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Efficacy of Cognitive Behavior Therapy with Deliberate Self-harm in Incarcerated Women

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A one group intervention-based study was conducted in women jail, Karachi, Pakistan. The aim was to determine whether cognitive behavior therapy, administered in prison setting, was effective in reducing the frequency of deliberate self-harm in female prisoners. 40 female inmates were interviewed; nine inmates with a history of deliberate self-harm were screened out for 12 sessions of cognitive behavior therapy. Deliberate Self-harm Inventory (Gratz, 2001) and Brief COPE (Carver, 1997) were administered to explore deliberate self-harm behaviors and coping strategies of women prisoners. The number of deliberate self-harm episodes before and after therapy was the main outcome measure. An approximate 29% incarcerated women reported deliberate self-harm. Relief from anger and tension, and feelings of hopelessness, and helplessness were the main motives. Cutting and burning were the most common types of deliberate self-harm behaviors reported. The frequency of self-harm episodes was minimal during and after therapy. Findings and implications have been discussed.

Keywords: Deliberate self-harm, incarcerated women, cognitive behavior therapy

Prison self-harm is on the rise with more women harming themselves as compared to men (Brooker, Flynn, & Fox, 2010). According to the Corston Report of 2007, women alone accounted for 46% of self-harm incidents while being less than 6% of the total prison population (Corston, 2007). The limited literature on prison self-harm (Crighton & Towl, 2000) explains it as an attempt to cope with the strains of incarceration (Kilty, 2006). Incapacitating living

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conditions, disturbed relations with fellow prisoners and jail staff, solitary confinement, inconsistent prison rules, delayed justice, fear of losing custody of children, trauma, impulse control problems, dissociation, a need to express anger and frustration, negative life events, guilt, rejection by families, and self-criticism have been identified as some of the contributing factors (Borrill, Snow, Medlicott, Teers, & Paton, 2005; Dear, Thomson, Hall & Howells, 2001; Roe-Sepowitz, 2007; Snow, 2002).

A complex maladaptive coping mechanism (Favazza, 1998), deliberate self-harm (DSH) has been quite challenging for clinicians (Huband & Tantum, 1999). Although cognitive behavior therapy (CBT) with a problem solving component (Slee, Garnefski, Van Der Leeden, Arensman, & Spinhoven, 2008), acceptance based emotion regulation group therapy (Gratz & Gunderson, 2006), psychodynamic interpersonal therapy (Guthrie et al., 2001), and solution focused brief therapy (Lamprecht et al., 2007) have produced positive results, their efficacy is limited to nonforensic populations. Prison settings come with many limitations (Nee & Farman, 2005) that have to be considered when therapeutic interventions are being designed. Dialectical Behaviour therapy (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991) has been reported to be effective in treating self-harm in female prisoners but only as a symptom of borderline personality disorder (Nee & Farman, 2005). A recent review of interventions implemented for the management of self-harm in incarcerated populations suggested that group cognitive behavior therapy (CBT) could help in dealing with this perplexing behavior (Townsend et al., 2010).

Females make 1.4% of Pakistan's prison population (International Centre for Prison Studies, 2007). National statistics on deliberate self-harm in this highly stigmatized population are lacking. There are no psychiatric and psychological facilities available. Only 1 male (visiting) psychiatrist is reported to be deputed at the Central Prison, Karachi (Wasif, 2005). The present research, therefore, aimed to explore the prevalence of deliberate self-harm in Incarcerated women and investigate the efficacy of CBT in managing it in a group of Pakistani female prisoners. This group intervention was based on the experiential model of DSH (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). The model assumes that self-harm functions as a way to avoid unwanted emotions or cognitions. The selfharmer is temporarily relieved of her intense, uncontrollable, and painful thoughts, and feelings. This transient relief, in turn, serves as a negative reinforcement for repeating the maladaptive coping mechanism in the long term (Hayes et al., 1996). DSH was defined as

the direct damaging of body tissue without the conscious intent to kill oneself (Favazza, 1998); this was irrespective of prisoners' psychiatric diagnosis.

