therapeutic protocol based on acceptance and commitment therapy for the management of self-harm and violence. The protocol was piloted on three patients with a history of high levels of violence to self or others on a psychiatric intensive care unit in London. An outline of acceptance and commitment therapy is provided, together with a detailed description of the protocol for the intervention itself, and some of the outcomes achieved. Recommendations for further adaptations, studies and clinical trials are considered.

Keywords

Self-harm; violence; acceptance and commitment therapy; severe mental illness; mindfulness

BACKGROUND

Self-harm among sufferers of severe mental illness in the acute setting has consequences that are both immediate and long term. According to a recent report from the National Institute for Clinical Excellence on self-harm, 1.8% of those who commit self-harm manage to commit suicide the same year and 8.5% will die by suicide over a 22 year period (NICE, 2011). Violence and aggression are also of significant concern, particularly on psychiatric wards, where 58% of violent attacks are found to be serious and 78% are directed towards nursing staff (Owen et al. 1998). Additional evidence also points to a particular subset of individuals perpetrating this violence. It tends to be young males with a history of violence (El-Badri & Mellsop, 2006) and it also tends to be the same people (Lussier et al. 2009).

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Third wave therapies

The so called 'third wave' of cognitive behaviour therapies is a relatively new area in the field of mental health. They are said to include dialectic behaviour therapy (DBT), mindfulness based cognitive behaviour therapy (MCBT) and acceptance and commitment therapy (ACT).

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One of the common themes between them is the utilisation of mindfulness based practises for mental health problems (Baer, 2003). Such interventions have started to show positive results in the treatment of a variety of disorders (Baer, 2005), and are now also incorporated into NICE guidelines for treatments of these disorders. DBT has already demonstrated considerable success in dealing with both non suicidal self-harm (Muehlenkamp, 2006), suicidal behaviours (Linehan et al. 2006) and violence (Fruzzetti & Levensky, 2000).

One mechanism via which mindfulness based techniques are postulated to have an impact on such behaviours is through a reduction in *experiential avoidance* (Chapman et al. 2006). Experiential avoidance is a key construct in ACT, and it is defined as the attempt to alter the form, frequency, or situational sensitivity of negative private events (e.g. thoughts, feelings, and physiological sensations). An experiential avoidance model of violence and self-harm postulates that such acts are, in fact, attempts to avoid experiences such as thoughts, feelings, somatic sensations or other internal experiences that are uncomfortable or distressing (Chapman et al. 2006). A reduction in experiential avoidance is therefore the fundamental goal of ACT.

An intervention, therefore, that focuses on a reduction in such experiential avoidance, may well have an impact on propensity towards self-harm, violence and aggression in sufferers of severe mental illness.

ACCEPTANCE AND COMMITMENT THERAPY

According to the Association for Contextual Behavioural Science (the professional organisation for acceptance and commitment therapy) 'ACT illuminates the ways that language entangles clients into futile attempts to wage war against their own inner lives. Through metaphor, paradox, and experiential exercises clients learn how to make healthy contact with thoughts, feelings, memories, and physical sensations that have been feared and avoided.' (Hayes, 2005). The theoretical framework that underpins ACT is known as relational frame theory (RFT). RFT posits that humans possess an ability that is unique to our species; namely the deployment of sophisticated language. We do so by forming what are known as bidirectional associations between words and their meanings so that, over time, both a word and its meaning will start to fuse. We also develop complex and deep associations between different words and concepts, ultimately forming whole networks of such associations within our minds, which we may trigger at any time, in response to interactions with the environment, so taking us out of the present moment. As a result, we are particularly creative as a species, but this also makes us vulnerable to emotional distress due to the constant inner chatter that such a continual process involves. In addition, our tendency to then attempt to 'fix' this distress, as we would any external problem, leads us to devise methods of avoidance of that emotional distress (experiential avoidance) which, in the emotional terrain, only serves to exacerbate the problem. This ultimately makes us vulnerable to psychopathology (Fledderus et al. 2010).

ACT's techniques involve intentionally bringing one's attention to the internal and external experiences occurring in the present moment. Such interventions have been shown to be of considerable value in a number of disorders, including for psychosis in an acute ward setting (Bach & Hayes, 2002).

A core technique within the ACT treatment approach is cognitive defusion. Cognitive defusion is defined in the *ACT Skills Training Manual for Therapists* (Luoma et al. 2007) as follows: 'ACT argues that the problem with human suffering as it relates to thoughts, is not that we have the wrong thoughts, but rather that we spend too much time 'in' them or 'looking from' them rather than simply looking at them or observing them. Cognitive defusion attempts to circumvent this problem by drawing the client's attention to thinking as an ongoing behavioural process and helping clients to see thoughts as thoughts, so those thoughts can be responded to in terms of their workability, rather than their literal truth.'

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PROTOCOL

The intervention was delivered to three patients on Picasso Ward (the psychiatric intensive care unit of Goodmayes Hospital in East London) all of whom had a lengthy history of regular bouts of violence towards themselves or others. One had a primary diagnosis of schizoaffective disorder, with frequent admissions (an average of two to three per year) for psychotic relapses involving significant self-harm including suicidal intent. The other two had bipolar affective disorder, with presentations including frequent bouts of violence toward family members, carers and ward staff.

