Brit. J. Psychiat. (1980), **137**, 494–496

Correspondence

IMMEDIATE PSYCHOLOGICAL HELP FOR SELF-HARMERS

DEAR SIR,

Some of those routinely assessing cases of deliberate self-harm may not be aware of useful psychotherapeutic approaches to such patients.

The act of self-harm can be seen as a communication with another person or people (Ramon, Bancroft and Skrimshire, 1975; and White, 1974). It demonstrates dependency or hostility, and usually combines the two. The act has manipulating or controlling elements. Usually, the individual seeks or is taken to professional help, when the doctor receives the communication contained in the act. An unsympathetic response by the doctor, clearly stated to the individual, might be appropriate. The individual then knows where he stands. He has been rejected. His problem and the responsibility for it remain his own. His ensuing anger with the doctor would also seem an appropriate and healthy response. An unsuccessful attempt to help by the inappropriate prescription of psychotropic drugs can be dangerous. The doctor's rejection is thereby disguised to look as if it were the opposite. The individual then finds it more difficult to give an open, angry response to the doctor, and might instead give a covert angry response of drug overdose.

If the doctor accepts, at face value, the individual's promise that he will never indulge in self-harm activity again, this implies that the act was something of which the doctor disapproved and was therefore an act of hostility to him. The individual, by his promise, tries to placate the doctor, rather than to examine his own behaviour. In the common example of self-poisoning following an argument, the doctor might challenge the individual who made such a promise by asking what alternative mode of dealing with his anger he proposes. Individuals often, then, make more positive suggestions. The doctor can then show that he finds these suggestions more acceptable and constructive than self-harm activity.

A variation of the promise never to do it again is a statement by the individual critical of his self-harm behaviour, such as feeling ashamed or saying it was a silly thing to have done. If the doctor, rather than simply being 'reassuring', can accept the individual's assessment that he has acted in a silly way he can then explore with him less silly ways in which he might have responded, and in which he might be expected to respond in future.

Murphy and Guze (1960) have written extensively on the general problem of the manipulative patient. A particularly difficult type is the young individual, frequently a woman, emotionally unstable but not mentally ill, who refuses to enter a psychiatric ward, and yet tells the doctor in forceful terms that she is going to kill herself. The sort of challenge by the patient is designed to make the doctor feel helpless and guilty. In this manipulation the individual has tried to pass responsibility for her behaviour to the doctor. The challenging response of the doctor might be to point out that she does not seem to wish to kill herself, but rather to have the doctor try to persuade her not to do so. With a response, she may be able openly to take back responsibility for her own actions.

These are some examples of an approach to immediate psychological help of self-harmers who do not require psychiatric admission. They are intended to be illustrative rather than exhaustive.

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OXYPERTINE FOR DEMENTIA

DEAR SIR,

In view of the recent interest in oxypertine (Freeman and Seni, *Journal*, May 1980, **136**, 522) I would like to report my clinical experience using this drug for disturbed patients with dementia.

Episodes of disturbed behaviour where hostility, aggression and overactivity are prominent features can cause considerable difficulty in the management of demented patients and are frequently the reason for an old person becoming a psychogeriatric

https://doi.org/10.1192/bjp.137.5.494b Published online by Cambridge University Press