Method

Participants

The inclusion criteria required the women inmates to be able to speak and comprehend Urdu, be not more than 50 years of age, and have a history of DSH.

The 40 consenting prisoners were interviewed in the jailer's office. Information related to demographics, duration of incarceration, self-harm, and access to mental healthcare was obtained. Three participants were excluded for being overage (above 50 years) and six were excluded because they could not speak Urdu. The psychological measures were then administered to the remaining 31 inmates. In case the participant was not literate, the measure was administered orally. Inmates reporting self-harm (six convicted and three under-trial prisoners) were recruited for therapy.

The sample, therefore, comprised of nine Pakistani inmates: six had self-harmed in jail and three had prior history of DSH. Their ages ranged from 21 years to 50 years (M = 30.9 years, SD = 11.16 years). They had been accused of theft, kidnapping of children and adults for ransom, murder, smuggling, and possessing drugs. They all consented (orally) to attend the sessions.

Measures

Deliberate Self-harm Inventory. Deliberate Self-harm Inventory (Gratz, 2001) was used to measure DSH in the female inmates. It is a behavior based, self-report questionnaire consisting of 17 items. It explores the type of self-harm reported by the participant; its severity, duration, and frequency. It has a high internal consistency (α = .82) and adequate test retest reliability (φ = .68, p <.001), and significant construct, convergent, and discriminant validity (Gratz, 2001). The number of episodes of deliberate self-harm was the main outcome measure in this study.

The inventory was translated into Urdu language by the authors and then translated back to English by the language faculty of

University of Karachi, Karachi, Pakistan. The back-translated version was then compared with the original version. Adjustments were made to make sure that the translated Urdu version reflected the original meanings.

Brief COPE. The Brief COPE (Carver, 1997) a self-report measure, was used to assess the women prisoners' methods of coping with imprisonment. The scale was translated into Urdu language by the authors for the current study; it has 28 items; 2 items each measure 14 coping strategies. The maladaptive coping methods measured are: self-distraction, denial, substance use, behavioral disengagement, venting, and self-blame. The adaptive coping methods assessed are: active coping, emotional support, instrumental support, positive reframing, planning, humour, acceptance, and religion. The participants have to rate their responses on a 4-point likert scale ranging from 0 "*I haven't been doing this at all"* to 4 "*I've been doing this a lot";* high scores indicate the preferred coping strategies. The scale has high Cronbach's alpha values for coping strategies of religion ($\alpha = .82$) and substance use ($\alpha = .90$), and adequate values ranging from .50 to .73 for all the other domains (Carver, 1997).

Procedure

The ethical approval was obtained from the Board of Advanced Studies and Research, University of Karachi, Karachi, Sindh, Pakistan. The Minister of Jails, and Inspector General Prisons, Sindh, granted permission to gain access to women wing of Karachi Central Jail. The Deputy Superintendent Police, Women Jail, introduced the researchers to the prisoners. The inmates were informed about the purpose of the study, their right to accept or refuse participation and withdrawal from the study at any point in time was conveyed. The researchers made clear that withdrawal would not in any way affect their life in prison. It was also explained that the information they would share during the study would remain confidential. A brief orientation of CBT was given to each individual participant.

As there were no prison records of self-harm, the jailer and prison nurse were interviewed separately to cross-check the type and number of episodes reported by the incarcerated women. They were partially aware of forms of self-harm such as beating oneself, and burning arms on the kitchen stove, but couldn't report the exact frequency of DSH incidents.

Intervention

The first author administered CBT to a group of nine prisoners. 12 sessions were conducted in total; one session per week for four months; each session lasted from 45 minutes to 60 minutes. The intervention aimed at (a)identifying the individual triggering events that led to self-harm, (b) recognizing the thoughts and feelings that these motivating factors produced, (c) accepting the distorted thinking and the resultant emotions, (d) changing distorted thinking, (e) accepting and becoming comfortable with the more adaptive thoughts and emotions, and (f) developing alternative adaptive coping skills; Psychoeducation, cognitive restructuring, problem-solving, and relaxation procedures were used.

