

Experiences of Dialectical Behavioural Therapy by Adults Diagnosed with Borderline
Personality Disorder

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Contents

	Page
Introduction	1
Dissertation Overview	1
 Chapter 1 - Literature Review	 3
Title Page	3
Abstract	4
Introduction	5
Personality Disorder	5
Borderline Personality Disorder	5
Personality Disorder Strategy in the United Kingdom	5
Diagnosis and Treatment	6
Dialectical Behaviour Therapy	7
Study Aims	8
Method	8
Literature Search	8
Inclusion and Exclusion Criteria	9
Results	10
Critiquing the Literature	12
Synthesising the Qualitative Literature	16
Discussion	19
Summary of Findings	19
Reflections on Quality and Validity	19
Experiences of Other Therapies	20

Synthesis of the Quantitative Literature	21
Future Research	23
Limitations	24
Conclusion	25
References	26
 Chapter 2 – Empirical Research	 34
Title Page	34
Abstract	35
Introduction	36
Borderline Personality Disorder	36
Psychological Treatment of Borderline Personality Disorder	37
Dialectical Behaviour Therapy	37
Effectiveness of Dialectical Behaviour Therapy	38
Gaps in the Qualitative Literature	40
Aims and Objectives	41
Method	42
Participants	42
The Dialectical Behaviour Therapy Programme	43
Procedure	44
Ethical Approval	44
Selection and Recruitment	44
The Interview	45
Data Analysis	46
Results	47
Therapeutic Group Factors	48

Shared Understanding	48
Learning from other Clients	49
Therapist Factors	50
Non-judging	50
Challenging Avoidance	51
Non-hierarchical	52
Supportive	53
Personal Change	53
Development of Skills for Achieving Practical Personal Goals	54
Increased Control of Strong Emotions and Life-Threatening Behaviours	54
Transformational	55
Permanence of Skills	55
Challenges to be Overcome	56
Anxieties about Starting the Skills Group	56
Difficulties Using the Phone Coach	56
Dynamic Group Composition	57
Hard Work	58
Personalised Problem Solving	58
Application of Skills to Self	58
Crises Resolution	59
Opposing Expectations	60
Optimistic	60
Pessimistic	60
Discussion	61
Summary of Findings	61
Exploring the experience and impact of each of the DBT components	61

The degree to which experiences of the DBT programme were aligned to initial expectations of the programme	62
The meaning of a ‘life worth living’ for someone diagnosed with BPD	63
Whether DBT contributes to a ‘life worth living’	63
Links to the Quantitative Literature	64
Implications	65
Future Research	65
Limitations	65
Reflexivity	66
References	68
 Chapter 3 – Concluding Discussion	 75
Extended Discussion	76
Overview of Findings	76
Links to the Existing Literature	76
Clinical Implications	80
Research Implications	82
Reflexivity	82
Different Version of the Empirical Research	85
Future Study	87
Potential Qualitative Studies	87
Research Proposal	89
Introduction	89
Literature Review	90
Aims and Objectives	91
Method	92

Participants	92
Ethical Considerations	92
Data Collection	93
Materials	93
Design	93
Strategies for Validating Findings	94
Sample Size	94
Biases	95
Challenges	95
References	96

List of Tables

Table 1:	Characteristics of Reviewed Studies	11
Table 2:	Characteristics of Reviewed Studies using the Consolidated Criteria for Reporting Qualitative Research (Tong, Sainsbury, & Craig, 2007)	12
Table 3:	Characteristics of Participants Interviewed	43
Table 4:	Master Table of Themes	47

List of Figures

Figure 1:	Results of Electronic Database Research Strategy	10
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List of Appendices

Appendix A:	Clinical Psychology Review Author Guidelines
Appendix B:	Journal of Clinical Psychology Author Guidelines
Appendix C:	Diagram Illustrating the Recruitment of Participants
Appendix D:	University of Liverpool Approval Letter

Appendix E:	University of Liverpool Intention to Sponsor
Appendix F:	Local Research Ethics Committee Approval
Appendix G:	Local NHS Trust Approval
Appendix H:	Participant Information Sheet
Appendix I:	Consent Form
Appendix J:	Letter of Invitation
Appendix K:	Demographics Sheet
Appendix L:	Interview Schedule
Appendix M:	Further Support Information Sheet
Appendix N:	Example of Transcript with Initial Comments
Appendix O:	Example of Transcript with Descriptive, Linguistic, and Conceptual Comments
Appendix P:	Analytic Development from Emergent Themes to Super-ordinate Themes

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Introduction

Dissertation Overview

This dissertation for the Doctorate of Clinical Psychology at the University of Liverpool focuses on the experiences of receiving dialectical behaviour therapy (DBT) in the community by adults diagnosed with borderline personality disorder (BPD). It comprises three distinct chapters, namely a literature review, an article detailing an empirical study, and an extended discussion.

Chapter one presents the findings from a literature review that systematically searched the qualitative literature for studies that explored the experiences of receiving community-based DBT by adults diagnosed with BPD. The chapter begins by briefly describing the history, diagnostic criteria, prevalence, and symptoms of BPD, before describing the components of DBT, a psychological treatment that has received strong empirical support for the treatment of BPD. Findings from the systematic search of the qualitative literature reveal five articles that fit the review's inclusion criteria; this paucity of qualitative research investigating clients' accounts of DBT in actual clinical settings is surprising considering that DBT has received growing support for its efficacy since the publication of its treatment manual in 1993. When considering the findings from the five qualitative articles, the picture of clients' experiences of DBT is unclear, as the studies vary fundamentally in their research design. For example, the qualitative studies differ in their research design, including the use of structured interviews, semi-structured interviews, and focus groups, and vary in the methodological approaches deployed to analyse the data. Also, the DBT programmes from which participants were recruited in the qualitative studies differ in their fidelity to the DBT model.

With the systematic search of the qualitative literature revealing so few studies exploring the experience of receiving community-based DBT by adults diagnosed with BPD, together with their methodological and analytical differences contributing to an unclear account of the experience, chapter two of this dissertation presents an empirical study aiming to augment the qualitative literature that explores the experience of receiving

community-based DBT by adults diagnosed with BPD. This empirical study is vital as not only does it consolidate the existing qualitative research, but, remarkably, is believed to be only the second study of its kind to be conducted in the National Health Service (NHS), with the first being conducted over 6 years ago. The aims of the empirical research are to capture participants' expectations and experiences of the DBT programme, the impact and experience of the multi-modal components of the programme, determine the meaning of a 'life worth living' to someone diagnosed with BPD, and gauge whether DBT contributes to a 'life worth living', which is DBT's overarching aim. Six participants are interviewed, all of whom are diagnosed with BPD and have experience of a community-based DBT programme delivered by the NHS. Six themes are found from analysing the qualitative data derived from the interview transcripts.

As the intention is to publish both the literature review and empirical paper in academic journals, and academic journals invariably set a limit regarding the maximum number of words or pages for research articles, the third chapter of this dissertation elaborates on the points made in the discussion section of the empirical article in chapter two. The elaborations extend the implications of the findings to the wider research. Links are made to the wider research literature that focuses on group therapies, and the literature suggesting that those diagnosed with BPD struggle to foster therapeutic alliances with therapists. Links are also made to clinical practice, especially in light of fundamental changes to the landscape of the NHS, such as the Coalition Government's target to make £20 billion of efficiency savings within the NHS by 2014, and the NHS now facing competition from 'Any Willing Provider' offering healthcare provisions. Overall, the participants' experiences of DBT found by the empirical study presented here is encouraging, and it is hoped that such positive views from users of the NHS may go some way to balance the criticism the NHS has received over the years regarding the quality of care it provides to the public. Chapter three also includes a different version of the empirical article, written for employees and clients of the Trust in which the research was conducted. Chapter three concludes with a section detailing how the empirical research presented in this study could be usefully extended.

A review of the experiences of dialectical behaviour therapy by adults diagnosed with borderline personality disorder.¹

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¹ To be submitted to See Appendix A for author guidelines.

Abstract

Psychological therapy is regarded as the first-line treatment for borderline personality disorder. Dialectical behaviour therapy has gathered the most evidence of the psychological therapies for the treatment of borderline personality disorder. This study reviews qualitative studies that have explored the experiences of community-based dialectical behaviour therapy by adults diagnosed with borderline personality disorder. A systematic approach was used to search the literature. Studies were identified by searches of electronic databases. Five qualitative studies were reviewed. Findings indicate that the experience of community-based dialectical behaviour therapy by adults diagnosed with borderline personality disorder is generally positive; the skills group is beneficial for learning skills to manage emotions and self-destructive impulses; phone coaching is useful in crises; and individual therapy provides an opportunity to consolidate skills taught in the skills group. With the United Kingdom's Department of Health requiring public healthcare to provide services to people diagnosed with a personality disorder, it is imperative that research continues to explore the experiences of dialectical behaviour therapy delivered by public healthcare services to gauge its effectiveness for those diagnosed with a personality disorder.

Keywords: Borderline personality disorder, clients' experiences, dialectical behaviour therapy, interpretative phenomenological analysis, literature review, qualitative research.

Declaration of interest: none.

Personality Disorder

The International Classification of Mental and Behavioural Disorders (ICD-10; World Health Organisation, 1992) defines personality disorder (PD) as a disturbance in the characterological and behavioural tendencies of an individual, often resulting in considerable personal and social disruption. According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994), personality disorder is considered as a pattern of inner experience and behaviour that deviates from cultural expectations and is pervasive, inflexible, enduring, and often leads to distress or impairment.

Borderline Personality Disorder

Stern (1938) first used the phrase ‘borderline personality’ to describe mental health patients whose presentations did not fit into specific conditions, but, instead, ‘bordered’ between neuroses and psychosis. Kernberg (1967) coined the term ‘borderline personality organisation’ to refer to patients who exhibited unstable behaviour characterised by what he considered to be a disturbed psychological self-organisation. The American Psychiatric Association (APA) defines borderline personality disorder (BPD) as a pervasive pattern of instability of affects, self-image, interpersonal relationships, and impulse control (APA, 1994).

PD Strategy in the United Kingdom (U.K.)

The National Institute of Health and Clinical Excellence (NICE, 2009) states that BPD is considered not to have an ‘acute’ phase, but instead is pervasive. Therefore the treatment of BPD in the public healthcare system, whose aim is to ‘treat’ people during an ‘acute’ stage of illness, is often ill-matched. In response to this, over the years, the Department of Health (DOH) has produced policies to ensure public healthcare services cater for the needs of those diagnosed with a PD; the National Institute for Mental Health in England (NIMHE), in conjunction with the National Service Framework for Mental Health, implemented national guidance for the development of services for people with PD (DOH, 2003). This guidance sets out The Personality Disorder Capabilities Framework to support the development of services to enable people with PD to access appropriate clinical care from specialist mental health services (NIMHE, 2003).

Diagnosis and Treatment

Although a discussion on the validity of the diagnosis of BPD is beyond the scope of this article, the DSM-IV defines BPD using nine criteria, of which five must be met for a diagnosis (APA, 1994). The ICD-10 does not use the term BPD, but instead uses ‘Emotionally Unstable Personality Disorder’, of which there is an impulsive and borderline type (World Health Organisation, 1992), the latter characterised by instability of emotions, self-image, and relationships, which is considered commensurate with the DSM-IV definition of BPD. Co-morbidity is often present, as rarely does an individual with BPD meet criteria for only a single PD (Ferguson & Tyrer, 2000). Many individuals diagnosed with BPD also present with depression, anxiety, and eating disorders, further complicating the psychological treatment of BPD (Zanarini et al., 1998). In addition to co-morbidity, Aviram, Brodsky, and Stanley (2006) report that individuals with BPD often have difficulty establishing a therapeutic alliance, which is a further challenge for therapy. This heterogeneity of those diagnosed with BPD, and therefore a lack of a clearly defined ‘core problem’, results in no single target on which to focus therapy (NICE, 2009).

Roth and Fonagy (1996) argue that BPD is a controversial diagnosis partly due to the lack of an exact neurobiological explanation, an argument also shared by Gunderson (2009), and a controversy shared with a number of other diagnosable mental health conditions. As an alternative to a neurobiological explanation for BPD, research has argued that an individual’s childhood history may contribute to a BPD presentation; Zanarini et al. (1997) found that approximately 90% of adults diagnosed with BPD had a history of childhood physical and/or sexual abuse. Therefore, it is argued that many individuals diagnosed with BPD may have unresolved insecure attachment styles (Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004). Given research evidence indicating that BPD symptoms may be an adaptive response to invalidating and abusive early environments (Shaw & Proctor, 2005), NICE (2009) recommends that psychological therapy is better suited than pharmacological treatment for those diagnosed with BPD.

Despite recommendations for psychological therapy to be the first-line treatment for BPD, the overall evidence base for psychological therapies in the treatment of BPD is of moderate quality (NICE, 2009). A number of therapies have been evaluated for the treatment of BPD, including mentalization-based therapy (MBT; Bateman & Fonagy, 2004), therapeutic communities (Lees, Manning, & Rawlings, 1999), cognitive analytic therapy (Ryle, 2004), psychodynamic psychotherapies (Gabbard, 2001), transference-focused psychotherapy (TFP; Kernberg, Yeomans, Clarkin, & Levy, 2008), cognitive behavioural therapy (Davidson, 2007), schema-focused therapy (SFT; Giesen-Bloo et al., 2006), and dialectical behaviour therapy (DBT; Linehan, 1993a). Of all the therapies evaluated for treating BPD, DBT has received the strongest empirical support (McSherry, O'Connor, Hevey, & Gibbons, 2012). The Cochrane Collaboration systematically reviewed a number of psychological interventions for BPD using a meta-analysis of 28 studies that involved a total of 1,804 individuals with BPD, and concluded that DBT has the strongest evidence of efficacy relative to the other treatments investigated (Stoffers et al., 2012). Corroborating this finding from The Cochrane Collaboration, Feigenbaum et al. (2011) report that DBT has been recommended as a treatment of choice for BPD by a number of influential bodies, such as the APA (2001) and NICE (2009).

Dialectical Behaviour Therapy

DBT offers a biosocial explanation for the development of BPD, suggesting that individuals diagnosed with BPD are born with an emotional vulnerability and respond intensely to emotional stimuli. Based on this theory, the primary objective of DBT is to help individuals learn strategies to manage their emotions through the acquisition of effective coping strategies. DBT is typically a one year multi-modal therapeutic programme, comprising a weekly skills training group, weekly individual therapy sessions, and telephone consultations. DBT therapists attend weekly consultation meetings that offer opportunities to discuss cases and develop DBT skills (Linehan, 1993b).

Study Aims

With U.K. government directives requiring the National Health Service (NHS) to include the treatment of PD in their service design (DOH, 2003), and clinicians and academics recommending that such services should be co-produced with service-users (Duffy, 2010), it is prudent to qualitatively explore the experiences of psychological therapy of those with a PD; findings from such qualitative research would help design healthcare services better equipped to meet the needs of those diagnosed with a PD. Additionally, with DBT garnering the strongest evidence of the psychological therapies in the treatment of BPD (NICE, 2009; Stoffers et al., 2012), and therefore being used among NHS settings in the treatment of BPD, it is vital to capture the qualitative experiences of NHS-delivered DBT by those diagnosed with BPD to ensure that DBT delivered within the NHS is clinically effective and tailored to meet the needs of those with BPD.

Machai and McEvoy (2009) report that as evidence-based practice within healthcare continues to be important, literature reviews are becoming increasingly relevant for guiding current practice. Therefore, this study uses a systematic approach to search the qualitative literature that explores the experience of community-based DBT programmes for adults diagnosed with BPD. The relevant literature is then reviewed.

Method

Literature Search

On the 7th and 8th of February 2013 a systematic approach guided by the Cochrane Collaboration Qualitative & Implementation Methods Group guidelines was employed to search for relevant literature (Booth, 2011). Eight electronic databases were searched from their inception for relevant published literature. The electronic databases were chosen to encompass several professional disciplines, including Medicine (MEDLINE and PubMed), Psychology (PsycINFO), Nursing (CINAHL), general healthcare and science (Scopus, Web of Knowledge, and ScienceDirect) and systematic reviews (The Cochrane Database of Systematic Reviews).

The search terms ‘dialectical’, ‘behaviour’, ‘behavior’, ‘behavioural’, ‘behavioral’, and ‘DBT’ were used to search the electronic databases. The search strategy also comprised an examination of reference lists of relevant studies, an examination of high yield journals, a search of electronic theses, and contacting authors of relevant studies to enquire about yet unpublished studies.

Inclusion and Exclusion Criteria

Included for review were qualitative studies that used interviews or focus groups to explore the experience of community-based DBT by adults diagnosed with BPD. Studies comprising individuals with co-morbid presentations were included if the aim of the DBT intervention was to alleviate symptoms associated with BPD. Studies of adapted DBT programmes were included.

Studies were excluded if participants were receiving DBT in a non-community setting such as a forensic or inpatient setting. Studies were excluded if the DBT programmes were not specifically treating the symptomology of BPD, for example solely treating eating disorder or substance abuse difficulties. Non-English articles were excluded to prevent cultural and linguistic misinterpretations in translation. Studies were excluded if participants were engaged in DBT in addition to other therapies. Studies were excluded if they used questionnaires as the sole method for data collection, or reported only quantitative data. Qualitative studies exploring the experiences of individuals considered to have a learning disability were also excluded.

Results

Results from searching the electronic databases using the search terms yielded 2363 citations (Figure 1). The titles, abstracts, and content of the output of the search were reviewed to determine which of the articles were relevant; applying the inclusion and exclusion criteria and removing duplicates resulted in 2,358 research articles being rejected.

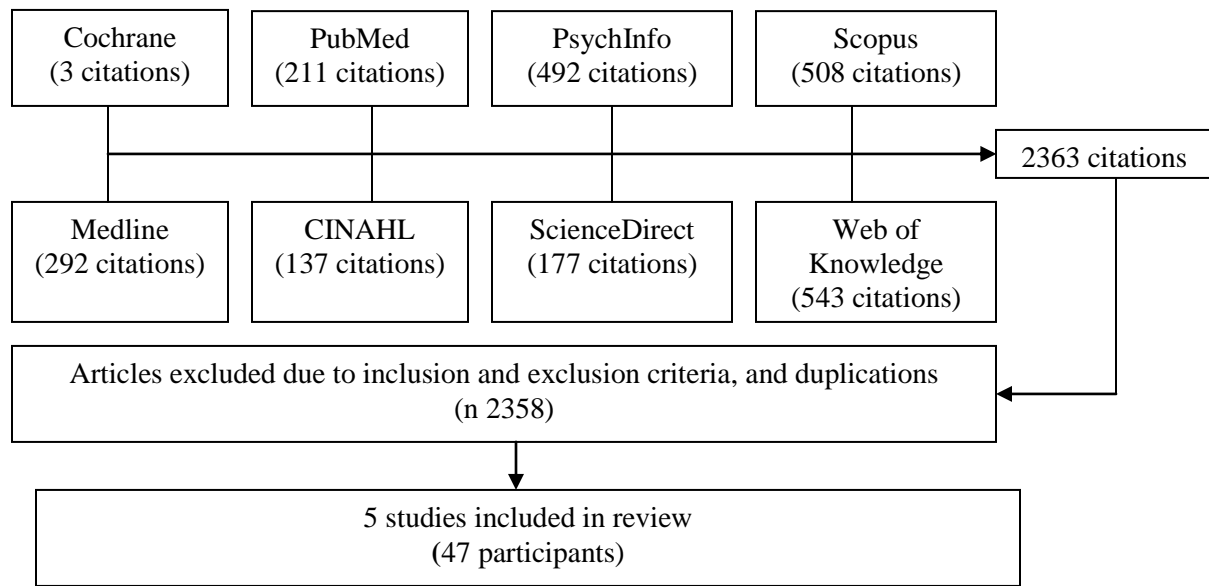


Figure 1. Results of electronic database research strategy

Five published studies were included in the review (Table 1). The five articles used a combination of interviews and focus groups to explore the experiences of DBT by 47 participants diagnosed with BPD. All of the studies reviewed in this study were found by searching the electronic databases.