The intervention was commenced with the schizoaffective patient once his risk of imminent self-harm had reduced. He was no longer actively responding to auditory hallucinations but continued to report them regularly with consequent thoughts of self-harm. Similarly, in the case of the two patients diagnosed with bipolar affective disorder, their imminent risks of violence had reduced before commencing the therapy, but they continued to display aggressive and abusive behaviour toward staff and/or family members.

The treatment consisted of daily 20 minute one to one sessions, provided over a period of two to three weeks.

Phase one

Each session starts with a specific defusion exercise in which the patient is asked to bring a difficult (particularly emotive) thought or feeling to mind and, instead of ruminating on or turning them over, just to hold them and notice how their bodies react to this for a few moments. This is followed by a wider cognitive defusion exercise, in the form of metaphor based guided meditation. The script for this rotates each day between 20 available scripts; each script is based on the idea of watching thoughts and feelings as the observer and container of them, rather than going into their content. The different metaphors used included concepts such as fish in the sea; where each thought or feeling is like a fish swimming in the sea and the person is the sea itself. Other metaphors included people in a busy office block where, again, the thoughts and feelings are the different people doing different jobs in the building and the person experiencing them is the building (the context) itself.

'Self as context' is an important concept in ACT treatment (Luoma et al. 2007). It is seen as a dimension of the self (the observer self) that is an alternative to the self that is embroiled in and fused to the world of thinking and doing, known as 'self as content'. Practicing experiencing one's self from this perspective is a key objective of each cognitive defusion exercise.

Phase two

The next phase is an exercise in the contemplation of values (another core process in the ACT schema; Luoma et al. 2007) via visual cues. Here, the patient is asked to read to themselves a values statement they prepared earlier in an introductory session, which lists their key life values in terms of what kind of person they would like to be in the areas of life most important to them (e.g. a loving partner, a dedicated student). The list is normally written within an outline drawing of a person. They are asked to read through the list, and then look upon the figure in soft focus as if it were a mirror or photo in which they could see themselves.

Phase three

Each session then finishes with a few minutes of discussion around the patient's experience of the exercises. The clinician always guides the discussion towards a highlighting of the experience of the thoughts and feelings within the body during the exercise, rather than the content of the thoughts themselves. This way, through sharing of multiple examples, they will learn to mindfully notice their thoughts and feelings more, and become entangled in their content less.

At every stage, the clinician engages in each of the exercises together with the patient, making it a collaborative exercise in personal growth for them both.

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Outcomes

Levels of aggressive and abusive behaviour were determined for each patient based on regular nursing shift reports, describing their behaviour over the course of the day. Changes in the levels of such behaviours were noted, as were changes in expression of self-harm or suicidal ideation as noted after interviews or ward reviews.

In the patients with a diagnosis of bipolar disorder, a clear reduction in aggressive and abusive behaviour was observed during the treatment period, and each developed an increasing confidence in their ability to manage such impulses in future. The Clinical Global Index (CGI) is a rating scale that is routinely used to determine clinical progress of patients on the ward and, in each case, a consistent reduction in severity of illness scores was observed during the period of treatment. Behaviours of an abusive and aggressive nature towards staff were regularly reported for one patient prior to commencement of therapy and, during treatment, such outbursts consistently reduced. At the end of the treatment, reports of aggressive and abusive outbursts had ceased entirely.

The patient with a diagnosis of schizoaffective disorder experienced a mark reduction in self-harm and suicidal ideation as well as a reduction in derogatory auditory hallucinations. He too showed a consistent reduction in severity of illness CGI scores during the period of treatment, and he also reported a more positive mood and self esteem during formal ward reviews.

The patient feedback regarding the intervention was universally positive, with each feeling that the ACT sessions contributed significantly to a reduction in their impulsive and violent behaviours. At the end of each course of treatment, the patient asked for information about the exercises so that continued mindfulness practice might be facilitated in the community after discharge. This was then provided in the form of a print out describing self directing exercises along the same lines.

DISCUSSION

There is a clear evidence base for the efficacy of mindfulness based treatments across various psychopathologies and there is some indication that this may also translate to the use of treatments such as ACT for the management of acute self-harm or violence. This initial experience of utilising ACT based treatments on a psychiatric intensive care unit has produced some positive results. The study, however, was not a controlled one and each patient undergoing the intervention was also subject to treatment as usual (i.e. standard pharmacological therapies as appropriate to their condition) which would also have an effect on levels of aggressive and abusive behaviours and self-harm ideation. More study is, therefore, required to further verify the effect of such interventions with controlled trials across wider samples using validated outcome measures.

Currently under development is a group-based intervention, based on this protocol, which is designed to facilitate daily mindfulness practice for both staff and patients together on psychiatric wards, entitled Integrated Mutual Participation Acceptance & Commitment Therapy (IMPACT) groups. A study to examine more global change, with outcome measures including use of PRN medication, use of restraint, Clinical Global Index (CGI) scores and lengths of stay is currently underway. This is a historically controlled trial and was launched in late 2011.

As data accumulates on the efficacy of such measures, implementation of similar protocols, in either a one to one or group setting, may become a viable treatment option across PICUs and forensic units for the management of self-harm or violent behaviour. It will require engagement and cooperation from the patient and so will not have universal applicability, but where patients are amenable, such interventions may serve as a useful additional medium term tool at the disposal of clinicians.

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