The intervention was primarily for the female prisoners, it was felt (later) that the jail staff should have been oriented towards the functions of self-harm, and involved in some (additional) therapeutic sessions designed to equip them with the skills to deal with and support the self-harm group. This was important because the prisoners had to keep on living in jail for quite some time, lacking in adequate social support, and also because no post-therapy help was available.

Results

The data was analysed using SPSS version 19. One-way repeated measures ANOVA was applied on the Brief Cope scores (pre and post-intervention) to evaluate for the impact of CBT on the coping methods of the women participants. Log rank test was administered to assess the impact of CBT on DSH. Kaplan-Meier statistics was used to explore distribution and descriptive statistics for duration of DSH.

DSH was found in 29% (n = 9) of the incarcerated women (n = 31). An approximate half (n = 4) of these inmates had initiated self-harm after imprisonment and a nearly equal number (n = 5) had been self-harming before incarceration.

Reasons for DSH ranged from complex psychological conflicts and minor daily hassles and irritants. Cutting (injuring), burning body parts with hot spoons or the kitchen stove fire (56%) were the most common types of self-harm practiced followed by banging of head, rubbing glass into skin (33%), severely scratching one's skin, burning oneself with cigarettes, lighter or match (22%), preventing wounds from healing, and severely punching and biting oneself (11%). Majority of the women expressed that they indulged in DSH to release

their anger and inner tension and turmoil; one-third of the group reported that they harmed themselves out of feelings of hopelessness and helplessness. Some other reasons given for engaging in deliberate self-harm were excessive guilt, to punish oneself, to express one's needs (n = 2), to escape isolation, and for enjoyment (n = 1); imprisonment, conflict with fellow inmates, critical and sarcastic comments of other prisoners, biased attitude of jail staff, and long delays in family visits were some additionally cited precipitating events. The demographic details of the self-harm group are given in Table 1.

Table 1

Demographic Characteristics of DSH in Sample (N = 9)

Demographics		*f*
Education	Illiterate (Couldn't read Urdu)	4
	Illiterate (Could read Urdu)	1
	Undergraduate	1
	Graduate	3
Marital status	Single	1
	Married	7
	Divorcee	1
Children in custody	Lost custody of children	5
	Children in jail	1
Legal status in jails	Convicted	6
	Under trial	3
DSH initiated after incarceration	Convicted, not under trial	5
	Convicted, under trial	1
DSH initiated before incarceration	Convicted, not undertrial	1
	Convicted, undertrial	2

As is evident, an approximate half of the participant inmates were going through the pain of losing their children. The earliest age of onset of DSH was reported to be 11 years and the latest age was 49

years (*M* = 25.5 years, *SD* = 12.8 years). None of the women inmates reported having access to mental health services before or after incarceration. The number of DSH episodes had increased with the time spent in jail. The stay in jail varied from 12 months to 84 months (*M* = 29 months, *SD* = 23.47 months). Those who had been in prison for 12 to 24 months reported less than 5 episodes of self-harm as compared to the more than 15 episodes of those who had been in jail for 48 to 84 months. Five of the nine women had begun to self-harm in jail indicating that incarceration had an important role to play as a psychodynamic for DSH. Occurrence of DSH ranged from one day before contact (for present study) to 150 days before contact (*M* = 53 days, *SD* = 63.1 days); the last DSH episode had occurred some two months (average) back.