Study Authors	Date of Publication	Country	Aim of Study	Participant Group	Number of Participants	Setting of Study	Data Collection	Analysis Methodology	Findings Summary
Brassington and Krawitz	2006	New Zealand	Assess degree of satisfaction of DBT by individuals with BPD	Clients	10	Community	Standardised interview questions	Not stated	Satisfaction with DBT
Cunningham, Wolbert, and Lillie	2004	US	Understand the experience of DBT by individuals with BPD	Clients	14	Community	Semi-structured interview	Ethnographic	DBT had a positive impact on the lives of individuals with BPD
Hodgetts, Wright, and Gough	2007	England	Exploration of DBT by individuals with BPD	Clients	5	Community	Semi-structured interview	Interpretive Phenomenological Analysis	DBT facilitated positive change
Perseius, Ojehagen, Ekdahl, Åsberg, and Samuelsson	2003	Sweden	Investigate patients and therapists' perception of DBT	Clients and therapists	10	Community	Semi-structured interview	Qualitative Content Analysis	Individuals with BPD considered DBT as vital to their wellbeing
McSherry, O'Connor, Hevey, and Gibbons	2012	Ireland	Exploration of DBT by individuals with BPD	Clients	8	Community	Semi-structured interview and focus group	Thematic	An adapted DBT programme is valuable to individuals with BPD

Table 1. Characteristics of reviewed studies.

Critiquing the Literature

Critical appraisal is the process of systematically examining research evidence to assess its validity, results, and relevance (Hill & Spittlehouse, 2003). The five articles were critiqued using the Consolidated Criteria for Reporting Qualitative Research (Tong, Sainsbury, & Craig, 2007). This critiquing framework uses 32 items covering the three domains of ‘research team and reflexivity’, ‘study design’, and ‘data analysis and reporting’ to enable the transparent critiquing and reporting of qualitative studies. Table 2 illustrates the characteristics of the five articles using the 32 items of the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007).

No. Item.	Brassington and Krawitz (2006)	Cunningham et al. (2004)	Hodgetts et al. (2007)	Perseus et al. (2003)	McSherry et al. (2012)
Domain 1: Research team and reflexivity					
<i>Personal characteristics</i>					
1. Interviewer	Consultant Psychologist (JB)	Students	Trainee psychologist (AG)	Nurse (K-I P)	First author (PMcS)
2. Credentials	Consultant Psychologist (JB) and Consultant Psychiatrist (RK)	The students were ‘extensively trained’ in interviewing. But no report of the credentials of the researchers	Clinical psychologist (AH), trainee psychologist (AG), and unknown (JW)	Nurse (K-I P). The credentials of the other researchers not reported	Not reported
3. Occupation	Consultant Psychologist (JB) and Consultant	Not reported	Clinical psychologist (AH), trainee psychologist (AG), and unknown (JW)	Nurse (K-I P)	Not reported

	Psychiatrist (RK)				
4. Gender	Female (JB) and male (RK)	2 females (KC and BL), and 1 male (RW)	2 females (AH and AG), and 1 male (JW)	Not reported	1 female
5. Experience	Not reported	The interviewers had 'extensive training in and experience with ethnographic interviewing'. No report of the experience of the researchers	Not reported	Not reported	Not reported
<i>Relationship with participants</i>					
6. Relationship established	Participants were unknown to the researchers, and the researchers were not involved in the delivery of DBT	Participants were unknown to the researchers, and the researchers were not involved in the delivery of DBT	The interviewer (AG) had once been part of the DBT skills group	Participants were unknown to the researchers, and the researchers were not involved in the delivery of DBT	Participants were unknown to the researcher, and the researcher was not involved in the delivery of DBT
7. Participant knowledge of the interviewer	No	No	Yes. Participants knew the interviewer had once been connected to the DBT skills group	No	No
8. Interviewer characteristics	Not reported	Students with experience of	Female trainee clinical psychologist	Female nurse	Female

		'Ethnographic' interviewing			
Domain 2:					
Study design					
<i>Theoretical framework</i>					
9. Methodological orientation and theory	Structured interviews. Analysis methodology not reported	Semi-structured interviews. Ethnographic analysis	Semi-structured interviews. Interpretative Phenomenological Analysis	Semi-structured interviews. Qualitative content analysis	Semi-structured interviews. Thematic analysis
<i>Participant selection</i>					
10. Sampling	Purposive sampling	Purposive sampling	Purposive sampling	Purposive sampling	Purposive sampling
11. Method of approach	Participants receiving treatment as usual	Participants receiving treatment as usual	Participants receiving treatment as usual	Participants receiving treatment as usual	Participants receiving treatment as usual
12. Sample size	10	14	5	10	8
13. Non- participation	1	Not reported	Not reported	1	22
<i>Setting</i>					
14. Setting of data collection	Not reported	Interviews conducted at a place of the 'participants' choosing'	Four interviews in the participants' homes, with 1 in a health service setting	Premises of the DBT team	Health service setting
15. Presence of non-participants at the interview	No	No	No	No	No

16. Description of the sample	Ten females all diagnosed with BPD. Age ranged from 21 to 53 years. Mean 34.3 years. Median 34 years. 9 New Zealand / European. 1 Maori / European. 6 had histories of childhood sexual abuse	Fourteen females all diagnosed with BPD. Age ranged from 23 to 61 years. Mean 38.7 years. Median 39 years. All had previous self harm incidents	Three females and two males. Age range from 24 to 48 years. Mean 35.6 years	Ten women aged between 22 to 49 years. Median 27 years. All had a diagnosis of BPD, 9 had previous suicide attempts.	Six females and 2 males. Age ranged from 32 to 55 years. All had a BPD diagnosis, and had been attending mental health services for 2 to 25 years.
<i>Data collection</i>					
17. Interview guide	Interview guide not reported. Not piloted	Interview guide reported. Not piloted	Interview guide not reported. Not piloted	Interview guide reported. Not piloted	Semi-structured interview and focus group. Not piloted
18. Repeat interviews	No	No	No	No	No
19. Audio/Visual recording	Not reported	Recorded, but not reported if audio or visual recording used	Audio recorded	Audio recorded	Audio recorded
20. Field notes	Not reported	Not reported	Not reported	Not reported	Not reported
21. Duration	Not reported	30 minutes to 1 hour	1 hour to 90 minutes	50 to 90 minutes	Not reported
22. Data Saturation	Not reported	Not reported	Not reported	Not reported	Not reported
23. Transcripts returned	No	No	For 2 participants	No	No
Domain 3: Analysis and findings					
<i>Data analysis</i>					

24. Number of data coders	Not reported	3. The authors	3. The authors	2. The first and third author	1. The first author
25. Description of the coding tree	Not explicitly	Not explicitly	Not explicitly	Not explicitly	Not explicitly
26. Derivation of themes	Themes derived from the data	Themes derived from the data	Themes derived from the data	Themes derived from the data	Themes derived from the data
27. Software used	No	Yes. ATLAS.ti	No	No	No.
28. Participant checking	No	No	Yes. 2 participants	No	No.
<i>Reporting</i>					
29. Quotations presented	No	Yes	Yes	Yes	Yes
30. Data and findings consistent	Yes	Yes	Yes	Yes	Yes
31. Clarity of major themes	Yes	Yes	Yes	Yes	Yes
32. Clarity of minor themes	No	No	No	No	No

Table 2. Characteristics of reviewed studies using the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007).

Synthesising the Qualitative Literature

Although the studies differ in a number of ways, there are common findings. A common theme among the studies reviewed pertained to the life-saving nature of DBT, which was a finding in the Perseius et al. (2003) study, which aimed to capture clients' and therapists' experience of receiving and delivering DBT. Participants within the Perseius et al. (2003) study attributed the life-saving quality of DBT to developing skills in managing suicidal and self-harm impulses. This finding relating to the life-saving nature of DBT was also found by Cunningham et al. (2004), who aimed to capture the impact of DBT on the participants' lives, and explore participants' views of individual therapy, skills group, and telephone coaching.

Cunningham et al. (2004) found that participants attributed the life-saving nature of DBT to participants' improved ability to manage self-harm urges and control their emotions. The life-saving nature of DBT was also found by Brassington and Krawitz (2006), who reviewed a six-month pilot of DBT to determine the 'clinical utility and feasibility of implementing DBT into a standard New Zealand public mental health service' (p. 313). Their study comprised a pre and post quantitative component, and post therapy qualitative interviews. The reported findings from the qualitative component of this study are sparse, whereby all that is presented in the article are the number of participants who responded with certain answers to interview questions, rather than an interpretation of their answers in interviews. Brassington and Krawitz (2006) found that 10 participants reported benefitting from acquiring alternative skilful responses to deal with life-threatening behaviours. A reported increase in the ability of participants to manage their emotions was also found by McSherry et al. (2012), who explored participants' experiences of an 'adapted' DBT.

Studies also found that participants of DBT reported an improvement in skills that helped with the achievement of personal daily goals. For example, Cunningham et al. (2004) and Brassington and Krawitz (2006) found that participants reported improvements in their relationships, inter-personal skills, and daily interactions, whilst achieving long-term personal goals. McSherry et al. (2012) found that participants reported that the acquisition of DBT skills improved their confidence and interpersonal relationships.

Another common finding amongst the studies is the participants' report of the benefit of the therapeutic relationship with the DBT therapists. Participants within the Perseus et al. (2003) study reported appreciating the degree to which they believed the DBT therapists genuinely understood the difficulties of living with BPD. Similarly, Cunningham et al. (2004) reported that participants appreciated the effort applied by DBT therapists to ensure that DBT clients and therapists were equal partners in the therapeutic relationship. The merits of the therapeutic relationship was also found by Hodgetts et al. (2007), who found that the therapeutic relationship played a significant role in participants' progress; the authors contrast this

progress with research that argues that individuals with BPD are often deemed as being hard to engage therapeutically (Benjamin & Karpiak, 2001).

Participants among the studies valued the skills group as a place where their personal difficulties were validated by DBT therapists and other DBT clients. McSherry et al. (2012) report the value to participants of sharing difficulties with other members of the skills group, which provided a sense of normality. Equally, Cunningham et al. (2004) report that participants found the skills group beneficial as it provided support from other clients experiencing similar difficulties. As well as the skills group being perceived as validating, Perseus et al. (2003) report that the DBT skills group can also be challenging; with one of the biggest challenges being becoming acquainted with the nomenclature of DBT (McSherry et al., 2012). Perseus et al. (2003) also found that participants considered the skills group to be challenging, however, participants found the skills group beneficial as well as challenging as participants benefitted from meeting others experiencing similar difficulties.

Another common theme apparent in the reviewed studies concerned participants' renewed sense of hope and recovery attributable to DBT. Brassington and Krawitz (2006) found that participants reported developing a sense of responsibility for their own recovery, and an increased sense of hope and happiness. Perseus et al. (2003) found that participants of DBT were able to construct a new understanding of their problems, and develop a sense of responsibility for their own lives and recovery. Similarly, Cunningham et al. (2004) found that participants expressed hope regarding their difficulties being controllable rather than controlling them.

Lastly, participants among the studies had a sense of ambivalence towards the telephone coaching. Participants considered phone coaching to be useful during a time of crisis, when participants were too overwhelmed by emotions to use the skills they had been taught (Perseus et al., 2003; Cunningham et al., 2004). However, participants reported having to overcome feelings of anxiety surrounding using the phone

coaching as participants believed they would be an inconvenience to the phone coach (Perseius et al., 2003; Cunningham et al., 2004).

Discussion

Summary of Findings

By systematically searching and reviewing the available qualitative literature, this study captures the experience of community-based DBT by adults diagnosed with BPD. The common finding from five qualitative studies indicates that community-based DBT makes a positive contribution to the lives of adults diagnosed with BPD. The skills group is thought to be beneficial for learning skills to manage suicidal and self-harm impulses; however, as the skills can be complicated, participants reported the importance of facilitators being knowledgeable and skilled in the application of skills to daily examples; participants appreciated the support from peers within the skills group; phone coaching is perceived as being useful in crises, although some participants reported difficulty overcoming their concern of inconveniencing the telephone coach; individual therapy provides a tailored opportunity to consolidate skills taught in skills group; DBT improves relationship and inter-personal skills; and participants expressed hope regarding their difficulties being controllable rather than controlling them. However, a number of participants reported a lack of choice regarding treatment prior to joining DBT.

Reflections on Quality and Validity

The use of the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007) explicitly presented the important aspects of the qualitative studies included in the review. The studies varied in many important aspects, for example, the studies used different qualitative approaches in their analysis, including thematic analysis, content analysis, and IPA; a number of studies did not report whether steps were taken to validate themes from the findings; researchers were of varying levels of expertise; studies differed in the degree to which DBT staff were trained, with only few staff being fully 'DBT accredited'; and some studies were based on DBT services that were not full programmes, but shortened or moderated

versions. Due to differences among the studies reviewed, it is imperative that some consideration is given to the quality and validity of the studies before drawing any conclusions.

Experiences of Other Therapies

Considering that DBT has the strongest empirical evidence base of the psychological therapies in the treatment of BPD (Stoffers et al., 2012), and this body of empirical evidence far outweighs the qualitative equivalent, it is unsurprising that there are strikingly fewer qualitative articles exploring the experiences of the other non-DBT therapies in the treatment of BPD. Due to this lack of qualitative equivalents, the findings of this current review cannot be compared to the qualitative reviews of other non-DBT therapies specifically treating BPD, solely because they do not exist. Nevertheless, certain links can be made between the findings from the qualitative studies reviewed in the present article and general experiences and observations of psychological therapy.

In a qualitative study reviewing the experiences of pilot studies for the treatment of personality disorders, Crawford et al. (2007) found that the experience of group psychotherapy was mainly positive for individuals diagnosed with a personality disorder, with some clients reporting that the group setting was an ideal setting to share experiences with others and benefit from peer support; findings that echo the general finding of the studies reviewed in this article. The benefit to individuals diagnosed with BPD of sharing similar lived-experiences with other members of a therapeutic group is a finding linked to the wider literature of group psychotherapy in treating BPD. For example, Whewell, Lingam, and Chilton (2004) found that individuals diagnosed with BPD benefited from a therapeutic group that fostered an appreciation of a reflective space that respected the experience of living with BPD. The benefits of a therapeutic space can also be found beyond the BPD literature, and extend to the group psychotherapy literature in general. Yalom (1985) reports that the therapeutic factors of group psychotherapy, such as the universality of not feeling alone, and the imitative behaviours of modelling another's recovery skills, are evident in therapeutic groups generally.

Although therapeutic groups have been found to benefit those diagnosed with BPD, Crawford et al. (2007) found that some participants diagnosed with personality disorder struggled with group therapy, particularly in understanding the way the group operated and its accompanying rules. This finding is similar to the findings of the studies reviewed in this article, although the participants of the studies reviewed in this article reported that the challenges pertaining to the DBT skills group were related, instead, to the difficulty of understanding the DBT nomenclature of the skills group. However, anxieties pertaining to therapeutic groups are not uncommon (Bernard et al., 2008).

Due to the paucity of studies reviewing the experience of non-DBT therapies in the treatment of BPD, it is not entirely certain if the qualitative findings from the DBT studies reviewed in this article, such as the life-saving nature of therapy, the challenging nature of the skills group, the achievement of daily goals, the sense of validation of BPD symptoms by both therapists and other clients, and a sense of hope and recovery are unique to the DBT approach of treating BPD. Therefore it is essential that further research enables this distinction by qualitatively exploring the experience of non-DBT therapies in the treatment of BPD. But as DBT continues to attract support from a number of empirical studies, it is doubtful that such qualitative studies of non-DBT therapies in the treatment of BPD will happen imminently. However, if such qualitative studies were to occur, it would be beneficial to capture the experiences of TFP, MBT, and SFT, popular psychological interventions used in treating people BPD (Stoffers et al., 2012).

Synthesis of the Quantitative Literature

The findings from this review show that DBT is reported to be effective in the treatment of BPD symptoms. This finding appears to be corroborated by a number of quantitative studies. In the first randomized control trial (RCT) investigating the outcomes of DBT in the treatment of women diagnosed with BPD, Linehan, Armstrong, Suarez, Allmon, and Heard (1991) found that after one year of DBT, women diagnosed with BPD had made many improvements in comparison to the control group; DBT clients showed reduction in

the severity and frequency of parasuicidal behaviours, and fewer hospitalizations. These findings were maintained one year later (Linehan, Heard, & Armstrong, 1993). In another RCT, Verheul et al. (2003) found that women diagnosed with BPD who had received DBT had overall reduced BPD symptoms in comparison to the control group. Overall, findings from empirical studies have found DBT to help those diagnosed with BPD (Verheul et al., 2003; Koons et al., 2001; Linehan et al., 1993; Linehan et al., 2006; van den Bosch, Koeter, Stijnen, Verheul, & Van den Brink, 2005).

Considering the empirical studies that have attempted to dismantle DBT in an attempt to establish which components of DBT lead to it being the treatment of choice for BPD, there have been mixed findings. For example, when investigating the role of DBT's therapeutic alliance, which was valued by the participants of the studies included in the present review, Little (2009) reports that although there are theoretical essays emphasizing the importance of the therapeutic relationship in DBT (Robins & Koons, 2000; Swales & Heard, 2007), there is a lack of empirical data investigating the quality of the therapeutic alliance in DBT and its relationship to therapeutic outcomes. Therefore, Little (2009) investigated the relationship between treatment outcomes and the therapeutic alliance in an outpatient DBT programme, and found that there was no significant relationship between therapeutic alliance and treatment outcomes. This is an important yet unusual finding, as DBT was developed with an appreciation of the challenges of building and maintaining a therapeutic relationship with individuals diagnosed with BPD (Linehan, 1993a). Further, whilst therapeutic alliance has been found to be a predictor of treatment outcome in psychological therapy generally (Hilsenroth, Peters, & Ackerman, 2004), this finding from Little (2009) suggests this might not be the case for DBT. One potential reason for this is that studies investigating the relationship between alliance and treatment outcome have typically investigated the client-therapist alliance in psychological treatments that are supportive or humanistic in nature, as opposed to the structured approach of DBT (Little, 2009).