Table 2

Coping Strategies Utilized by the DSH Group Pre-therapy and Post-therapy (N = 9)

Coping strategies	Pre-therapy		Post-therapy	
	M	*SD*	*M*	*SD*
Maladaptive self-distraction	2.44	.73	2.56	1.07
Denial	1.94	.73	1.94	.77
Substance use (cigarettes/tea)	2.89	1.36	3.33	1.12
Behavioral disengagement	1.94	.98	2.28	1.12
Venting	2.50	.75	2.72	.67
Self-blame adaptive	2.56	.63	2.50	.90
Active coping	2.33	1.06	2.11	1.27
Emotional support	2.11	1.05	2.44	.90
Instrumental support	1.50	.71	1.67	.90
Positive reframing	2.22	.71	2.28	.97
Planning	2.44	.73	2.17	.90
Humour	1.72	.83	1.72	1.03
Acceptance	2.78	.79	2.56	.84
Religion	2.78	.97	3.00	1.03

A One-way repeated measures ANOVA was conducted to compare scores on coping with imprisonment before therapy and after therapy. Although there was no significant effect for therapy for any

of the 14 different types of coping strategies, the mean scores of some of the adaptive coping methods showed improvement post-therapy (see Table 2). Excessive smoking and consumption of tea, venting, and self-blame were the most frequently used coping methods.

The participants attended all 12 sessions of group CBT. Although court appearances, family visits, overtime in craft classes, an occasional bad mood sometimes made them late; on the average they never missed a session. Figure 1 show Kaplan-Meier survival curves for the duration of DSH incidents during and after treatment.

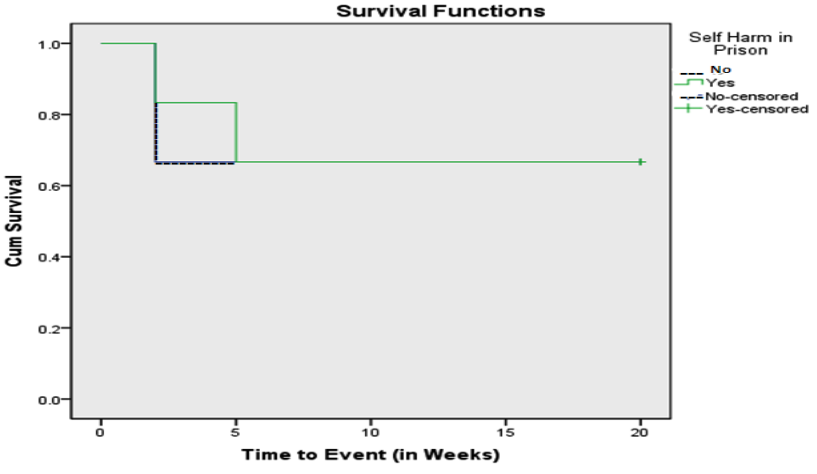

Figure 1: Kaplan-Meier Survival Curve for the Duration of DSH Episodes during and after CBT

Kaplan-Meier statistics is used primarily to study the survival function, that is, if the frequency of DSH decreased, for how long the self-harmer was able to maintain her control. The smooth line curve in the figure represents the DSH episodes of the women who had self-harmed in prison, and the blue fragmented curve represents the women who had a previous history of DSH but had not self-harmed in prison. The breaks where the curves fall show that 1 woman who had a history of prison DSH and another who had not self-harmed in prison, self-harmed during the second week of therapy. The other break at the fifth week shows that one woman who had been self-harming in prison, self-harmed in the fifth week of the therapy. The rest of the smooth curve indicates that there were no more episodes of DSH till the follow-up, that was done a month after the intervention was completed i.e., at the 20th week. The last attempt of DSH (pre-therapy) had been made on an average of 7.6 weeks back. Therapy had delayed this time to 14.3 weeks (*SE* = 2.68): 14.5 weeks

(*SE* = 3.2) in the women who had self-harmed in jail, and 14 weeks (*SE* = 4.89) in the women who had not self-harmed in jail, suggesting that the prisoners had learned to control their DSH behaviors. The impact of CBT however, was statistically nonsignificant (log-rank test: $\chi^2 = .004$, $df = 1$, $p = .95$).