The present review also reveals how providers of DBT often implement ‘adapted’ programmes to treat BPD. However, without adherence to the DBT model, DBT programmes can gradually drift, resulting in a treatment that no longer resembles DBT. To date, it is believed that only one RCT (Linehan, 1993a) has investigated the importance of adhering to the DBT model for the treatment of BPD. Linehan (1993a) investigated whether the DBT skills group, when separated from the other components of DBT, is efficacious for individuals diagnosed with BPD. Individuals diagnosed with BPD were randomly assigned to receive either DBT skills training or a waiting list control. After 1 year of treatment, while participants in both conditions improved over time, there were no significant differences between conditions in any outcome variables, including self-injurious behavior, suicide attempts, hospital visits, and inpatient admissions. This RCT indicates that providing components of DBT separated from the comprehensive model does not improve clinical outcomes for individuals with BPD. According to Dimeff and Linehan (2008), given the strength of data on the full DBT programme for individuals diagnosed with BPD, the absence of data supporting a “lighter” version of DBT, and the high-risk nature of the client population, it is advisable to preserve DBT’s treatment integrity.

Although the empirical literature supports DBT in its treatment of BPD, the paucity of research indicating precisely the mechanisms for such promising outcomes is under investigated. Therefore, as argued by (Martens, 2005), further research is needed to investigate which components of the full DBT programme are essential for the treatment of BPD, and how DBT works exactly.

Future Research

Further qualitative research exploring the experience of DBT by adults diagnosed with BPD is needed to augment this existing corpus. Findings from such research could be used to inform the design and content of future DBT programmes, thus enabling programmes to be tailored to meet the varying and complex needs of those diagnosed with BPD. In particular, to complement the only qualitative study exploring the experiences of an NHS community-based DBT programme (Hodgetts et al., 2007), further qualitative

studies exploring the experience of DBT programmes within an NHS setting are needed, especially with adults diagnosed with BPD, which is the population for whom DBT receives the strongest empirical evidence (NICE, 2009; Stoffers et al., 2012). Continuing research within the NHS would shed light on the experience of receiving DBT in the public health service, a service mandated to treat those with a PD (DOH, 2003), which is facing increasing financial pressures. With the Health and Social Care Act of 2012 permitting ‘any willing provider’ to compete with public sector healthcare, qualitative research exploring individuals’ experiences of NHS-based therapies would highlight where improvements need to be made within the NHS to remain competitive. With the DOH including the concept of ‘recovery’ in its *No Health Without Mental Health* mandate for healthcare services (DOH, 2011), qualitative research could uncover the degree to which those who have received DBT consider themselves to be ‘recovered’ and living meaningful lives. Qualitative research would also be ideally suited to explore the degree to which individuals who have received NHS-delivered DBT consider themselves to be closer to living a ‘life worth living’, which is the overarching aim of DBT.

Limitations

A potential limitation of this literature review is that the process of searching and critiquing the relevant literature may not be as thorough as that undertaken by an experienced researcher with a pedigree in qualitative research. However, as this review took a systematic approach to retrieving relevant qualitative studies, used the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007) for reviewing the studies, and its methodology and findings were shared with and guided by a professor of psychology with extensive experience of undertaking qualitative research, it is believed that this review has a certain degree of rigour and adds value to the existing evidence base. As the core qualitative studies in this field were obtained and reviewed, it is argued that this review fills a gap in the qualitative literature of DBT that hitherto had not been filled; it is believed that this article is the first, to date, to review the qualitative literature investigating the experience of community-based DBT by adults diagnosed with BPD.

Conclusion

Findings from the literature review show that, overall, adult diagnosed with BPD do testify to the effectiveness of DBT delivered in community settings. This literature review also reveals the dearth of qualitative studies exploring the experiences of DBT by individuals with BPD, with only one study based on an NHS community-based DBT programme in the U.K. Such a paucity is surprising considering that the DBT treatment manual was first published in 1993 and over the years DBT has been garnering robust quantitative evidence that has led to many influential bodies recommending it as the psychological therapy of choice for treating BPD (APA, 2001; NICE, 2009; Stoffers et al., 2012). The body of qualitative literature is surprisingly meagre in comparison to the burgeoning quantitative research in the same field exploring efficacy and effectiveness of DBT. More qualitative research exploring clients' experiences of DBT in regular clinical services is needed to derive a true account of the effectiveness of DBT.

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Experience of dialectical behaviour therapy by women diagnosed with borderline personality disorder.²

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Short title: Experience of DBT by individuals diagnosed with BPD

Keywords: Borderline personality disorder; clients' experiences; dialectical behavior therapy; interpretative phenomenological analysis; qualitative research.

² To be submitted to See Appendix B for author guidelines.

Abstract

Objective To explore the experience of dialectical behaviour therapy by adults diagnosed with borderline personality disorder, their expectation of the programme, their personal meaning of a ‘life worth living’, and whether such a life can be achieved with dialectical behaviour therapy.

Method Six women with a diagnosis of borderline personality disorder were interviewed about their experience of a dialectical behaviour therapy programme delivered by the National Health Service. Interview transcripts were analysed using Interpretative Phenomenological Analysis.

Results Dialectical behaviour therapy was experienced as challenging yet transformational, and that a ‘life worth living’ is not only the removal of harmful behaviours but the addition of life improving qualities, both of which are achievable with dialectical behaviour therapy. Six master themes were found: therapeutic group factors; therapist factors; personal change; challenges to be overcome; personalised problem solving; and opposing expectations.

Conclusion Dialectical behaviour therapy’s efficacy evidence translates to effectiveness within actual clinical services.

Declaration of interest: none.

Borderline Personality Disorder

Borderline personality disorder (BPD) is considered to be a 'severe and persistent mental disorder' (Lajoie, Sonkiss, & Rich, 2011, p. 325) affecting approximately 4% of the general population and 20% of mental health clinical populations (Kernberg & Michels, 2009). According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994), BPD is defined using nine criteria, of which five must be met for a diagnosis. The International Classification of Mental and Behavioural Disorders (ICD-10; World Health Organisation, 1992) does not use the term BPD, but instead uses 'Emotionally Unstable Personality Disorder', of which there is an impulsive type, and a borderline type, the latter characterised by instability of emotions, self-image, and relationships, which is considered commensurate with the DSM-IV definition of BPD.

BPD is a condition defined by a pervasive fear of abandonment, unstable personal relationships, impulsivity, suicidal behaviour, affective instability, and chronic feelings of emptiness, often in combination with anxiety, depression, and substance abuse (American Psychiatric Association, 1994). Individuals with BPD are considered difficult to treat, in part because of the difficulties of establishing a therapeutic alliance (Aviram, Brodsky, Stanley, 2006); Kelly et al. (1992) report that up to 50% of clients diagnosed with BPD drop out of therapy within six weeks. In addition to this therapeutic challenge, McMain et al. (2009) report that approximately 69% to 80% of individuals with BPD attempt suicide; Linehan (1993a) reports that the degree of risk individuals with BPD present often evokes a sense of uneasiness amongst therapists involved in their treatment. Despite a high degree of therapeutic disengagement (Kelly et al., 1992), individuals with BPD seek treatment at high rates, often resulting in a heavy reliance on mental health services (Gunderson, 2009); therefore the cost to public health services is considered to be high (Sharma, Dunlop, Ninan, & Bradley, 2007).

Psychological Treatment of BPD

Despite recommendations for psychological therapy to be the first-line treatment for BPD, the overall evidence base for psychological therapies in the treatment of BPD is of moderate quality (National Institute for Health and Care Excellence, 2009). A number of therapies have been evaluated for the treatment of BPD, including mentalization-based therapy (Bateman & Fonagy, 2004), therapeutic communities (Lees, Manning, & Rawlings, 1999), cognitive analytic therapy (Ryle, 2004), psychodynamic psychotherapies (Gabbard, 2001), transference-focused psychotherapy (Kernberg, Yeomans, Clarkin, & Levy, 2008), cognitive behavioural therapy (Davidson, 2007), schema-focused therapy (Giesen-Bloo et al., 2006), and dialectical behaviour therapy (DBT; Linehan, 1993a). Of all the therapies evaluated for treating BPD, DBT has received the strongest empirical support (McSherry, O'Connor, Hevey, & Gibbons, 2012). The Cochrane Collaboration systematically reviewed a number of psychological interventions for BPD, using a meta-analysis of 28 studies that involved a total of 1,804 individuals with BPD, and concluded that DBT has the strongest evidence of efficacy relative to the other treatments investigated (Stoffers et al., 2012). Corroborating this finding from The Cochrane Collaboration, Feigenbaum et al. (2011) report that DBT has been recommended as a treatment of choice for BPD by a number of influential bodies, such as the American Psychiatric Association (APA; 2001) and the National Institute for Health and Care Excellence (NICE; 2009).

Dialectical Behaviour Therapy

Dialectical behavioural therapy (DBT; Linehan, 1993a), which was first developed as a psychological treatment for suicidal women, is an empirically supported psychological treatment for BPD (Salsman & Linehan, 2006). Such empirical support has led DBT to be considered the treatment of choice by both the American Psychiatric Association (2001), the Department of Health (DOH) of the United Kingdom (U.K.; National Institute for Mental Health in England, 2003), and the National Institute for Health and Clinical Excellence (NICE; 2009). According to the DBT model of BPD, some people who may have been born with an emotional vulnerability will respond quickly and intensely to emotional stimuli, and

have difficulty returning to their baseline (Linehan, 1993a). The DBT model for BPD continues to state that other people, instead of recognising this emotional sensitivity, might respond with invalidation, such as rejecting or dismissing the expression of emotional sensitivity. Linehan (1993b) argues that receiving prolonged invalidation to emotional sensitivity from others leads to the development of the pervasive emotional regulation difficulties commensurate with BPD. Some individuals diagnosed with BPD who have difficulty regulating strong emotions often engage in an array of harmful behaviours to control their emotions. Therefore, the DBT therapeutic approach is to help individuals learn adaptive strategies to regulate their emotions (Linehan, 1993a). DBT is grounded in a dialectical philosophy, which attempts to synthesize ‘change’ underpinned by cognitive behavioral tenets, with ‘acceptance’ based on Zen traditions (Linehan, 1993b). Importantly, the overall goal of DBT is to help patients not only survive, but build a ‘life worth living’, which is the overall aim of DBT (Linehan, 1993b). DBT is a contractual one-year multi-modal therapy delivered by a skills training group, individual therapy, telephone coaching, and consultation meetings for therapists.

Effectiveness of DBT

Despite the burgeoning empirical quantitative support for the efficacy of DBT in the treatment of BPD, a prevailing concern is the question of how the empirical support for efficacy is translated to effectiveness in clinical practice (Feigenbaum et al., 2011). Whilst the National Health Service (NHS) aims to implement empirically supported therapies, minimal staff training and lack of suitable supervision raises the question of whether the efficacy of therapies realistically translates to clinical effectiveness in regular clinical practice (Feigenbaum et al., 2011). Augmenting this point, concerns have been raised as to whether the embrace of DBT in clinical settings has preceded the establishment of a sufficiently robust ‘clinical’ evidence base (Blennerhassett & O’Raghallaigh, 2005; Scheel, 2000).

Qualitative research exploring the experience of DBT by individuals diagnosed with BPD is ideally suited to gauge effectiveness of DBT in real clinical settings. However, as reported by McSherry, O’Connor,

Hevey, and Gibbons (2012), ‘few qualitative studies have explored the contribution service-users can offer about their experiences of DBT (p. 540).’

To date, it is believed that five qualitative studies have explored individuals’ experiences of a community-based DBT programme that focused on treating the symptoms of BPD. Perseus, Ojehagen, Ekdahl, Åsberg, and Samuelsson (2003) explored patients and therapists’ experiences of receiving and delivering DBT. Their findings showed that participants found the therapy to be life-saving, and reported being understood and respected by therapists. Participants also described therapy not solely as an opportunity to talk, but to work on harmful behaviours. Telephone coaching was considered to be helpful, but participants reported thinking they were being an inconvenience to the telephone coach. The skills group was deemed to be difficult because of the complexity of skills, but useful for developing skills to manage emotions and self-harm.

Similar positive findings were also found in a qualitative study conducted in the United States, where Cunningham, Wolbert, and Lillie (2004) interviewed fourteen women about their experiences of a DBT programme and its impact. Participants considered DBT to be life changing, and benefited from individual therapists who were challenging. Participants also reported that DBT had taught them skills that helped improve their relationships, reduce suffering, increase hope, and manage emotions.

In a study based in New Zealand, Brassington and Krawitz (2006) used quantitative and qualitative measures to review a six-month pilot of DBT for individuals diagnosed with BPD. The study had encouraging findings, although the standardized nature of the interview schedule restricted the richness of the qualitative analysis. The study found that five participants reported that DBT helped with the achievement of long-term goals, three participants reported developing a sense of responsibility for their own recovery and an increased sense of hope and happiness, and all of the participants reported DBT to be useful, benefiting from the acquisition of alternative skilful responses to deal with target problems.

Hodgetts, Wright, and Gough (2007) explored individuals' experiences of an NHS community-based DBT programme that focused on treating the symptoms of BPD. It is believed that this is the only study of this nature based on within the NHS. Findings showed that participants reported a positive change in their lives that they attributed to DBT. Participants reported a lack of treatment choice prior to joining DBT, and valued the relationship with the therapists.

McSherry et al. (2012) examined the effectiveness of an adapted DBT programme delivered within a rural community mental health setting in Ireland for individuals diagnosed with BPD. The findings were encouraging, with participants reporting that the newly acquired skills were helpful in managing strong emotions, whilst, overall, participants reported being understood by other members of the skills group, with a renewed sense of identity.

Gaps in the Qualitative Literature

Although this qualitative evidence suggests an overall positive experience of community-based DBT by individuals diagnosed with BPD, and therefore strengthening the argument for DBT's effectiveness in real clinical settings, this corpus of qualitative research is meagre in comparison to that of the empirical studies quantitatively reporting DBT's efficacy and clinical effectiveness. Moreover, findings from this body of qualitative research should be interpreted with a degree of caution as the DBT programmes among the studies vary in their fidelity to model and the degree to which the DBT treatment team received fully accredited DBT training. The studies also differ in their methodological rigour, with differences in the style of interview schedules, the qualitative analytic approaches used, the approach used to validate findings, and researchers varying in their degree of research expertise.

Since the first publication of the DBT manual (Linehan, 1993b), only one study has qualitatively explored the experience of an NHS-delivered community-based DBT programme by individuals diagnosed with

BPD (Hodgetts et al., 2007). This leaves a number of unanswered questions. The meaning of a ‘life worth living’ by those diagnosed with BPD, and the extent to which individuals diagnosed with BPD who have received NHS-delivered community-based DBT consider themselves to be living a ‘life worth living’, remains unexplored. Findings from such research pertaining to a ‘life worth living’ could then be compared to the definition of ‘recovery’ in the *No Health Without Mental Health* mandate for public healthcare services introduced by the Department of Health (DOH; 2011). Such a comparison would be a step toward gauging the degree to which the overall aim of DBT, a therapy widely used in the NHS, is aligned to the term ‘recovery’ as defined by the DOH, the public organisation governing the NHS. Also, to date, research has not specifically qualitatively explored the experience and impact of the various components of an NHS-delivered community-based DBT programme by adults diagnosed with BPD, or explored the degree to which the experience of such a programme is aligned to expectations.

Aims and Objectives

Lucock et al. (2003) report that rather than deriving research data from randomised controlled trials, research should be practice-based evidence of real and complex clients within actual clinical services. Therefore, with a focus on complex clients within actual clinical services, the aim of this research is to explore the overall experience of an NHS-delivered community-based DBT programme by individuals diagnosed with BPD. The research will specifically focus on exploring individuals’ experience and impact of each of the DBT components, the degree to which their experience of the programme is aligned to their initial expectations, what a ‘life worth living’ means to a person diagnosed with BPD, and whether DBT contributes to a ‘life worth living’.

Method

Participants

Purposive sampling was used to identify and recruit participants who had experience of the phenomenon in question (Ryan, Coughlan, & Cronin, 2007), which, in the present study, was experience of an NHS-delivered community-based DBT programme, and a diagnosis of BPD. A sample of 10 women with a diagnosis of BPD and currently enrolled in, graduated from, or dropped-out of a single DBT programme in the North West of England were identified. Specifically, the sample consisted of six women currently enrolled in the programme, two women who had graduated from the programme, and two women who had dropped out of the programme. All of the six women currently enrolled in the programme consented to partake in the study; however, two did not respond to emails regarding the arrangement of interviews and therefore were not interviewed and excluded from the study. The two women who graduated from programme consented to partake in the study, and were interviewed. Consent forms were not received from the two women who had dropped out of the study, and therefore were excluded. The graduates from the programme graduated 14 months prior to being interviewed. In total, six participants were interviewed in this study, comprising four women who were currently enrolled in the DBT programme, and two who had graduated previously (Appendix C).

The six participants were British and fluent English, with English being their first language. Regarding ethnicity, five participants were white, and another participant was white-other. All participants were living in the North West of England, had reached varying levels of educational attainment, ranging from GCSE to degree, had never been married, and were either studying, unemployed, or in employment at the time of being interviewed. The age of the participants ranged from 22 to 30 years, with a mean age of 26 years. A table of the characteristics of the participants at the time of interview is shown in Table 3. At the time of interview, all of the participants reported current co-morbid mental health difficulties, including depression and psychosis. Aside from BPD, all of the participants reported previous mental

health difficulties, including anxiety, post-traumatic stress disorder, psychosis, obsessive compulsive disorder, and agoraphobia. All had received prior psychological therapy for a number of mental health difficulties. Participants first received their diagnosis of BPD between two and 12 years previously (mean 4.6 years). Four participants were currently taking psychiatric medication. Four had previously been an inpatient for mental health difficulties.

Participant	Gender	Status	Number of months on programme.
1	Female	Graduated	12
2	Female	Graduated	12
3	Female	On programme	15
4	Female	On programme	16
5	Female	On programme	14
6	Female	On programme	6

Table 3. Characteristics of participants interviewed.

The DBT Programme

The treatment team for the DBT programme comprised a consultant psychiatrist who was also qualified as a psychotherapist, a principal clinical psychologist, and four specialist mental health nurses. All but one member of the treatment team, a mental health nurse, had received the fully accredited intensive DBT training in June 2009 and January 2010. The treatment team leader received DBT supervision from an accredited DBT trainer every two months, and attended quarterly DBT continuing professional development. The treatment team received annual DBT development from an accredited DBT trainer. Treatment fidelity was not formally measured; however, adherence to the DBT model was monitored by the team through weekly case discussion. The DBT programme followed the standardised manualised DBT treatment manual (Linehan, 1993b). Clients received one hour of individual therapy every week,

2.5 hours of skills group every week, and had access to telephone coaching; the phone coach was the client's individual therapist. The treatment team also held a weekly consult meeting for 2.5 hours per week. The full DBT programme was delivered as described by Linehan (1993b). The skills group consisted of the modules mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness, which began every three months. New clients joining the DBT programme would join at the start of a new module. Prior to joining the programme, clients completed a pre-treatment phase, which ran for six weeks and involved goal setting and commitment building as specified in the DBT treatment manual. Clients were offered an initial contract for one year of treatment, which was renewable as specified by the DBT treatment manual.

Procedure

Ethical approval

A research proposal was submitted to the Research Committee of the Division of Clinical Psychology at the University of Liverpool in December 2011, and on gaining University approval in January 2012 (Appendix D), followed by the University's intention to sponsor in April 2012 (Appendix E), ethical approval was granted from both the Local Research Ethics Committee in September 2012 (Appendix F) and the local NHS Trust Research Governance Committee in October 2012 (Appendix G).