Discussion and Conclusion

The current study was aimed at investigating the efficacy of CBT therapy in reducing the frequency of DSH in incarcerated women. Considering that our prison systems, the prevalence rates in this study were quiet high and similar to the ones reported in the other parts of the world (Corston, 2007; Kilroy, 2000). Majority of the self harming women were young and convicted (Kenning et al., 2010). Nearly half of them had begun to harm themselves in jail lending further support to the view that DSH is a means to rebel against the lack of control women experience over their lives and circumstances during incarceration (Kenning et al., 2010; Kilty, 2006). The jail administration are only partially aware of the intensity of prison DSH (being practiced), and do not provide any mental healthcare services. These findings call for urgent clinical attention. The present study with all its limitations, and tentative findings, suggests that cognitive behavior therapy can be a promising intervention for managing DSH.

Interventions based on CBT did not yield a statistically significant impact, though the intervention group felt relatively better after intervention. The number of DSH episodes was minimal during the therapy, and after intervention evaluations did not report any act of DSH. There was also an improvement in the mean scores of the adaptive coping methods as assessed by the Brief COPE (Carver, 1997). A number of therapeutic factors are supposed to have contributed to these positive results. The therapy sessions were something different from the dull routine of prison life (Rhodes as cited in Thomas, Leaf, Kazmierczak, & Stone, 2006). According to the women prisoners, the role of the therapist as a facilitator who accepted and respected them (National Institute for Clinical Excellence, 2004), led to the development of strong association. They appreciated that their criminal histories had not been mentioned in the sessions; they were not reprimanded for being late; they could openly share their feelings and thoughts without being judged. Defining and exploring self-harm from their perspective (Mangnall & Yurkovich, 2008) made them feel understood (McAllister, Creedy, Moyle, & Farrugia, 2002). Literature provides evidence that therapist alliance

contributes to the effectiveness of CBT (McGinn & Sanderson, 2001) and women prisoners have responded favorably to healthcare staff with caring attitudes (Kenning et al., 2010). The role of therapeutic association in making cognitive behavior therapy work with this specific population needs to be explored further.

The women prisoners had a heightened awareness of their emotional suffering and an associated tendency to express it through avoidance behaviors. Their inner anguish found expression through heavy smoking of cigarettes, consuming excessive amount of tea, watching TV, spilling out their negative emotions, or self-condemning. They also used more emotion-focused coping strategies as compared to problem-focused (active coping, planning, and instrumental support). The work on cognitions and emotions developed a sense of control over (one's) behavior giving these women a feeling of empowerment much needed to survive in a prison environment (Kilty, 2006). Some participants were able to see the connection between DSH and their own thoughts and subsequent feelings in maintaining it. Still others were overwhelmed by these realizations, and guilt surfaced; this was believed to be one of the reasons behind the DSH episodes observed during the sessions. Self-harming people suffer from serious interpersonal problems that can be aggravated in an incarcerated environment. The current group therapy facilitated the participants to identify their interpersonal conflicts and work along-with each other. It was observed that with the progress of therapy they appeared to be more accepting of each other. They seemed to relate to each others' motives for engaging in DSH and began to seek comfort in the group. This is also evident from an increase in the post-therapy scores on the coping methods of utilizing emotional support and positive reframing. It is therefore, assumed that this decrease in their interpersonal conflicts could also be one of the reasons of their lowered tendency for DSH. Relaxation exercises were also reported by the participants to have helped them in easing the tension in their bodies.

There were some conflicting findings in the post-therapy CBT evaluations; the participants although developing control over their DSH behaviors, showed an increase in the use of avoidance behaviors (self distraction, substance use, and venting). It is assumed that this was because the women needed other coping methods to deal with their stress. As they had a tendency to avoid their emotional pain rather than accept it (Haines & Williams, 2003), and the limiting prison environment (Kilty, 2006) did not allow for the needed social support (Dear, Thomson, Hall, & Howells, 1998), therefore, it is understandable that the alternate methods these women would more

readily turn to, would be the ones they were already habitual of. There was also a decrease in the adaptive coping methods of acceptance and planning. This was viewed as an improvement by the therapist as planning for most of these women primarily meant being occupied with thoughts of unrealistic ideas of getting released. As they had little control over resources and circumstances, their efforts usually amounted to nothing. The resultant (repeated) frustration and agitation then led to anger and self-harm. Acceptance of the fact that they had been incarcerated for a number of years developed an attitude of resignation to their predicament that lowered their trust on themselves. They felt helpless, and incapable of surviving it. A decrease in the level of acceptance suggested that their belief in their ability to survive was being reinstated. This meant that they would strive to better cope with the adverse experience of incarceration and (consequently) moderate the frequency of their DSH behaviors.