Selection and recruitment

The researcher liaised with the team leader of the DBT programme to enquire if the women within the DBT group would agree to the research being presented to them by the researcher at the start of a DBT skills group session. After this approval, the researcher attended the location of the DBT group, introduced himself, presented the research, issued an information sheet (Appendix H) and consent form (Appendix I), and offered to answer any questions about the research. The skills group members were told that the researcher was not associated with the DBT programme. They were also told that consenting to partake in the research was not obligatory, and not consenting would not affect their progress on the

programme. The women were informed that they could have as much time as needed to think about consenting, and were given the researcher's contact details so that questions concerning the research could be answered. The women also agreed for the researcher to attend the group two weeks later to answer any questions that they might have.

Regarding the recruitment process of those no longer attending the DBT programme, the DBT programme leader sent the same documents that were distributed in the skills group to the homes of those no longer attending the programme, together with a letter of invitation to participate (Appendix J) and a pre-paid envelope addressed to the researcher's University address. Once the researcher received the consent forms, participants were contacted via email to arrange interviews. All participants' identifying data were anonymised and stored securely in a locked filing cabinet.

The interview

Interviews ranged between one to two hours and took place between the researcher and participant during November 2012 to January 2013 in a quiet room in the premises of where the DBT programme is run. At the start of the interview, the limits of confidentiality regarding risk were discussed. Participants had already been informed that the interview would be recorded using a digital recording device, and that all recordings would be stored safely. Participants were informed that they could stop the interview at anytime for any reason, and could take a break at anytime. Participants were asked if they had any questions. Participants were asked to complete demographic information (Appendix K) before the researcher followed a semi-structured interview schedule (Appendix L) that was collaboratively developed with the researcher's supervisors; a professor of forensic clinical psychology, and a consultant psychiatrist and psychotherapist. The interview schedule was piloted with a colleague prior to the first interview. The semi-structured interview schedule provided a guide to the interview, but was used flexibly to allow the natural exploration of participants' experiences of the DBT programme. Specifically, the interview schedule explored the overall experience of the DBT programme, the

experience and impact of different components of DBT, prior expectations of the programme, participants' meaning of a 'life worth living' and whether they considered to be living a 'life worth living' due to DBT. At the end of the interview, participants were thanked for their involvement, informed that they could receive a copy of the final article of the research if they so wished, and were provided with a short document listing different providers of support that could be contacted if they felt distressed after the interview (Appendix M). Also, their transport costs were reimbursed and they were given a £20 high street voucher.

Data analysis

Each recorded interview was transcribed verbatim by an employee of the University experienced in transcription. Participants were allocated an alias. Analysis of the interview transcripts adhered to Interpretative Phenomenological Analysis (IPA) guidelines outlined by Smith, Flowers, and Larkin (2009). IPA was chosen as an analytic approach for this study as its idiographic focus captures a deep understanding of an experience from an individual perspective, which, coupled with an inductive approach that aims to prevent it from being influenced by prior hypotheses (Smith & Osborn, 2003), makes it a suitable analytic approach to achieve the research aims of this study. The researcher read the first transcript a number of times whilst listening to the associated interview audio file and making initial notes on the transcript (Appendix N), before making descriptive, linguistic, and conceptual comments (Appendix O), as recommended by Smith et al. (2009). Emergent themes were developed from the first transcript and clustered together by the process of 'abstraction' to create super-ordinate themes according to the researcher's interpretation of the data and the relationships therein (Smith et al., 2009). Starks and Trinidad (2007) refer to the researcher's interpretation as a subjective truth; the researcher is attempting to understand and interpret an individual's interpretation of their own experience, which Smith, Jarman, and Osborn (1999) refer to as a 'double hermeneutic'. This analytic process was conducted for subsequent transcripts, with newly arising themes checked against previous transcripts. To ensure that the interpretation of the transcripts remained valid and credible, themes and super-ordinate themes were

discussed and shared with the researcher's supervisors, both of whom possess extensive experience in conducting clinical research. Appendix P illustrates the analytic development from emergent themes to super-ordinate themes for one participant; a list of the super-ordinate themes for all participants; and a document the details the links between the emergent themes, to super-ordinate themes, and master themes for all participants.

Results

Using IPA, six master themes, together with nested sub themes were found (Table 4).

<i>Master Themes</i>	<i>Sub Themes</i>
Therapeutic Group Factors	Shared understanding Learning from other clients
Therapist Factors	Non-judging Challenging avoidance Non-hierarchical Supportive
Personal Change	Development of skills for achieving practical personal goals Increased control of strong emotions and life-threatening behaviours Transformational Permanence of skills
Challenges to be Overcome	Anxieties about starting the skills group Difficulty using phone coach Dynamic group composition Hard work
Personalised Problem Solving	Application of skills to self Crises resolution

Opposing Expectations	Optimistic Pessimistic
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Table 4. Master table of themes.

Therapeutic Group Factors

Participants spoke about the benefits of being in a group with other people sharing the same experiences of living with BPD.

Shared Understanding

Participants described the value of being accompanied in the skills group by other DBT members whom they believed truly understood their experiences and difficulties. For example, Gill spoke about finally being understood by others, understood by other members of the skills group.

Gill – ‘I’ve pretty much spent my entire life being surrounded by people who don’t understand. Now I’m in a room with other people who, like, I’ll say something and they’ll go “yes, I do that,” it’s good just knowing that I’m not the only one.....talking to the other girls in the group, I know that when they say “I understand”, there’s a very good chance that they actually do.’

Tilly spoke about a sense of finally being understood by others, and no longer feeling alone with the ‘condition’ of BPD.

Tilly – ‘It’s meeting other people with the same condition as you. I’ve never ever met anyone with the same thing as me. And it’s like especially with borderlines, we feel like we’re being misunderstood all the time by everyone, and like when you finally meet a group of people that no matter how weird whatever you’re going to say is they’ll be like “yeah, I get that as well”. And it’s like, just the fact that you’re not alone anymore.....’

Participants' interview excerpts indicate that, prior to DBT, they had lived a number of years alone with BPD, a life of being misunderstood. The majority of participants' accounts suggested a feeling of enlightenment regarding finally being truly understood by others; other members of the skills group also diagnosed with BPD. This understanding appeared to not only remove the loneliness of living with the painful emotions and often destructive behaviours associated with BPD, which are often misunderstood by others, but also add a sense of cohesion and relatedness among the skills group members.

Learning from other clients

A sense of being understood by others in the group was a strong platform through which participants were willing to reciprocally learn from others, and guide others. For example, Gill spoke about the genuine nature of the advice offered by other group members; a lived-advice offered by group members who had attempted to apply the DBT skills to their lives, lives influenced by BPD, lives comparable to that of Gill's.

Gill – 'I feel like the advice they're giving me isn't fake. It's not something that they've just read in a book. It's something that they've tried and it's worked for them.'

Helen spoke about the value of joint problem solving in the skills group is acknowledged by the skills group therapists who encourage the valuable contributions from the DBT skills group members.

Helen – 'We all have you know, different advice. We have different ways of using skills that we might not have thought of ourselves. We'll talk about a problem that we've tried to use skills for and then it's not worked and then one of the skills trainers will let you know "does anyone have any other ideas?" and then someone might come up with "I'd try this", you know, and that's helpful.'

Tabitha succinctly described the value of sharing the skills group with others living with BPD.

Tabitha - ‘We’re learning a hell of a lot more off each other.’

The majority of participants mentioned feeling truly understood by others. Participants also spoke about benefiting from the ‘real life’ guidance from other clients regarding applying DBT skills to alleviate some of the difficult emotions and behaviours associated with BPD. The perceived notion among the skills group members of ‘a shared experience of the difficulties of living with BPD’ appeared to add value and credence to the contributions and guidance from members of the skills group.

Therapist Factors

Considering that prior to DBT all of the participants had received previous therapy over years, a strong theme emerged regarding unique therapeutic attributes of DBT therapists.

Non-judging

Considering that the majority of the participants reported a number of years of not being understood, namely for behaviours and emotions associated with BPD that often evoke strong and confusing feelings in others, participants valued the non-judging stance of the DBT therapists. Cathy speaks about how this non-judging response from her therapist provided her with a place of safety.

Cathy - ‘I could say anything knowing that it wasn’t going to be judged. I’ve never felt that feeling before. I’d always been ashamed of what was going to come out my mouth.’

Tilly also spoke about how she valued the non-judging stance from her therapist.

Tilly – ‘You get used to the fact that if you’re going to say something that’s really painful for you, they’re not going to judge you No matter how crazy whatever it is you’re admitting to or saying, they’re not gonna judge you in any way, or, not even in their expression either. Which is good.’

Overall, participants valued the non-judging relationship with DBT therapists, which was a foundation of safety on which participants described being able to talk about topics that might not only be difficult to discuss, because of the emotional nature of the topics, but also be difficult to hear. Participant’s accounts indicate that responses from previous therapists to such topics often resulted in participants feeling misunderstood. However, the non-judging response from DBT therapists permitted a helpful openness to talk about difficult topics.

Challenging avoidance

Participants spoke about the value of DBT therapists resolutely attempting, in a skilled way, to encourage participants to talk about things that might be difficult to talk about, but beneficial to address.

Megan – ‘If I wanted to leave something, it wouldn’t get left. If I didn’t want to talk about anything and they knew I didn’t, they’d kind of move onto something else, but bring it back.’

Tabitha – ‘My therapist is very intuitive and won’t let anything slip. If they think that something needs to be dealt with, they’ll deal with it there and then. And confront you head on.’

Although participants found it difficult talking about harmful behaviours and distressing emotions, they valued the therapists who deliberately ensured that such difficult things were spoken about in therapy rather than avoided, as it developed the application of DBT skills to life situations.

Non-hierarchical

Participants spoke about valuing the non-hierarchical nature of therapists, who deliberately ensured that therapeutic rules applied to themselves too, as reported by Tilly.

Tilly – ‘They’re part of the group as well so the rules still apply, it’s a mutual respect. We’re all on the same level. No, “I’m the therapist so you have to do this.”’

Gill described how she valued the personal qualities of the therapists, and their non-authoritarian teaching style.

Gill – ‘You can see like, they’re people, they’re human beings, they’re not just these horrible like authority figures like.’

This perception of the human qualities of the therapists is shared by Tilly, who appreciated the therapists talking about how they too were trying to use DBT skills in their lives, and candidly expressing the difficulties in doing so. By knowing that the DBT therapists were also working at using DBT skills, Tilly spoke about how this helped her connect with the therapists, as she believed the therapists had a shared experience of the difficulty of practicing DBT.

Tilly – ‘And they talk to you about situations, like giving examples out of their life where they were in an emotional mind and this is what skill they did..... if a therapist tells us about some of their experiences like using skills, and where they’ve not done it right or where they did it well, it kind of helps us to connect with them so we feel like they understand.’

In brief, participants appeared to value the non-hierarchical setting of the skills group. Participants mentioned appreciating how the group rules applied to therapists too, and appreciated knowing that the skills trainers were attempting to practise DBT skills in their own lives.

Supportive

Participants described a palpable sense of support from the DBT staff. Tilly was aware of the DBT staff trying three approaches to help the clients, i.e. individual therapy, skills group, and phone coaching.

Tilly - ‘I didn’t expect it to be so supportive as it is. They cover it from all angles so it’s like, it’s not just trying one way, they’re trying three ways to really help you.’

Cathy was also aware of the DBT staff trying a number of ways to help.

Cathy – ‘I just think there’s so many different parts to it that they all come together to help.’

To summarise, the participants valued the non-judging stance of the therapists, which allowed for a candid dialogue. Participants spoke about being challenged in therapy to discuss difficult topics, which although quite difficult, would enable joint problem solving and the application of DBT skills to manage difficulties. The non-hierarchical nature of DBT therapists fostered a sense of equality between staff and participants. Participants described a strong sense of being supported by DBT staff.

Personal Change

A theme emerging from the data was the degree and specifics of personal change that participants attributed to DBT.

Development of skills for achieving practical personal goals

All of the participants described how DBT had helped with the achievement of personal goals.

Megan – ‘I don’t think I would have stayed on at university, got me job.

Helen - ‘Whereas before DBT I couldn’t even you know, get up in the morning. I couldn’t go outside. I couldn’t talk to people. I was a proper recluse. I only went outside to go to the doctors. Whereas now I’m living alone. I moved out of my family home.....I live alone. I’m at college.’

Tabitha described how DBT had prepared her for looking for employment, commenting on improvements with her interpersonal relationships too.

Tabitha – ‘I’m looking to maybe starting work and actually holding down a full time job. I’ve got more stable relationships now, they’re a lot more settled and no problems there.’

Participants’ accounts suggest important improvements in various realms of life, which participants attribute to DBT.

Increased control of strong emotions and life-threatening behaviours

The majority of participants appeared to have also improved skills to regulate strong emotions associated with life-threatening behaviours.

Tabitha – ‘I’m not self-harming no more, no trips to Accident and Emergency to get stitched up all the time. All that inconvenience. Well I’ve not self-harmed now for two and a half years.....It saved my life DBT. I’ve not overdosed. I used to do it on a regular basis. Every single day. Some of them were very serious. So I was going down a really really dark path and I could have easily killed myself.’

Gill - ‘I’ve not self-harmed in about, I think it’s about two months now. Whereas before it was on a regular basis. Any little problem that I had, straight to self-harm..... Before it was just “problem, okay, self-harm”, now I’ve got loads of techniques that I can use... knowing that those skills are there and knowing I’ve got something to turn to and other options has really really helped with the self-harm.’

The accounts show that the participants’ testimonies relating to the frequency and degree of self-destructive behaviours prior to DBT is as striking as the degree at which such behaviours are now being managed, which the participants attribute to DBT.

Transformational

The majority of women described their lives as having being completely transformed when comparing it to their lives prior to DBT.

Megan – ‘Without DBT, I wouldn’t be where I am now.’

Helen – DBT has ‘Given me a new lease of life.’

The profundity of the participants’ accounts relating to the degree that DBT has changed their lives is indicative of the transformational nature participants attribute to DBT.

Permanence of skills

Participants spoke about how DBT had not only taught them skills for managing their emotions and achieving personal goals, but that the skills had an indelible nature about them that were not easily forgotten. Cathy and Megan describe how the DBT skills are now part of their daily life.

Cathy – ‘I think taking the actual learning content of what we were taught in the groups has kind of stayed with me, and that’s something that’s on my mind every day.’

Megan – ‘They’re still like a part of me life..... built up so many skills that I obviously didn’t have before and that was good. So, to have them and know that I do still have them.’

To surmise, participants describe how the DBT tenets are memorable, to the extent that they become part of daily living.

Challenges to be overcome

The majority of participants spoke about a number of challenges that they had to overcome in order to engage fully with DBT.

Anxieties about starting the skills group

Every participant gave an account of being nervous about joining the skills group.

Tabitha - ‘I was a little bit anxious about meeting other people in the group.’

Gill – ‘I was genuinely scared about going to group and being surrounded by lots of other people.’

These accounts indicate that the prospect of being in the company of others in the skills group was daunting.

Difficulties using the phone coaching

The majority of participants spoke about finding it difficult to use the phone coaching that was available.

Helen and Gill expressed believing they were being an inconvenience to the phone coach.

Helen – ‘I don’t like really using the phone much anyway I’m there twice a week and I don’t want to be contacting them and taking up more of their time.’

Gill – ‘Just that anxiety of not wanting to piss people off, be interfering; because I think the way I see it, with phone coaching, my therapist is at work seeing other patients. This isn’t my time, I don’t want to interfere.’

The participants’ anxieties regarding using the phone coaching stemmed from either their personal discomfort of using the telephone, especially to talk about problems, and/or concerns that they would be an inconvenience to the phone coach.

Dynamic group composition

Participants spoke about the effect of the changing composition of the skills group, with members either joining, graduating, or dropping out. Megan spoke about how difficult it was for the group after someone dropped out of DBT.

Megan – ‘It felt like everything was breaking up and stuff. I found it hard.....we were all proper gutted when one of them dropped out, just knowing that you spent all this time with them, and kind of learned so much about them, kind of got them, and they kind of got you as well, and they’re just gone, and like you’re not going to see them again. That was hard.’

Cathy described how the dynamic of the group would change so quickly, therefore she found it safer to attend every week.

Cathy - ‘I think it was more knowing that I’d feel really awkward going back in. I think even though it was a week I’d feel as though I’d missed so much that the whole group would be different. The dynamics would be different. So it was almost kind of safer for me to be there every week so that I could kind of almost keep an eye on the changes that might be happening.’

Accounts show that changes in the physical composition of the skills group affected members of the group, with even a temporary absence having an emotional effect on the other group members. Also, participants spoke about the emotional temperature in the skills group changing so rapidly that weekly attendance of the group ensured keeping abreast with the changes.

Hard work

The majority of the participants described the challenge of how difficult it was to partake in DBT.

Tilly – ‘DBT is hard work.’

Gill - ‘Once I’ve done it enough times and it’s properly drilled into me head, then it should get easier.’

Personalised Problem Solving

The majority of participants valued the personalised problem-solving nature of DBT.

Application of skills to self

Cathy spoke about individual therapy being a place whereby the individual therapist assists with applying the skills taught in the DBT group to individualised personal problem solving.

Cathy – ‘It was always about taking the skills from skills group, and then individual therapy could help you use them in real life. So that was when your therapist would always draw on the skills you’d learned recently to try and fit them in with your life, your problems.’

Tilly spoke specifically about the individual therapist’s use of chain analysis to assist with personalised problem solving.

Tilly – ‘It’s helped me understand my thought process with chain analysis, where the therapist does chain analysis with me in a situation I’ve not handled well. Going through each thought, each urge, and knowing the point where you can use your skills to sort of break the cycle that goes round.’

Crises resolution

A number of participants spoke about the value of phone coaching for obtaining immediate skills to help regulate strong emotions; emotions that were perceived by the participants as being too overwhelming to be regulated alone.

Cathy – ‘I guess it’s having it at that real point of need. So it’s that kind of make or break moment when you can have the phone coaching. You know, so it might be either getting rid of the pills or taking them, and without the phone coaching that’s my choice. But with the phone coaching, it’s almost still my choice, but I’m going to get a lot of encouragement to do the better thing.’

Tabitha – ‘Because it was in my own time, it was in my own space when things were going on that were out of my control. And my skills therapist could empower me to get control back in the situation.’

Participants' accounts indicate the value of having access to a phone coach at moments when they are too emotionally aroused to be able to deploy the skills learnt in DBT; the phone coach is able to remind them of skills that would help manage the strong emotions.

Opposing Expectations

Participants' accounts appeared to differ vastly concerning their initial expectations of the programme, with some having very high expectations, whilst some had low expectations.

Optimistic

The following participant accounts indicate the optimism some participants had for DBT.

Tilly - 'I thought that after the year I'd been here everything would be perfect.....which is a bit unrealistic, but that is what I thought.'

Megan – 'I kind of expected that by the time I had finished I would not have any problems ever again.'

Pessimistic

Yet the following participant accounts indicate the pessimism some participants had for DBT.

Cathy – 'I did not have much hope for it at all really.'

Tabitha – 'My only expectation was that this is not going to work'

The participants' accounts depict the dichotomy of expectations of DBT.

Discussion

Summary of Findings

The aim of this study was to explore the experiences of an NHS-delivered community-based DBT programme by individuals diagnosed with BPD. The study is important as it augments and extends the findings from the only other study exploring, specifically, an NHS-delivered community-based DBT programme for individuals diagnosed with BPD (Hodgetts et al., 2007). The present study identified six master themes relating to therapeutic group factors, therapist factors, personal change, challenges to be overcome, personalised problem solving, and opposing expectations. Findings from the present study indicate DBT's effectiveness for real and complex clients within actual clinical services, which echoes the argument of Hayes, Masuda, Bissett, Luoma, and Guerrero (2004), who argued that the effectiveness of DBT in clinical practice is congruent with the efficacy of clinical trials.

Exploring the experience and impact of each of the DBT components

Participants' accounts indicate participants' anxiety regarding starting the DBT skills group. However, the skills group became a place where participants reported learning from each other, findings shared by Cunningham et al. (2004), Hodgetts et al. (2007), McSherry et al. (2012), and Perseus et al. (2003). Participants also experienced the skills group as a place where they finally felt understood, with their thoughts, feelings, and emotions validated. The skills group was considered to be a place where skills were learnt that helped not only manage strong and often harmful emotions, but aided with the functioning in daily living. Participants experienced the changing group dynamics of the skills group as unsettling, and commented on being affected by other group members. Considering the wider literature of group therapies, the emotional influence of therapeutic groups is not unique to DBT (Yalom, 1985). Participants experienced individual therapy as a personalised therapeutic space to consolidate the skills learnt in the skills group, learning how to apply the skills specifically to their personal difficulties.

Considering the experience and impact of phone coaching, participants commented that it provided an immediate and desperately needed voice of reason during emotionally overwhelming periods; although participants had to overcome thinking they would be an inconvenience to the phone coach for calling, a finding shared with Cunningham et al. (2004) and Perseius et al. (2003).

Participants experienced, and benefited from, DBT therapists who were non-judging, non-hierarchical, supportive, and challenged avoidance. The non-judging nature of therapists indicates that the DBT therapists were practicing a DBT tenet of being non-judgmental, whilst the challenging nature of therapists is aligned to the 'acceptance and change' dialectic of the DBT principles (Linehan, 1993b). Although Benjamin and Karpiak (2001) reported that those diagnosed with BPD often find it difficult to foster therapeutic relationships, the findings from the present study offer contrary findings, whereby participants comment on the value of the relationship they had fostered with their DBT therapists, a finding shared by Cunningham et al. (2004), Hodgetts et al. (2007), and Perseius et al. (2003).

The degree to which experiences of the DBT programme were aligned to initial expectations of the programme

Some participants did not expect DBT to help, which might be related to the previous negative experiences of psychological therapies prior to DBT. However, other participants, who also had experience of previous therapies, were optimistic about the potential DBT could have on their life lives; the multi-modal nature of DBT, not experienced before, contributed to participants' optimism. Regarding the actual experience of DBT, findings indicate that although all participants expected it to be hard work, it was harder than expected, which is a finding shared with Cunningham et al. (2004) and Perseius et al. (2003). In particular, participants of the present study found it difficult to learn new skills to manage ingrained harmful behaviours for coping with strong emotions; the transformational nature of DBT meant that clients had to work very hard at changing behaviours and attitudes that had been developed over the years. The participants also did not expect DBT to consist of so much homework, and

they found the amount and content of weekly homework quite challenging. Although participants reported benefiting from individual therapy, they found the challenging nature of individual therapists quite difficult to begin with, but acknowledged that the challenging approach enabled them to confront difficult topics that enabled them to learn skills to manage difficult emotions and destructive behaviours.

The meaning of a 'life worth living' for someone diagnosed with BPD

This study found that a 'life worth living' for the participants is not only the reduction of harmful behaviours and regulation of strong emotions associated with BPD, but the addition of things that they accounted for as 'normal'; participants spoke about a willingness to be able to live independently, go shopping, go for a walk in the park, study, work, and have healthy relationships with others.

Whether DBT contributes to a 'life worth living'

Pertaining to the research objective of exploring whether clients of DBT perceive themselves to be closer to achieving a 'life worth living', participants reported undergoing a number of positive personal changes, which they attributed to DBT. Participants gave accounts of the achievement of personal goals, findings shared by Brassington and Krawitz (2006), Cunningham et al. (2004), Hodgetts et al. (2007), McSherry et al. (2012), and Perseus et al. (2003). Participants in the present study also gave an account for their development of skills to regulate strong emotions and life-threatening behaviour, which is important as the first priority of DBT is to target life-threatening behaviours (Linehan, 1993b). Participants in the present study gave account of the transformational nature of DBT, with many reporting that DBT had saved their lives. Unlike the other similar studies investigating the experiences of DBT, participants in the present study described the permanent nature of the skills developed, citing that the skills had become a part of their daily functioning. Links can be made between a 'life worth living', which is the overarching goal of DBT, and the definition of 'recovery' as outlined in the Department of Health's (DOH) *No Health Without Mental Health* mandate (DOH, 2011).

Links to the Quantitative Literature

Participants in the present study reported a reduction in parasuicidal behaviours, which echoes the quantitative findings of the first randomized control trial (RCT) for DBT, conducted by Linehan, Armstrong, Suarez, Allmon, and Heard (1991), which found that women diagnosed with BPD who had undertaken one year of DBT had a reduction of parasuicidal behaviours in the first four months, and after one year, of DBT. There is a robust quantitative evidence base for DBT in its treatment of self-harm among individuals diagnosed with BPD, an example of which is found in the results from a meta-analysis of DBT that revealed consistent moderate effect sizes for self-harm and suicidal behaviours (Kliem, Kroger, & Kosfelder, 2010).

Concerning quantitative findings unrelated to parasuicidal behaviours, in another RCT, Linehan, Tutek, Heard, and Armstrong (1994) found that the social adjustment scores of women diagnosed with BPD who had completed DBT were significantly better than the similar scores of participants in the treatment as usual group. This finding mirrors the findings from the present qualitative study, whereby participants reported an improvement in the areas of achieving personal social goals, such as fostering and maintaining healthy personal relationships. Considering other quantitative findings pertaining to DBT's influence on improvements in the quality of life for those diagnosed with BPD, the findings of an RCT by Carter, Willcox, Lewin, Conrad and Bendit (2010) found that women diagnosed with DBT reported a higher quality of life and less disability compared to participants within the treatment as usual group. Similarly, in an RCT by Koons et al., (2001) it was found that women diagnosed with BPD who had completed DBT had a greater reduction in measures of hopelessness in comparison to participants within the treatment as usual group. Findings from quantitative studies indicating DBT improving the quality of life, and increasing a sense of hope, of those diagnosed with BPD, is commensurate with the qualitative findings of the current qualitative research, whereby participants reported a transformational nature of DBT.

Implications

Clinical implications of findings from this research lend support to the argument that the NHS can provide an effective DBT service; participants' qualitative accounts suggest that an NHS-delivered community DBT programme did contribute to a 'life worth living'. This finding indicates that the NHS is continuing to fulfill its mandate to provide healthcare for those diagnosed with a personality disorder (Department of Health, 2003); this is being fulfilled whilst facing the U.K. Coalition Government's targets to make £20 billion of efficiency savings within the NHS by 2014 as set out in the Health and Social Care Act of 2012. One could argue that DBT's concept of a 'life worth living' and the DOH's concept of recovery are fairly well matched, and both achievable through an NHS-delivered community DBT programme.

Future Research

Although the present study attempted to recruit those who dropped out of DBT, their consent was not received, and thus they were not included in the study. Qualitative studies exploring the experience of DBT of those who dropped out would be valuable for a number of reasons. Firstly, qualitative findings from this group would provide a balance to the findings provided by graduates and those currently in the programme who might have favourable experiences of DBT. Secondly, qualitative findings from those who dropped out of the programme could be used to determine why some clients drop out of DBT, why DBT might be failing this population, and what needs to be done to ensure that clients with BPD are catered for by the NHS, as mandated by the DOH (2003). Research qualitatively exploring the reasons why some clients drop out of DBT is vital, as preventing therapy-interfering behaviours is the second of four priorities of DBT, second only to reducing life-threatening behaviours (Linehan, 1993a).

Limitations

There are a number of limitations to this study. Firstly, there was a gap of up to 14 months for two participants from when they completed the DBT programme to when they were interviewed. Although the accounts from these two participants were rich, it is possible their recollections were affected by other

experiences. Similar to a limitation shared by Hodgetts et al. (2004), three participants had knowledge that the interviewer had once helped co-facilitate the skills group, which might have affected their accounts. Also, one participant in this study had 6 months experience of DBT, which is less than that of the other participants; although the accounts from this client were comparable with that of the other participants, and similar studies have also recruited participants with as few as 6 months experience of DBT (Brassington and Krawitz, 2006; Cunningham et al., 2004). It is possible that accounts from the two participants who dropped out of DBT, and from whom consent forms were not received, might have described a negative experience of DBT, which needs to be considered when reviewing the findings of this study. Although this study was not intending to focus entirely on British women, due to the demographics of the DBT programme from which the participants were recruited, it is appreciated that, because all of the participants were all female and British, doubts arise regarding the degree to which the findings from this study can be generalised; however generalisation is a limitation of qualitative research in general, as rarely does qualitative research have sample sizes that enable generalising to broader populations. No measures of therapists' fidelity to the DBT model were conducted in this study; however, the aim of the study was to explore clients' experiences of a DBT programme within the NHS, a therapeutic setting where fidelity to therapeutic model is not routinely monitored. It is possible that interviews conducted in the building where the DBT skills group takes place might have influenced the findings. However, the choice of interview venue was carefully chosen, with a priority to ensure comfort, convenience, and safety for the participants.

Reflexivity

IPA involves a 'double hermeneutic' (Smith & Osborn, 2003), whereby the researcher is making sense of the participants making sense of their experience; the experience being the phenomenon under investigation. The researcher views the participants' experience through a personally unique experientially-informed lens (Smith et al., 2009). Therefore, it is possible that the same research, conducted by a researcher with different experiences and beliefs, could result in different findings. This

is an opinion shared by Brocki and Wearden (2006), who reported that qualitative research is ‘inevitably subjective as no two analysts working with the same data are likely to come up with an exact replication of the others’ analysis’ (p. 98). Starks and Trinidad (2007) recommended that the researcher must be ‘honest and vigilant’ (p. 1376) to their own perspective, pre-existing thoughts, beliefs, and developing hypotheses. Further to this analytic honesty and vigilance, Brocki and Wearden (2006) reported that a mistake a number of researchers using IPA make is not explicitly recognising ‘either the theoretical preconceptions they bring to the data or their own role in interpretation and this is a vital facet of IPA and one which ensures its accessibility and clarity’ (p. 101). Therefore it should be explicitly stated that the researcher of this study naturally brought certain beliefs to the analytic process; beliefs about the usefulness of DBT for helping those diagnosed with BPD, doubts surrounding BPD as a valid construct, hope regarding recovery, and a conviction that labeling someone’s personality as ‘disordered’ is unhelpful to the person receiving the label. These personal beliefs, which were probably augmented by clinical psychology training and co-facilitating a DBT skills group, formed the researcher’s unique experientially-informed lens through which the analysis was undertaken, and may have led to overly positive interpretations of participants’ experiences of DBT.

To enhance the researcher’s self-reflective process and improve validation of the analysis, the researcher shared the analysis of themes with both a professor of psychology and a consultant psychiatrist. On reflection, this validation would have been further strengthened if the themes were shared with the participants too, as sharing the themes with the participants would have enabled the researcher to further ‘bracket off’ ‘a priori knowledge and assumptions, with the analytic goal of attending to the participants’ accounts with an open mind’ (Starks & Trinidad, 2007, p. 1376). However, to improve analytic validation, the researcher deliberately included a number of participant excerpts in the empirical article to ensure a ‘grounding in examples’ (Elliott, Fisher, & Rennie, 1999, p. 222), which allows the reader to make assessments of the researcher’s analytic interpretations.

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Concluding Discussion

Extended Discussion

This chapter is divided into three sections. The first section extends the discussion of the empirical article. The second section presents a different version of the empirical report, which is intended to be included in the newsletter that is distributed amongst employees of the Trust in which the study was conducted. The third section proposes how the present study could be extended.

Overview of Findings

The present study was exploratory in nature and aimed to strengthen and extend the existing qualitative research exploring the experience of dialectical behaviour therapy (DBT; Linehan, 1993) for adults diagnosed with borderline personality disorder (BPD; American Psychiatric Association, 1994). Six women diagnosed with BPD were interviewed about their experiences of a DBT programme delivered within the community by the National Health Service (NHS). The specific objectives of the research were to explore the lived experience of each of the DBT components, the degree to which the experience of the programme is aligned to the initial expectations, what a ‘life worth living’ means to a person diagnosed with BPD, and whether DBT contributes to a ‘life worth living’. Analysing the interview transcripts using Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) identified six master themes relating to therapeutic group factors, therapist factors, personal change, challenges to be overcome, personalised problem solving, and opposing expectations.

Links to the Existing Literature

Findings from the present study indicate that participants were influenced by the changing composition of the skills group, with members of the skills group graduating and/or joining every three months, and other members dropping out. It is possible that due to this fluid dynamic of the skills group, the stages of group development cited by Tuckman and Jensen (1997), namely forming, storming, norming, performing, and adjourning, occur more often in a DBT skills group, and result in frequent disruptions to the status quo.

This is certainly something for facilitators of DBT programmes to consider, as the narratives from participants of the present study suggest that a change in the group dynamics has a negative effect on the remaining skills group members.

Although participants in the present study reported initially being anxious about starting the skills group, the anxiety of starting a therapy group is not specific to that of DBT but therapeutic groups in general, ‘starting group therapy is almost always a very anxiety-provoking experience for the client’ (Bernard et al., 2008, p. 461); which raises questions regarding the steps facilitators of therapeutic groups can take to alleviate the concerns clients have regarding starting therapeutic groups.

Although initially anxious about starting the skills group, participants also spoke about the immense value of sharing experiences with other members in the skills group who had similar lived experiences. These findings are aligned to the wider literature on group psychotherapy. For example, Whewell, Lingam, and Chilton (2004) found that individuals diagnosed with BPD benefited from a therapeutic group that fostered an appreciation of a reflective space that respected the experience of living with BPD. The therapeutic factors of group psychotherapy as defined by Yalom (1985), such as the universality of not feeling alone, and the imitative behaviours of modelling another’s recovery skills, were also certainly evident in the responses of the participants in the present study. Continuing with the powerful nature of the skills group, McSherry, O’Connor, Hevey, and Gibbons (2012) argue that the validation and universality experienced by the members of the skills group provides a ‘decoupling of the self from the “diagnosed self”’ (p. 545). The authors continue to argue that the medical classification of BPD as a psychiatric disorder ‘detracts from a service user’s traumatic history and pathologises their psychological distress as being symptomatic of illness’ (p. 545). The validation and universality obtained from the skills group provides a ‘powerful adaptive shift in identity, which challenges the medicalised condition’ (p. 545).

Participants in the current study described the value of the challenging approach of DBT therapists to participants' destructive behaviours. Such a therapeutic approach stems from DBT's concept of 'change and acceptance'. Dimeff and Linehan (2001) reported that 'the dance between change and acceptance are required to maintain forward movement in the face of a client who at various moments oscillates between suicidal crises, withdrawal and dissociative responses, rigid refusal to collaborate, attack, rapid emotional escalation, and a full collaborative effort' (p. 11).

Participants reported that regardless of how strange their personal experiences might be, including how harrowing an experience of self-harm might be, DBT therapists were experienced as validating. Validation is a key component of DBT as set out in the DBT manual, and so the participants' experience of therapists being validating suggests that treatment fidelity does not get lost in the translation of DBT from clinical trials to its application in regular clinical settings such as that offered by the NHS. Linehan (1997) extols the role of validation in DBT, 'it would be difficult to overestimate the over importance of validation' (p. 355).

Participants in the current study also described the value of therapists who were genuine, which is a therapeutic approach DBT refers to as Radical Genuineness. Radical Genuineness is concerned with treating clients as valid people, rather than fragile patients; therapists respond to the client as a person of equal status rather than responding in the typical prescribed therapist role. Dimeff and Linehan (2001) reported that DBT therapist must 'practice radical acceptance of the client in each moment while keeping an eye on the ultimate goal of the treatment: to move the client from a life in hell to a 'life worth living' as quickly and efficiently as possible' (p.11).

Participants valued the non-hierarchical quality of DBT, commenting on the efforts of DBT therapists to ensure that clients' voices are not only heard, but respected, that the rules of the skills group apply to therapists, and that therapists apply DBT skills to their lives too. This reduced demarcation between DBT

therapists and clients is aligned to the wider literature of the ‘flattened hierarchy’ of therapeutic communities, whereby ‘staff members are essentially themselves with the patients, engaging in dialogue that is authentic, meaningful and natural, rather than self-consciously playing the professional role’ (Campling, 2001, p. 370).

Although participants described phone coaching as extremely useful when they were too emotional to deploy DBT skills, participants reported their difficulties in using the phone coach, explaining that they did not want to be an inconvenience to the coach. The mood of those diagnosed with BPD has been correlated to the view they have of themselves (De Bonis, De Boeck, & Lida-Pulik, 1998), therefore it could be argued that when the mood of a client with BPD is so low as to warrant using the phone coach, the correlated negative view they have of themselves might be that of unworthiness; unworthy of calling the phone coach to work on alleviating themselves of the crises.

Harrison (1984) commented that recovery from physical illness does not mean that the suffering has disappeared and that functioning is restored entirely. Similarly, a person considered to have a ‘mental illness’ can recover despite the ‘mental illness’ not being ‘cured’; recovery is considered as living a satisfying life even with the limitations caused by illness (Anthony, 1993). The recovery literature comments on the changing of attitudes, values, and feelings that may contribute to recovery. The findings from the present study put forward the argument that the skills group, where those diagnosed with the ‘mental illness’ of BPD share their experiences with others and observe how others have successfully applied DBT skills to improve their lives, facilitates positive change in attitudes and values that instill hope in the possibility of living a meaningful life despite having a diagnosis of BPD. Recovery also means recovering from the stigma attached to illness (Anthony, 1993). Participants in this study spoke about feeling, for the first time, understood; understood by therapists and other group members. The findings from the present study put forward the argument that this sense of being understood may be the start of recovering from the unhelpful stigma of BPD many living with the diagnosis of BPD may have

incorporated into their very being; unhelpful ingrained stigmas about being damaged and untreatable. Unhelpful stigmas possibly generated by society's views of mental illness, and, more specifically, society's view of personality disorders being untreatable. It is argued that the experience of being understood and validated in DBT helps clients replace their internalised and unhelpful pre-conceived stigmas with those that are more hopeful.