An increased involvement in religion (an adaptive emotion focused coping strategy) was also observed. The limited literature on incarcerated women's coping mechanisms has shown that being religious helped these women in adjusting and coming to terms with incarceration (O'Connor, Ryan, Sakovich, & Parikh as cited in Levitt & Loper, 2009). The belief and trust in a Supreme Being who was capable of understanding and forgiving them, and had the power to change their circumstances instilled hope in the confined women. They were able to get off drugs, be at peace with their past, their emotions, and anxieties about their futures (Greer, 2002). Holding on to religion minimized physical and verbal aggression, enhanced their mood (Levitt & Loper, 2009) and reduced self-harm (Eytan, 2011). Future work needs to explore this coping mechanism in more depth considering societal and cultural context-specific dimensions of religion.

Although these findings provide a preliminary support to CBT being instrumental in managing prison self-harm, caution must be exercised in interpreting the results. The current study was conducted in only one jail of Pakistan with a small number of voluntary participants that limits the generalisability of the findings. It is assumed that DSH might have been misreported (Borrill et al., 2003) for confidentiality reasons. The psychological measure used to assess deliberate self-harm was also not designed for forensic populations. It included some modes of self-harm that were not possible in jail, e.g., drinking poisonous liquids, and rubbing body parts with sand paper as the jail rules did not permit the prisoners' access to such elements. Deliberate self-harm was addressed irrespective of the clinical and personality diagnosis. Reduction in the incidence of self-harm

behaviors could have been the result of an improvement in the participants' clinical symptoms (Raj, Kumaraiah, & Bhide, 2001). Prospective work, therefore, needs to control these limitations, and aim at experimental studies of CBT for discrete groups of clinical and non clinical self-harm with longer follow-ups in order to better evaluate its efficacy.

Limitations

Certain limitations affected the results of the present study. The researchers had access to prison for only six months. The recruitment process consumed a whole month. The unstable law and order situation in Karachi resulted in the therapy being completed in 16 weeks rather than the 12 weeks planned. Only one follow-up was thus conducted a month post-intervention; a very short time period to assess the impact of CBT on a complex behavior like DSH. The therapist was not permitted to conduct the sessions in a separate room. The verandah adjacent to the jailer's office was the only space that she could utilize for therapeutic purposes. This disturbed the privacy of the experimental group. Non-participant prisoners passed by or watched from a distance out of curiosity. The jailer, the security staff or the nurse tended to attend the ongoing sessions for an approximate 10 to 15 minutes. This temporarily blocked the flow of the sessions; women prisoners tended to be guarded in their presence, and diverted from the therapeutic discussion to more general ones like complains about delayed family visits, tribal feuds, pending requests for paroles, etc. Some of the more vocal participants occasionally involved the jailer in describing their self-harm methods. This also wasted the already limited time of the session, and sometimes some therapeutic work had to be carried over in the next session minimizing the impact of therapy. Although the therapist briefed the jail staff about the necessity of privacy in the therapeutic sessions, they did not seem to understand or appreciate it. It was realized that a group effort involving prison staff, administration, and psychologists (Nee & Farman, 2005) would have been more effective. An adequate orientation into therapeutic programs should have been given to the prison administration and staff before the commencement of the study in order to avoid these inappropriate responses.

The small number of participants did not allow for a control group. This caused limitations in the study and findings. It also might have affected the statistical significance of the findings. Further it was

not a homogenous group. The participants varied greatly in age, literacy levels, life-events, and the time spent in jail.

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