Clinical Implications

The findings from the present qualitative research illustrate the value of conducting qualitative research in the NHS, as it is believed that the findings from the present study are valuable to a number of audiences. Findings from qualitative research exploring clients' lived experiences of NHS therapies would provide NHS commissioners, managers, and clinicians with valuable information concerning their clients' experiences of the NHS; information of particular importance in light of the recent negative experiences of care experienced by users of the Mid Staffordshire NHS Foundation Trust. In a report detailing the occurrences at Mid Staffordshire NHS Foundation Trust, Francis (2010), who was commissioned by the Secretary of State to investigate what led to the inadequate care, stated that individual experiences are of the utmost importance:

“If there is one lesson to be learnt, I suggest it is that people must always come before numbers. It is the individual experiences that lie behind statistics and benchmarks and action plans that really matter, and that is what must never be forgotten when policies are being made and implemented” (p.3).

In light of this recommendation made by Francis (2010), the challenge for the NHS is the task of balancing the continuing financial pressures, such as making a £20 billion saving by 2014 as set out by the Health and Social Care Act of 2012, with the incisive recommendations from reports such as that of Francis (2010) imploring the NHS not to overlook the experiences of the service it offers to the public.

Qualitative research within the NHS would be a big step to ensuring that the experiences of the public are not overlooked.

The use of qualitative research to continue to explore clients' experiences of NHS therapies would be sensible in light of legislature permitting any willing provider of healthcare provisions to compete with the NHS, as set out in the Health and Social Care Act of 2012. Findings from such qualitative research would provide important information to NHS commissioners, managers, and therapists, which could be used to ensure that the NHS remains competitive against the healthcare provisions offered by private healthcare providers.

A clinical implication from the findings of the present study is the degree to which the participants considered themselves to be recovered according to the definition outlined in the Department of Health's (DOH) *No Health Without Mental Health* mandate (DOH, 2011). It would be reasonable to expect that the participants in this study would consider themselves to be closely aligned to the concept of 'recovery' as defined in the DOH mandate (DOH, 2011), considering that the participants were recruited from a DBT programme delivered by the NHS, and the NHS is governed by the DOH. A review of the findings of the present study indicates that participants described improvements in relationships, educational and employment goals, as well as a reduction in clinical symptoms, which are fitting with the DOH's concept of recovery that 'emphasises the importance of good relationships, education, employment and purpose alongside reductions in clinical symptoms' (DOH, 2011, p. 21). As findings from the present study show, recovery for those diagnosed with BPD is not just about the removal of painful emotions and destructive behaviours associated with BPD, but the addition of personal goals too, such as employment, healthy friendships and relationships, and being independent, to name just a few.

Research Implications

The accounts from the majority of participants in the present study indicate the fostering of strong therapeutic relationships with their therapists, which is counter to the research suggesting that those diagnosed with BPD have difficulty fostering therapeutic relationships (Benjamin & Karpiak, 2001). A potential research implication of this study is to question why clients diagnosed with BPD who are being treated by other therapies fail to establish strong therapeutic relationships with their therapists.

Findings from the present study offer a counter argument to that of Corrigan (2001) who argues that the application of third wave therapies in clinical settings was ‘ahead of their data’ (p.192), and that supporters of such therapies were ‘devotees of interventions that lack the data to support them’ (p. 192) who ‘posed some eloquent arguments against the scientific method’ (p. 192). In order to balance such views, more qualitative research exploring the experiences of therapies undertaken in the NHS is needed, as the findings of this study indicate that the evidence from those undertaking DBT in regular clinical settings is ‘inline’ with the empirical data supporting DBT’s efficacy.

Reflexivity

Salmon (2003) suggests that ‘results of psychological research reflect the researcher as much as the researched’ (p. 26). Regarding IPA in particular, Brocki and Wearden (2006) report that ‘IPA is inevitably subjective as no two analysts working with the same data are likely to come up with an exact replication of the others’ analysis’ (p. 98). Starks and Trinidad (2007) recommend that as a researcher becomes immersed in the qualitative data, the researcher must be ‘honest and vigilant’ (p. 1376) to their own perspective, pre-existing thoughts, beliefs, and developing hypotheses. Smith and Osborn (2003) support the role of self-awareness of the researcher, recommending that care should be taken to distinguish between the participant’s original account and the researcher’s interpretations. Brocki and Wearden (2006) report that a mistake a number of researchers using IPA make is that they ‘do not always explicitly recognise either the theoretical preconceptions they bring to the data or their own role in

interpretation and this is a vital facet of IPA and one which ensures its accessibility and clarity' (p. 101). Therefore, the researcher is aware that being a trainee clinical psychologist, and therefore believing that clinical psychology can help people lead better lives, may have led to overly positive interpretations of participants' experiences of DBT. Whilst it is important to remain objective throughout the analytic process, the researcher naturally brought certain beliefs to the analytic process; beliefs about the usefulness of DBT, doubts surrounding BPD as a valid construct, and hope regarding recovery. These beliefs would have been informed by prior experience of co-facilitating a DBT skills group; a conviction that labeling someone's personality, something that is so core to a person, as 'disordered' is no help at all to the person receiving the label, but, instead, is damaging; and an equal conviction that those considered to have a 'disordered personality' can change their unhelpful thoughts and behaviours. Thompson and Russo (2012) refer to the difficulty psychologists face when conducting qualitative research, stating that psychologists undertaking research must be aware of the distinctions between a therapeutic encounter, which is for facilitating change, and the researcher encounter, which is for gaining information.

Although the analysis of themes of the empirical study was shared with a professor of psychology and consultant psychiatrist to enhance the researcher's self-reflective process and improve validation of the themes, sharing the themes with the participants would have strengthened the validation process of 'bracketing off' 'a priori knowledge and assumptions, with the analytic goal of attending to the participants' accounts with an open mind' (Starks & Trinidad, 2007, p. 1376). However, the researcher deliberately included a number of participant excerpts in the empirical article to ensure a 'grounding in examples' (Elliott, Fisher, & Rennie, 1999, p. 222), which allows the reader to make assessments of the researcher's analytic interpretations.

The researcher learnt so much through undertaking this study. Learning included, but was not limited to, the process and challenges of obtaining ethical approval for a study with NHS clients; designing and piloting interview schedules; conducting interviews; improving IPA skills, developing an appreciation of

the effort required to code approximately 12 hours of interview transcripts using IPA, and improving report writing skills. Although the researcher had no prior experience of performing qualitative research of this magnitude, it is believed that such inexperience may have been helpful as there were no pre-conceived notions of what should be done or avoided; the IPA approach was guided by the literature and not prior experiences.

The researcher was struck by the participants' willingness to partake in this study, and the effort they exerted in the interview to answer fully despite the unearthing of some difficult subjects. The researcher often wondered if this degree of surprise relating to the participants' commitment to the study would have been so strong if he was not so familiar with the literature that reports the difficulty those diagnosed with BPD have with engagement. This notion that those with BPD are difficult to engage certainly contributed to the researcher's anxieties from the outset, as the wording of every email and correspondence to the participants was deliberated over tirelessly to ensure that participants would not be offended and subsequently drop-out of the study. However, in person, the researcher found participants to be undeserving of their disengagement reputation. Of course, the researcher is conscious that an interview relationship in a single interview does not compare with the therapeutic relationship.

Despite the adage stating that those diagnosed with BPD are often considered untreatable, the findings from this study indicate that those with BPD are not only wanting of help, but are willing to work hard in therapy to improve their lives, and can benefit from psychological treatment; therefore it is hoped that at some point their 'untreatable' reputation is replaced with 'treatable and willing.'

Different Version of the Empirical Research

The report below is a modified version of the empirical article presented in chapter two. The target audience for this modified report are the employees and service users of the NHS trust from which participants of this study were recruited. The intention is for the modified report to be circulated via the Trust's newsletter.

Life for those with borderline personality disorder (BPD) can be really difficult. For nearly three years the Trust has been running an outpatient dialectical behaviour therapy (DBT) programme for service users diagnosed with BPD. The programme runs for 12 months. During the programme, service users attend a weekly skills group, which teaches skills on Mindfulness, Distress Tolerance, Emotional Regulation, and Interpersonal Effectiveness. Service users also attend weekly individual therapy, which focuses on the personal application of DBT skills to the current difficulties experienced in the lives of service users. Service users of the programme also have access to phone coaching from a member of the DBT team, the purpose of which it to provide DBT support during difficulties.

DBT has been shown to be effective in treating BPD in clinical trials, but rarely have studies investigated its effectiveness in actual clinical services by capturing the voices of service users who have undertaken this therapy. A trainee psychologist from the University of Liverpool interviewed service users diagnosed with BPD who attended the outpatient DBT programme offered by the Trust. The aim of the interview was to explore service users' experiences of the programme and its impact on their lives.

Analysing the interviews revealed that service users achieved personal goals and improvements in their lives, with a reduction in the harmful behaviours and emotions associated with BPD. Service users described the programme as being challenging at times, with weekly homework set by DBT therapists for completion between therapy sessions; DBT homework consists various things, such as the completion of

mood and behaviour diary sheets, and implementing and recording the use of DBT skills. DBT therapists were described as supportive and genuinely interested in helping service users. The DBT skills group was described as an opportunity to learn DBT skills with others also living with BPD. Individual therapy was considered a place where service users worked with their individual therapist to find ways of applying the DBT skills to their current difficulties. Phone coaching was considered useful in providing immediate support during difficult periods, although service users reported having to overcome some personal anxieties about contacting the phone coach.

Overall, service users explained that their lives have improved considerably in comparison to their lives before starting the programme, with many service users describing the change to their lives as ‘transformational’.

It is encouraging to learn that the DBT programme the Trust provides to its service users is valued and make a difference to their lives. It is imperative that service users continue to benefit from the services offered by the Trust.

For more information about the DBT programme offered by the Trust, please contact (name and email of the DBT programme leader).

Further Study

This section of the report begins by outlining three potential qualitative studies, findings from which would develop the study presented in this dissertation and possibly contribute to improving the effectiveness of DBT within actual clinical services for complex clients diagnosed with BPD. A research proposal is then presented for a prospective qualitative study.

Potential Qualitative Studies

To date, it is believed that a study is yet to qualitatively explore why clients of DBT experience tremendous anxiety at the thought of using phone coaching, findings revealed in the present study and that of others (Cunningham, Wolbert, & Lillie, 2004; Perseius, Ojehagen, Ekdahl, Åsberg, & Samuelsson, 2003). Although clients of DBT testify to the merits of the immediate support offered by phone coaching, many clients have to overcome their anxiety before using phone coaching; participants are anxious about being an inconvenience to the phone coach. A useful qualitative study would be to explore why clients of DBT think they might be an inconvenience to the phone coach, especially considering that it is the phone coach's paid responsibility not to be inconvenienced by clients. Findings from such research would help DBT programmes implement steps so ensure that their clients do not perceive their phone coaches as being inconvenienced. Another useful piece of research regarding the use of phone coaching would be to examine whether the degree of clients' ambivalence towards phone coaching is aligned to phone coaches' ambivalence towards offering phone coaching. It is vital that clients of DBT feel comfortable using phone coaching, and therefore harness the entire suite of therapeutic modalities offered by DBT; DBT without the use of phone coaching is not DBT.

It would also be useful to investigate qualitatively why some clients of DBT drop out; preventing therapy-interfering behaviours is the second of four priorities of DBT, second only to reducing life-threatening behaviours (Linehan, 1993). Qualitative research could explore exactly what is it about the DBT

programme that possibly influences clients to drop out, and what is missing from DBT programmes that might prevent clients from dropping out. It is believed that, to date, no such study has been undertaken with clients of an NHS-delivered community DBT programme. In a non NHS-based study, Skodol, Buckley, and Charles (1983) found that individuals diagnosed with BPD who dropped out of therapy had more severe symptoms at baseline and more prior treatments. In a qualitative study involving NHS-based therapies, Chiesa, Drahorad, and Longo (2000) found that educational level, occupational status, and social class predicted the completion of psychological therapy by individuals diagnosed with BPD, although DBT was not included in the collection of psychological therapies examined. Qualitative research examining the influences causing those with BPD to drop out of an NHS-delivered community DBT programme would be useful to determine the steps DBT programmes could take to cater for this population. If qualitative findings from this research indicate that certain life circumstances prior to DBT contribute to a high risk of client drop out, screening assessments could be introduced when clients start DBT to ensure that the NHS provides enhanced support to those who are at risk of dropping out of an NHS-delivered DBT programme.

Although DBT's first goal is to address life-threatening behaviours, a minority of clients in the present study reported current urges to self-harm. While DBT has garnered support for its efficacy across a range of clinical symptoms relevant to BPD, DBT is not successful with all clients. This finding is echoed by Salsman, Harned, Secrist, Comtois, and Linehan (2008) who reported that approximately 36% of individuals diagnosed with BPD do not respond to DBT. Thus, there is a need to qualitatively examine why some clients do not respond to the DBT skills that are geared, specifically, to targeting tolerating distress, and regulating painful emotions.

Research Proposal

Exploring the lived experience of life after dialectical behavioural therapy

Introduction

Borderline personality disorder (BPD) is defined by a pervasive pattern of instability of interpersonal relationships, self-image, affects, with a marked impulsivity that is present in a variety of contexts (American Psychiatric Association, 1994). The causes of BPD are unclear, and no one model has been advanced that integrates all of the available evidence (National Institute for Health and Clinical Evidence, 2009). Individuals with BPD are considered difficult to treat, in part because of the difficulties of establishing a therapeutic alliance (Aviram, Brodsky, & Stanley, 2006); Kelly et al. (1992) report that up to 50% of clients diagnosed with BPD drop out of therapy within six weeks. Despite this high degree of therapeutic disengagement, individuals with BPD seek treatment at high rates, often resulting in a heavy reliance on mental health services (Gunderson, 2009); therefore the cost to public health services in treating BPD is considered to be high (Sharma, Dunlop, Ninan, & Bradley, 2007).

Psychological therapy is recommended as the first-line treatment for BPD by the National Institute for Health and Care Excellence (NICE, 2009). The Cochrane Collaboration systematically reviewed a number of psychological interventions for BPD using a meta-analysis of 28 studies that involved a total of 1,804 individuals with BPD, and concluded that dialectical behaviour therapy (DBT; Linehan, 1993) has the strongest evidence of efficacy relative to the other treatments investigated (Stoffers et al., 2012). Corroborating this finding from The Cochrane Collaboration, Feigenbaum et al. (2011) report that DBT has been recommended as a treatment of choice for BPD by a number of influential bodies, such as the APA (2001) and NICE (2009).

The primary objective of DBT is to help individuals learn strategies to manage their emotions through the acquisition of effective coping strategies. DBT is typically a one year multi-modal therapeutic programme, comprising of a weekly skills training group, weekly individual therapy sessions, and telephone consultations. DBT therapists attend weekly consultation meetings that offer opportunities to discuss cases and develop DBT skills (Linehan, 1993).

Although DBT has gathered robust clinical evidence for its efficacy over the years, and is also developing its evidence base for clinical effectiveness in typical healthcare settings, it is believed that no qualitative research has been undertaken exploring the lived experience of living with BPD after graduating from a DBT programme delivered by the National Health Service. This point is shared with Martens (2005) who reported that ‘without data on the long-term effects of DBT, it is very difficult to discuss the usefulness of DBT’ (p. 11). Benefits from the findings of qualitatively exploring the lives of those diagnosed with BPD after graduating from a DBT programme will augment the current qualitative evidence supporting the effectiveness of DBT in clinical settings. This research proposal outlines the qualitative literature pertaining to clients’ experiences of DBT delivered in the community, and defines the research aims, objectives, and research methodology.

Literature Review

Whilst DBT has been garnering robust evidence for its efficacy and quantitative effectiveness since its inception in 1993, the same cannot be said for qualitative research investigating clients’ lives after DBT. To date it is believed that only five qualitative studies have explored individuals’ experiences of a community-based DBT programme that focused on treating the symptoms of BPD. In a qualitative study conducted in Sweden, Perseius et al. (2003) found that clients considered DBT to be life-saving. Similar positive findings were also found in a study conducted in the United States, whereby Cunningham et al. (2004) interviewed fourteen women about their experiences of a DBT programme and its impact, and using ethnographic analysis of the interviews indicated that participants found DBT to be life changing;

participants reported that DBT had taught them skills that helped improve their relationships, reduce suffering, increase hope, and manage emotions. In a study based in New Zealand, Brassington and Krawitz (2006) used quantitative and qualitative measures to review a 6 month pilot of DBT for individuals diagnosed with BPD, and found that participants were more capable of achieving long-term goals, had developed a sense of responsibility for their recovery, had increased hope and happiness, and reported benefiting from the acquisition of alternative skilful responses to deal with target problems. Hodgetts, Wright, and Gough (2007) explored individuals' experiences of a community-based DBT programme offered by the NHS. Five participants were interviewed, and using Interpretative Phenomenological Analysis (IPA; Smith, 1996), findings showed that participants reported a positive change in their lives that they attributed to DBT. McSherry, O'Connor, Hevey, and Gibbons (2012) examined the effectiveness of an adapted DBT programme delivered within a rural community mental health setting in Ireland for individuals diagnosed with BPD. The findings were encouraging, with participants reporting that the newly acquired skills were helpful in managing strong emotions.

Whilst these qualitative studies have explored the experiences of community-based DBT programmes by adult clients diagnosed with BPD, a qualitative study has yet to explore clients' lived experience of living with BPD after graduating from a DBT programme delivered by the NHS.

Aims and Objectives

The aim of this study to qualitatively explore the lived experience of the lives of those with a diagnosis of BPD who have graduated at least 1 year earlier from a DBT programme delivered in the community by the NHS. One year is chosen as the duration after graduation at which point participants will be interviewed as 1 year after therapy is the duration that Martens (2005) considers any effects of therapy to be classed as 'long-term' (p. 11).

The objectives of the study would be to explore the lived experience of the current lives of participants who had graduated from a DBT programme 1 year previously; and to explore whether participants considered themselves to be living a life ‘worth living’ given that a ‘life worth living’ is the primary goal of DBT.

Method

Participants

Participants will be adults with a diagnosis of BPD who have attended an NHS-based DBT programme delivered in the community of the North West region of England. It is intended that participants will be both male and female, and vary in ethnicity and nationality. Participants will be purposefully sampled due to their unique experience of having a diagnosis of BPD, and graduating 1 year prior from an NHS-based DBT programme delivered in the community. Purposeful sampling is often used in qualitative research, and it involves selecting research participants according to the needs of the study. Participants will be recruited from more than one NHS Trust.

Ethical considerations

Applications for ethical approval will be made to the NHS Trusts in the North West that are currently running a full DBT programme, as well as the Local Research Ethics Committee. Clients of DBT programmes will be informed that there is no obligation for them to be interviewed. They will also be informed that they are not obliged to answer every question in the interview, and they can stop the interview at anytime. Participants will receive a written account of the aims of the study, and be provided with the researcher’s contact detail if they have any questions. All participant data will be anonymised, and stored securely. Participants will not be identifiable in the final report. Written consent will be sought from participants. All travel expenses for the participants will be reimbursed.

Data collection

Once ethical approval is obtained, the researcher will contact local NHS Trusts in the region that are running a full DBT programme and ask the DBT team leader if existing and future DBT clients could be given consent forms and information packs detailing the research. Clients of the programmes will send their consent forms directly to the researcher. As a client who has consented to the research graduates from the programme, he/she will be contacted by the researcher (the researcher will know the expected graduation date as it would have been recorded on the consent form), and arrangements will be made for an interview to occur 1 year in the future. Ideally, participants will travel to the University of Liverpool to be interviewed in one of the offices. If participants are reluctant to travel to the premises of the University, which would have ensured that all interviews are conducted in the same room, participants will be interviewed in a quiet office on the premises of their local NHS Trust. Interviews will be used to gather qualitative information. It is not expected that interviews will take more than 1 hour. Immediately prior to the interview, participants will be given a brief rationale for the study, an information sheet describing steps to take if the interview elicits any negative emotions that might be considered overwhelming, and informed of their right to withdraw. Clients will be excluded if they are in therapy at the time of interview or if they have received subsequent therapy since finishing the DBT programme. Clients will be asked to report any current medication at the time of interview. Interviews will be recorded to be transcribed verbatim by the researcher.

Materials

A dictaphone will be needed to record interviews. A semi structured interview schedule will be devised and piloted with colleagues.

Design

Interview transcripts will be analysed using the interpretative phenomenological analysis epistemology (IPA; Smith, Flowers, & Larkin, 2009). IPA is considered the most appropriate analytical approach as

the research is focused on exploring the experiences and meaning of the lives of adults who have a diagnosis of BPD and who have graduated at least 1 year ago from a DBT programme delivered in the community by the NHS. IPA uses a systematic process of coding, whereby statements are analysed and categorised into clusters of meaning that represent the phenomenon of interest (Brocki & Weaden, 2006); the phenomenon of interest in the present study is the 'life of an adult diagnosed with BPD 1 year after graduating from a DBT programme delivered in the community by the NHS'. IPA has been used extensively in the academic literature to explore lived experiences. Each transcript will be read a number of times, with emerging themes noted, clustered, and documented (Smith & Osborn, 2003). Further to the researcher's interpretation, it is imperative that researchers using IPA recognise their own experiences and values on interpretation, which must be continually considered and acknowledged (Brocki & Weaden, 2006).

Strategies for validating findings

Themes will not only be validated with professors of psychology experienced in qualitative research at the University, who will act as expert consultants, but shared with the participants too. The researcher will also continuously check for fit between data and interpretations by checking themes against participant accounts. Triangulation will also be used to check and establish validity of the findings.

Sample size

Typical sample sizes for IPA studies range from 1 to 10 people (Starks & Trinidad, 2007). According to Smith and Osborn (2003), IPA studies have been published with one, four, nine, and fifteen participants. This study will remain open until 15 clients have been interviewed, and depending on how long it will take to recruit this number, this study may remain open for up to 2 years.

Biases

This study necessitates the explicit identification of personal values, assumptions, and biases of the researcher. The researcher is a trainee clinical psychologist and an advocate for the role of psychology in helping people achieve meaningful and better lives. The researcher has also co-facilitated a DBT skills group and believes that DBT can help those diagnosed with BPD change unhelpful thoughts and behaviours. Although considerable effort will be made to ‘bracket off’ personal bias to ensure objectivity, subjective personal bias may shape the interpretation of the data.

Challenges

It is noted that participants will be recruited from different DBT programmes, and therefore the programmes will vary in their degree of DBT fidelity, but they will share many important commonalities, including being a full DBT programme offered in the community by the NHS. Another challenge is protecting the interviewer from compromising complaints and allegations. In response to this, interviews will be recorded, providing audio evidence of everything said in the confines of an interview. Interviews will be conducted during working hours, and admin staff will be informed of the room in which the interviews will take place, together with the duration of the interviews.

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Appendix

Appendix A:	Clinical Psychology Review Author Guidelines
Appendix B:	Journal of Clinical Psychology Author Guidelines
Appendix C:	Diagram Illustrating the Recruitment of Participants
Appendix D:	University of Liverpool Approval Letter
Appendix E:	University of Liverpool Intention to Sponsor
Appendix F:	Local Research Ethics Committee Approval
Appendix G:	Local NHS Trust Approval
Appendix H:	Participant Information Sheet
Appendix I:	Consent Form
Appendix J:	Letter of Invitation
Appendix K:	Demographics Sheet
Appendix L:	Interview Schedule
Appendix M:	Further Support Information Sheet
Appendix N:	Example of Transcript with Initial Comments
Appendix O:	Example of Transcript with Descriptive, Linguistic, and Conceptual Comments
Appendix P:	Analytic Development from Emergent Themes to Super-ordinate Themes

Appendix A

This text box is where the unabridged thesis included the following third party copyrighted material:

The author guidelines from a targeted journal.

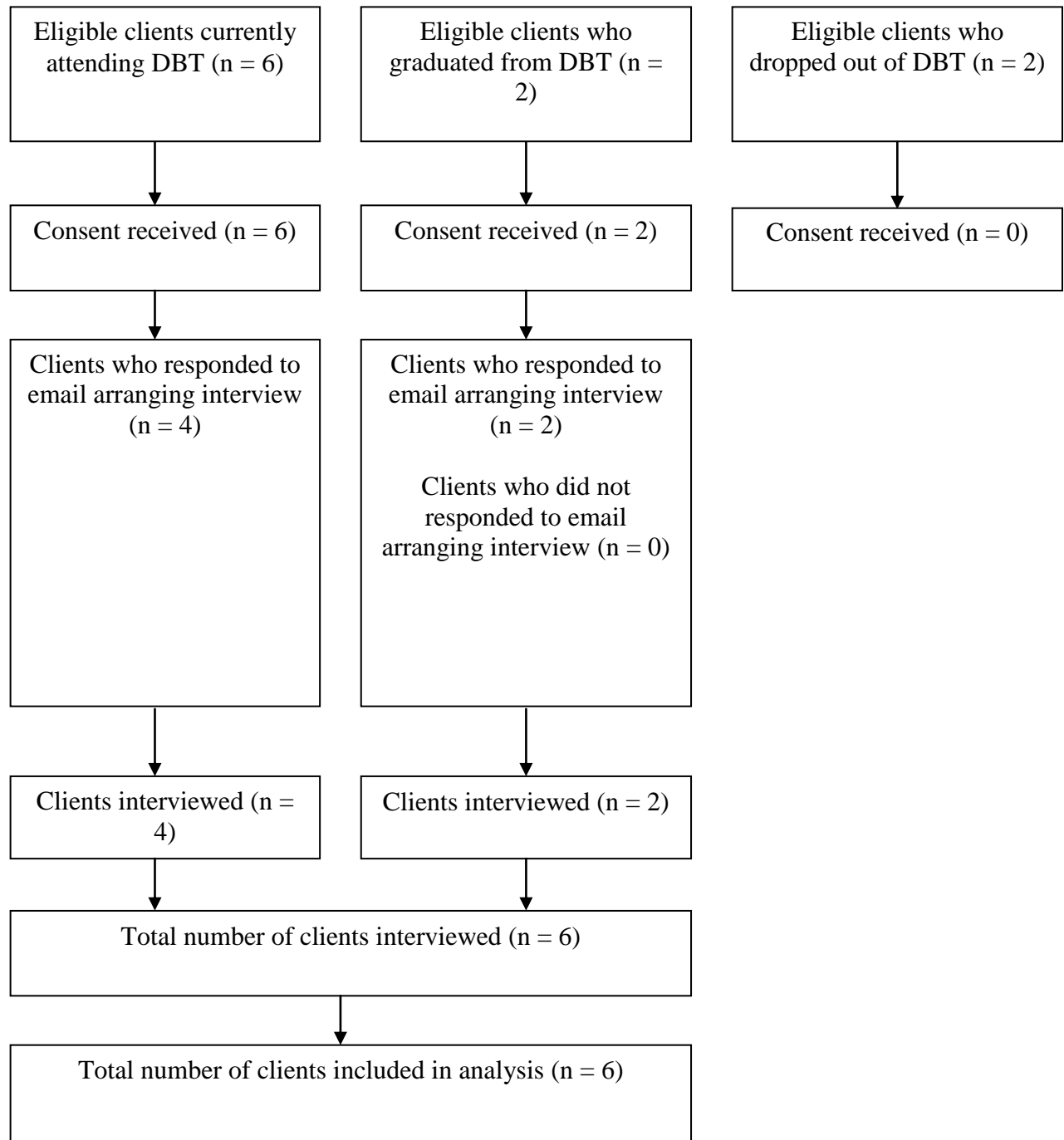
Appendix B

This text box is where the unabridged thesis included the following third party copyrighted material:

The author guidelines from a targeted journal.

Appendix C

Diagram Illustrating the Recruitment of Participants



Appendix D

University of Liverpool Approval Letter



D.Clin.Psychology Programme

Division of Clinical Psychology
Whelan Building, Quadrangle
Brownlow Hill
LIVERPOOL
L69 3GB

Tel: 0151 794 5530/5534/5877

Fax: 0151 794 5537

www.liv.ac.uk/dclinpsychol

Donald Smith
Year 2 Trainee Clinical Psychologist
29 January 2012

**RE: What are the experiences of dialectical behavioural therapy by women presenting
with borderline personality disorder symptoms?**

Dear Donald

Thank you for submitting a revised research proposal to the DCLin Research Committee, which has been reviewed and discussed by the Committee. I'm pleased to inform you that the modified proposal has been approved by the Committee and you can proceed to submitting an ethics application. Good luck with your research.

Yours sincerely

A handwritten signature in black ink that reads "Ian Fletcher".

Dr Ian Fletcher (Chair Yr 2 DCLin Research Committee)

Appendix E

University of Liverpool Intention to Sponsor



UNIVERSITY OF
LIVERPOOL

Mrs Lindsay Carter
Clinical Research
Governance Manager.

Research Support Office
University of Liverpool
Waterhouse Buildings
3 Brownlow Street
Liverpool
L69 3GL

Tel: 0151 794 8722
Lindsay.Carter@liv.ac.uk

Sponsor Ref: UoL000873

Professor James McGuire (Donald Smith)
Institute of Psychology, Health & Society

27 April 2012

Dear Professor McGuire

Re: Intention to Sponsor

**"What are the experiences of dialectical behavioural therapy by women presenting with
borderline personality disorder symptoms?"**

I can confirm that the University of Liverpool, in principle, will be willing to act as Sponsor for the above research project under the Department of Health's Research Governance Framework. The project is currently being reviewed through the necessary sponsorship approval procedure. It is envisaged that we will be able to confirm sponsorship within the next four weeks.

University professional indemnity and clinical trials insurances will apply to the study as appropriate.

In order that you can proceed with your NRES (National Research Ethics Service) application for NHS ethical approval, please contact me on 0151 794 8722 in order to arrange for the Declaration of Sponsor to be completed and signed by the University.

Yours sincerely,

PP
R. Turner

Mrs Lindsay Carter
Clinical Research Governance Manager, Research Support Office

Appendix F

Local Research Ethics Committee Approval



**Health Research Authority
National Research Ethics Service**

NRES Committee North West - Cheshire

HRA NRES Centre North West
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7818
Facsimile: 0161 625 7299

18 September 2012

Professor James McGuire
Course Director
Liverpool University
Division of Clinical Psychology
Whelan Building, Brownlow Hill,
Liverpool
L69 3BX

Dear Professor McGuire

Study title:	What are the experiences of dialectical behavioural therapy by women presenting with borderline personality disorder symptoms?
IRAS project number:	105449
REC reference:	12/NW/0557
Protocol number:	UoL000873

Thank you for your email of 13 September 2012, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair, Mr Peter Ward and Mrs Jean Welch.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		12 July 2012
Evidence of insurance or indemnity - Up to date insurance policy		02 August 2012
Interview Schedules/Topic Guides	1.7	21 June 2012
Investigator CV - James McGuire		
Investigator CV - Mr Donald Smith		
Letter from Sponsor		25 June 2012
Letter of invitation to participant	1	02 June 2012
Other: Information sheet for further support after the interview	1	27 April 2012
Participant Consent Form	3	01 September 2012
Participant Information Sheet	3	01 September 2012
Protocol	1.1	02 May 2012
Questionnaire: Demographic data	2	01 September 2012
REC application	3.4	27 June 2012
Response to Request for Further Information		13 September 2012
Summary/Synopsis	1.0	02 May 2012

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators

- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

12/NW/0557	Please quote this number on all correspondence
-------------------	---

With the Committee's best wishes for the success of this project

Yours sincerely

DM Cattell
JP

Mr Jonathan Deans
Chair

Email: nrescommittee.northwest-cheshire@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to:

This text box is where the unabridged thesis included the following third party copyrighted material:

Mention of the Trust where the research took place. To preserve confidentiality of the participants, the Trust where the research took place has been removed.

Appendix G

Local NHS Trust Approval

This text box is where the unabridged thesis included the following third party copyrighted material:

Mention of the Trust where the research took place. To preserve confidentiality of the participants, the Trust where the research took place has been removed.

Mr Donald Smith
Liverpool University
Division of Clinical Psychology
Whelan Building
Brownlow Hill,
Liverpool
L69 3BX

3rd October 2012

Dear Mr Smith

Formal Letter of Approval

Trust Ref: 2012/25: Trust Ref: What are the experiences of dialectical behavioural therapy by women presenting with borderline personality disorder symptoms?

Thank you for your research application which was reviewed by the Trust's Research Governance Committee on the 24th July 2012. The Committee were willing to approve subject to ethical approval and a satisfactory response to a query, regarding the Information Sheet.

This text box is where the unabridged thesis included the following third party copyrighted material:

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Accordingly, please take this letter as confirmation of Trust R&D approval. Please read the attached '*Information for Researchers – Conditions of Research Governance Approval*' leaflet, which details the research governance R&D approval conditions. Please contact the R&D Office should you require any further information. You may need this letter as proof of your approval.

When contacting the R&D office please quote the above Trust reference number.

May I wish you every success with your research.

Yours sincerely

A handwritten signature in black ink, appearing to read 'P. Parker', written in a cursive style.

Mrs Pauline Parker
R&D Manager

Appendix H

Participant Information Sheet

This text box is where the unabridged thesis included the following third party copyrighted material:

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Appendix I

Consent Form

This text box is where the unabridged thesis included the following third party copyrighted material:

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(Version 3. Dated 1st September 2012 May 2012)

Consent form

Experiences of dialectical behavioural therapy (DBT)

Researcher: Donald Smith, Trainee Clinical Psychologist.

If you wish to partake in this study, please read each statement below and write your initials in each corresponding box to indicate your understanding, then provide your signature and contact details in the section at the bottom of this form. This form can then either be given to me when I next attend your DBT Skills Group, or, if you no longer attend the DBT Skills Group, or if you prefer, you can send this consent form to me using the stamped and addressed envelope provided. Thank you. If you have questions please contact me on details at the end of this document.

☐

I have read and understood the Participant Information Sheet (Version 3. Dated 1st September 2012) and had time to consider the information and ask any questions.

☐

I understand that all data collected will be anonymous and any identifying information will be removed from the interview transcript.

☐

I understand that data collected during the study may be looked at by individuals from regulatory authorities, staff from the University of Liverpool, or staff from the NHS Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information.

☐

I understand that my participation in this study is voluntary and I may withdraw my participation from the study at any time, without giving a reason, and such a withdrawal will not affect my care or legal rights.

☐

I give consent to be interviewed, and the interview to be recorded and transcribed at a later date.

☐

I understand that anonymised and non-identifying quotes may be used in the final paper, which may be submitted for publication.

☐

I agree that under certain circumstances (i.e. where there is a risk of immediate serious harm) confidentiality cannot be guaranteed in the interest of obtaining appropriate support. The researcher will do this collaboratively with me.

☐

I agree that if I find the interview distressing, I will either contact my Care Coordinator or G.P.; use the DBT phone coaching; follow my DBT “crises plan” or “care plan”; or access other healthcare provisions to help.

☐

I understand that my medical notes and data during the study may be looked at by regulatory authorities and relevant persons where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information.

☐

I agree to take part in this study.

☐

I agree for the researcher to contact me to arrange an interview.

Do you wish to receive a copy of the results from this study? Yes / No

If you wish to partake in this research, please give your telephone number or e-mail so that the researcher can contact you to arrange a convenient time to hold the interview:

Telephone number/Email address

Name of participant:

Signature:

Date:

Name of researcher: Donald Smith

Signature:

Date:

If you wish to take part in this study please complete the participant section above and give/send to: Donald Smith, University of Liverpool, Clinical Psychology Doctorate Student, Clinical Psychology Department, Whelan Building, Brownlow Hill, L69 3GB.

Any questions - Donald can be contacted at Donald.smith@liverpool.ac.uk. Tel 0151-794-5530.

Supervised by - Professor James McGuire. Whelan Building, University of Liverpool, L69 3GB.

Appendix J

Letter of Invitation

This text box is where the unabridged thesis included the following third party copyrighted material:

Mention of the Trust where the research took place. To preserve confidentiality of the participants, the Trust where the research took place has been removed.

(Version 1. Dated 2nd June 2012)

Department of Clinical Psychology,
University of Liverpool,
Whelan Building,
Brownlow Hill,
L69 3GB.

Tel: 0151-794-5530

Email: donald.smith@liverpool.ac.uk

7th November 2012

Research Project: What are the experiences of dialectical behavioural therapy (DBT) by women presenting with borderline personality disorder symptoms?

Dear Former DBT Attendee,

My name is Donald Smith and I am a trainee clinical psychologist at the University of Liverpool. As part of my studies I aim to undertake a research project that explores the experience of partaking in dialectical behavioural therapy (DBT).

I would like to invite you to participate in the study. More information regarding what you will be required to do if you decide to participate can be found in the information sheet enclosed with this letter.

If you would like to participate in this study, please complete the consent form enclosed and send to me at the address above. If you have any questions please contact me on either 0151-794-5530 or donald.smith@liverpool.ac.uk.

Thank you for your time in reading this letter.

Yours faithfully

Donald Smith
Clinical Psychology Doctorate Student
Liverpool University

Appendix K

Demographics Sheet

This text box is where the unabridged thesis included the following third party copyrighted material:

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(Version 2. Dated 1st September 2012)

Demographic Data

"Answers to these questions would be useful to provide me with some background/demographic information, but you are not obliged to answer any of these if you would rather not".

Participant Unique Identifier (I, Donald, will complete this): _____

1. Age? _____
2. Time on the DBT programme? _____
3. When first diagnosed with BPD? _____
4. Any history of other mental health difficulties? _____
5. Currently any other mental health difficulties? _____
6. Any current medication? _____
7. Any time as an in-patient? _____
8. Number of years of schooling? _____
9. Employment status/history? _____
10. Marital status/ever married? _____

Appendix L

Interview Schedule

This text box is where the unabridged thesis included the following third party copyrighted material:

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(Version 1.7 Dated 21st June 2012)

Interview Schedule

Preamble: “Thank you for consenting to be interviewed. The interview may take between one and two hours, and will be recorded so that it can be analysed later; your answers will be confidential and will remain secure. You can ask for a break at any time during the interview; just tell me that you want a break.”

“Do you have any questions?”

“Before we start the interview, I was wondering if I could ask you some questions from a questionnaire to get some background information? You do not need to answer any of these questions if you choose not to, and I am only asking to get a better sense of you.” May I ask you the demographic questions?” (If so, refer to demographic questionnaire).

“Can we start the interview?”

(Useful probes for interviewer to remember: Can you tell me more about that? What effect did that have on you? What did that mean for you?

Start of Interview

(The following questions explore whether the expectations of DBT are aligned to the experiences of DBT)

1. “Before starting DBT, what were you expecting DBT to be like?” Probes – Why? Can you tell me more about that? What did you know about it? Did you know about the skills group, individual therapy, phone coaching? If so, what were you expecting them to be like?

2. “Could you describe your *actual* experience of DBT?” How would you describe DBT to someone else? Probe - Why? How? Can you tell me more about that? What effect did that have on you? What did that mean for you?

3. “What was your experience of how DBT *actually* was in comparison to your initial expectation? Probe - Why? How? What was expected/unexpected/different? **How did you experience that difference or similarity? What did that difference or similarity mean to you?**

(The following questions are to glean experiences of the DBT Programme, including explicitly asking about the different components and the impact of the different components)

INDIVIDUAL THERAPY:

4. "Could you describe your experience of starting work with the individual therapist?" *Probe – Why? How? Can you tell me more about that? What effect did that have on you? What did that mean for you?*

5. **"Could you describe your experience of Individual Therapy? What did you make of Individual Therapy?"** **On reflection, what did/does Individual Therapy mean to you?** *Probe – Why? How? Can you tell me more about that? What effect did that have on you?*

6. **"Could you describe your experience of** being in individual therapy for ??? number of months?" *Probe – Why? How? Can you tell me more about that? What effect did that have on you? What did it mean for you to be in Individual Therapy for ??? months?*

7. **"Could you describe your experience of how Individual Therapy impacted your life?"** *Probe - Can you tell me more about that? What effect did that have on you? What did that mean for you?*

SKILLS GROUP:

8. **"Could you describe your experience of starting the skills group?"** *Probe – Why? How? Can you tell me more about that? What effect did that have on you? What was your experience of meeting others who attended the group?*

9. **"Could you describe your experience of the skills group? What did you make of skills group? On reflection, what did/does skills group mean to you?"** *Probes – Why? How? Can you tell me more about that? What effect did that have on you? What did that mean for you? What was your experience of being with others in skills group? What was your experience of what was covered in skills group? What was your experience of skills group as an effective way to learn DBT skills? What is it like learning with others?*

10. "How would you describe being in skills group for ??? number of months? What was your experience of being in skills group for ??? number of months?" *Probe – Why? How? What was your experience of how skills group evolved? Can you tell me more about that? What effect did that have on you? What did that mean for you?*

11. **"Could you describe your experience of how skills group impacted your life?"** *Probe – Why? How? Can you tell me more about that? What effect did that have on you? What did that mean for you?*

TELEPHONE COACHING:

12. **"Could you describe your experience of telephone coaching? What did you make of telephone coaching? On reflection, what did telephone coaching mean to you?"** *Probe – Why? How? Can you tell me more about that? What effect did that have on you? What did that mean for you? Comment on using it? Comment on not using it? Comment on how much you used it? Comment on its helpfulness?*

13. **"Could you describe your experience of how telephone coaching impacted your life?"** *Probe – Why? How? Can you tell me more about that? What effect did that have on you? What did that mean for you?*

14. "Many therapies are delivered as either an individual therapy, or a group therapy. Can you describe your experience of being in a therapy that combined the two, and also had telephone coaching?" *Probe – Why? How? Can you tell me more about that? What effect did that have on you? What did that mean for you?*

(The following questions are to glean whether the experience of DBT is consistent with DBT's aim to help service-users achieve a life worth living.)

15. "DBT aims for clients to achieve a "life worth living", what does a life worth living mean to you?" *Probe – Why? How? Can you tell me more about that? What effect did that have on you? What did that mean for you?*

16. "Can you comment on how DBT may have contributed to a life worth living?" *Probe – Why? How? Can you tell me more about that? What effect did that have on you? What did that mean for you?*

Conclusion: "We have talked about a number of DBT-related topics during our time together today, and, as the interview comes to an end, I was wondering if you have any other thoughts about anything that we have discussed today or any comments to make about the interview itself?"

"Do you have any questions? "

"If, in the future, you think you would like to ask me any questions, may I give you a 'further support' form that has my contact details at the bottom? You will notice that the 'further support' form also has the contact details of other organisations that may be able to help you if you have found this interview distressing in anyway; you may remember that when you consented to partake in this study you agreed to adhere to your 'care plan' and/or seek other professional healthcare support to help you adaptively manage any difficult emotions. How have you found the interview?"

"Thank you so much for your time today. I wish you all the very best."

Appendix M

Further Support Information Sheet

This text box is where the unabridged thesis included the following third party copyrighted material:

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Information Sheet for Further Support after the Interview

Thank you for participating in the interview.

The interview aimed to explore:

- Experiences of the different components of the DBT, for example Skills Group, Individual Therapy, and Phone coaching;
- whether the experience of DBT is consistent with DBT's stated aims to help service-users achieve a life worth living;
- and whether the experience of the DBT Programme is aligned to expectations of the DBT Programme.

If this interview has left you feeling low, you may consider the following for assistance:

- **Your DBT Crises Plan (if you are still part of the DBT programme);**
- **DBT phone coaching (if you are still part of the DBT programme);**
- **Your Care-Coordinator/Care Plan;**
- **Your G.P.;**
- **Mind**, phone: 0845 766 0163, website: www.mind.org.uk;
- **The Samaritans**, phone: 08457 90 90 90 (24-hour helpline), website: www.samaritans.org.uk;
- **Sane**, Charity offering support, phone: 0845 767 8000 (daily, 6pm-11pm), email: sanemail@org.uk, website: www.sane.org.uk;
- **The Mental Health Foundation**, provides information and support, website: www.mentalhealth.org.uk

You are welcome to contact me at anytime, my details are:

Donald Smith

Trainee Clinical Psychologist, Liverpool University Clinical Psychology Doctorate Programme, Whelan Building, Brownlow Hill, Liverpool, L69 3GL.

Tel – 01517945530

Email: Donald.smith@liverpool.ac.uk

Or you can contact the research supervisor:

Professor James McGuire,

Liverpool University Clinical Psychology Doctorate Programme, Whelan Building, Brownlow Hill, Liverpool, L69 3GL.

Tel 0151-794-5530

E-mail – merc@liverpool.ac.uk

Appendix N

Example of Transcript with Initial Comments

222 And erm what was your experience? Because I guess once you've
223 accepted whatever individual therapy and going with it, what was
224 your experience of individual therapy as a whole?

225 It was a really, really good time. It was up and down. We'd have quite
226 a few arguments and stuff and our relationship was quite peculiar. We
227 got on really well.

228 And what about the stuff CCC that was covered in individual
229 therapy? Did you find it useful or-?

230 Erm yeah definitely. We did something that was called emotional
231 exposure and erm it exposes you to certain feelings that you may get
232 before you self-harm and you sit with it, and the longer you sit with
233 the pain and putting yourself back into that position where you're
234 about to self-harm and you sit with it instead of self-harming and the
235 pain and the stress tends to ease off more and more and more with
236 time, the longer that you sit with it. And it kind of helped me
237 massively that emotional exposure kind of like technique that we was
238 using with me and-

-I.T. Actual
USEFUL
SKILL

239 And he'd use it within the therapy sessions would he?

240 Yeah.

241 So that's feeling awful but not acting on it?

242 Yeah.

243 And he- wow, that's quite-

244 It worked. Like erm a while ago I went to a physiotherapist and I had
245 problems with my back and what they do is they hold onto the muscle
246 for thirty seconds, and it hurts like hell to begin with, and then after
247 thirty seconds you can't feel the pain. It disappears. That's the only
248 thing I can liken it to.

249 That's a perfect analogy for me. That's almost as if the pain's still
250 there but you just don't feel it anymore-?

251 Yeah.

252 That's really interesting. Would you say CCC that individual therapy
253 in itself, not the whole DBT but like the bit of individual therapy- was
254 there any part of that that impacted your life?

255 Massively. It all. It all because I think cos I had such a good therapist
256 erm who cared a lot about me made me learn to care about me as
257 well.

Therapist
was care
or
valued.

258 Okay, that's interesting. So when someone cares about you then you
259 might feel valued and worthy being cared for so you do it to yourself.

260 Yeah.

261 Okay, I'm just looking down CCC to see if where I want to go so
262 excuse me for a second. Let's move onto the skills group. What was
263 it like? I think you've already said this, this is me repeating myself
264 again. What was it like starting the skills group?

265 It was hell. It was just pure hell. I was just like- my first session that I
266 had there they were doing about child abuse and they had child abuse
267 pictures up on the walls and it was my first session there and I was just
268 like 'what the hell have I got myself into?' and I was just bombarded in
269 my first. It was just unfortunate that I come in at the specific time that
270 they had all these like child abuse photos around. It was kicking off my
271 post-traumatic stress disorder so I was like 'oh my good god' it was
272 just like- and then the second time I just recently had lost my dog and
273 they had pictures of dogs up and I was just like 'this is hell'.

S.G.

Starting
Pure
Hell.
Hell.

274 Despite those two, what kept you going back?

275 Erm, ~~the~~ my individual therapist. He was like come on CCC you've
276 got to keep on going, keep an open mind. And then I had a clash with
277 some of the people in the group. I erm- just differences of opinion and
278 stuff and because I was very emotional in an emotional mind all the
279 time I was just up and down up and down. My emotions ruled me
280 rather than my head actually, getting a grip on things and thinking
281 'come on, let's get a reality check'. I wouldn't do that. I'd say things
282 out loud which would upset the group and then there'd be loads of
283 conflict there and then we'd have to deal with the conflict and clear
284 the air and then the air still not cleared even today.

- emotional
mind
can
influence
the
group
dynamic.

285 I know you've been in the Skills Group for a while now. Now that, I
286 guess, those nerves have gone and you feel a bit, a little bit more
287 comfortable with it, CCC can you comment on Skills Group as a
288 whole, the usefulness and what it's like learning the skills?

289 Erm, it's really like a classroom situation where you're learning your
290 skills, you're there to learn. Erm, and they've got a task to do and you
291 stick to the schedule. Erm, but within that they do like homework
292 reviews. Now when there was only a few of us in the group you used
293 to have fifteen minutes of homework reviews were you'd have to talk
294 for fifteen minutes about your homework. And that was just hell
295 because like fifteen minutes is a long time.

S.G. -
classroom -
like
learning
skills

296 To talk about your homework?

15 mins
- oh homework review =
pure hell

297 Yeah. Whereas now there's seven people in a group so we only got
298 five minutes which is much better. Erm, so you can whizz around
299 everybody and we can both learn off each other more and give advice.

S.G.
learn off
each
other

300 And is there anything from the skills group, or anything about the
301 skills group, that you found really, really useful?

302 Erm just learning about- just reinforced your individual therapy,
303 having the skills groups there. And also with the second group that
304 I've just joined, erm, we've set up our own DBT forum on Facebook
305 and we're supporting each other through that.

306 That's useful. There's something about, I could be wrong CCC, but
307 something about the nervousness about meeting new people but
308 then once them nerves and you all start, there have been
309 disagreements and battles but after a while you get to stage
310 whereby you end up supporting each other?

311 Yeah.

312 It's crazy, you know, interesting and crazy. You know, well not crazy,
313 you know what I mean. Starting off 'don't know if I like her, don't
314 now of I want to talk to her' or 'whatever' and then at the end of it
315 'right, let's get a forum going and help each other'.

316 It's weird because like in youth work when I was doing my degree they
317 were saying that every single group they go through a stormin', a
318 normin' and a conformin' process. So, it happens all the time.

/ - sense
of
normin'
in group
dynamic

319 And that's happened?

320 And that's happened in this group. I could see it happening when I
321 was in it.

322 Do you think it's useful? Cos you could learn the skills with just
323 another therapist. So you've got your individual therapy then you
324 got your skills group therapist. Do you think- what's it like- do you
325 think it's useful learning skills in a group? Is there something about
326 the group that works?

327 Yeah because it brings you to your awareness. It's like you're not
328 alone in it. You know, other people are experiencing things that you
329 may of experienced and going 'Oh god yeah' when they're saying
330 something and you think 'well, yeah I was feeling like that maybe a
331 few months ago' or you can relate to what they're saying and also the
332 skills therapist, particularly ~~she~~ is very intuitive and she's very like,
333 she won't let anything slip. If she thinks that something needs to be
334 dealt with, she'll deal with it there and then. And confront you head

S.G.
Empathy
with others -
feeling
same pain.

Therapists
very intuitive -
+ will not let
anything slip.

- 335 on. And kind of travel right through the problem with problem
336 solving.
- 337 What's that like being confronted with a skills trainer who's intuitive
338 and deals with it there and then?
- 339 To begin with it was like 'Christ, spotlight on you'. But after a while
340 you realise that she's trying to help you. And you're like 'oh, ok, this is
341 actually quite therapeutic this, doing this'. So-
- 342 Okay, that's useful. That's really interesting. On reflection, it's a bit
343 of a vague question but what did skills group mean to you? Being
344 part of the skills group?
- 345 To begin with I hated it with the first batch of people that were there.
346 It was really- I wanted to avoid it all the time. Erm but with the second
347 lot of people that come in...it's been much better. It feels like we're all
348 friends. And we're all out there to support each other and to kind of
349 coach each other along. So even though I've not got that telephone
350 coaching there anymore, I've got the coaching of the friends. People
351 that you've met on the course.
- 352 And that's brilliant whereby you've actually said you consider them
353 friends. That's quite telling. Can you say something CCC about
354 erm...what's actually taught in the skills group? Is it useful? Is it not
355 so useful? The actual what the skills trainers go through and put up
356 on a projector or whatever. Is that useful?
- 357 Yeah, cos that's where I learned about borderline personality disorder.
358 To begin with I thought it was patronising. I thought it was patronising
359 cos I never understood about the diagnosis. And in the skills group I
360 learned about the diagnosis and what had happened, how it happens
361 to you and when you're adrenalin raises up and it takes you longer to
362 come back down because you've got emotional personality disorder.
363 Whereas a normal person would come back down out off that
364 adrenalin very fast and much quicker compared to somebody who's
365 got EPD. So- and learning skills to kind of combat that from
366 happening. Bringing it to your awareness.
- 367 Could you mention the erm, was it the surfing the urge or urging the-
368 Surf urging.
- 369 That was something taught in the skills group that you found useful?
- 370 Yeah.
- 371 What's it like being in the skills group for what twelve, thirteen,
372 fourteen, fifteen months? What's that like?

Tackled
head on
in S.G.
spot
light
but behind

S.G.
support
of others.

- learnt
about drugs
- EPD -
NOT A
NORMAL
PERSON

Appendix O

Example of Transcript with Descriptive, Linguistic, and Conceptual Comments

There are three main objectives to achieve the aims of the study:

- (1) To explore whether women's experiences of DBT is aligned to their expectations of the Programme.
- (2) To explore women's experiences of the DBT Programme, including explicitly asking about the different components and the impact of the different components stipulated by the model;
- (3) to consider whether the experience of DBT is consistent with DBT's stated aims to help service users achieve a life worth living;

'Exploratory Comments' below are defined by:

Descriptive comments (normal text)

Linguistic comments (*italics*)

Conceptual comments (underlined)

Emergent Themes	Original Transcript	Exploratory Comments
<p>Expectation of effort. Expectation of DBT to be similar to traditional therapy. Practical nature of DBT.</p> <p>Anxious about starting the group – meeting new people.</p> <p>Researching the therapy.</p> <p>Researching DBT A curiosity. Discovery of something new.</p> <p>Pre-therapy negative judgements.</p> <p>Hope.</p> <p>Last chance.</p>	<p>If you can cast your mind back before you started DBT, can you remember SSS what you were expecting DBT to be like? Well I'd heard that it was lot of work and I was kind of expecting - I was definitely expecting one to one to be more like seeing a counsellor more 'how have you been , how are you feeling?' and that kind of stuff 'tell me about your mother' which was very different. It's a lot more practical which for me is good cos in other types of therapy I end up rattling on for ages and ages and ages and we never actually get anywhere where this is 'right, diary sheet, let's focus on this particular thing' so it keeps me focused.</p> <p>With group I was genuinely scared about going to group and being surrounded by lots of other people. But it turned out to be a lot more relaxed. Did you have any expectations of the content of the group? What you were taught or- ?</p> <p>I had an idea purely because I'd done some research previously before I started it.</p> <p>On Dialectical Behavioural Therapy? Yeah, I looked a lot of stuff up online. So what did you know about it? I knew that there were different, like different like sections to it and stuff like that.</p> <p>I was quite judgemental at first I have to admit cos like reading what mindfulness was I was like 'ah, just a</p>	<p>Hard Work expectation. Expectation of therapy to be traditional – based on thinking and reflecting on/about the past. Therapy was, in fact, practical. <i>Rattling – prohibits getting anywhere.</i> <u>Practical therapy permits client to focus.</u></p> <p><i>"Genuinely scared" – an honest account of being scared???</i> But was a lot more relaxed.</p> <p>Client researching DBT before started. <u>An interest in the therapy they are about to undertake.</u></p> <p>Learnt that DBT different to other therapies. MULTI-MODAL. Client <u>had to learn about DBT herself – not provided with information.</u></p> <p><u>Judging thoughts.</u> Thought it was hippy stuff. <i>'Hippy stuff' a metaphor for 'new age therapies'??</i></p> <p>But change of heart. <u>Thought</u></p>

<p>Focussed therapy.</p>	<p>bunch of hippy stuff, I don't think I'll be able to get into this'.</p> <p>But then from what I read about things like the other aspects like the distress tolerance and the emotional regulation I was thinking this is something that could help. Considering nothing else previously had helped.</p>	<p><u>that it might actually be of help.</u></p> <p>Nothing helped previously.</p> <p><u>Sense of last chance.</u></p>
<p>Expectation aligned to previous therapy</p>	<p>And you spoke about that you'd been in therapy before and that had been more sort of looking back in the past where the individual therapist in DBT was more like chain analyses and the 'now' or something. Is that right?</p> <p>Yeah, more direct. So he was able to keep my focus on working out particular problems.</p>	<p>DBT individual therapy = more direct.</p>
<p>DBT'S FOCUS ON DETAIL</p>	<p>But did you know about that SSS, that that's how he'd be before you got to individual therapy?</p> <p>No.</p>	<p>Expectation that DBT individual therapy would be a place to chat.</p> <p>DBT not a place to chat.</p>
<p>DBT'S FOCUS ON DETAIL</p>	<p>So what did you expect individual therapy to be like just like how you'd had before?</p> <p>Yeah just like how it had been before. Just go in, have a chat sort of thing.</p>	<p>DBT a lot better.</p>
	<p>And it hasn't been like that?</p> <p>No.</p> <p>Tell me about that. How has it been?</p> <p>It's been a lot better I found.</p>	<p>DBT keeps client focussed. Focussed on what is happening.</p>
<p>Anxiety to use the phone. Keep problems to self.</p>	<p>Than previously?</p> <p>Than previous. Yeah.</p> <p>Better in what way for you?</p> <p>For me it's that losing focus thing that I have and this has kept me a lot more focused on exactly how things happen.</p> <p>Like especially the chain analysis I've found very very useful. And working out exactly how things escalate and stuff where before I'd just be like 'oh I was sat on the couch and then suddenly this happened and I've got no idea</p>	<p><i>'Very' used twice. Possibly indicating that interviewee believes that she really benefited from how chain analyses permits insight into the steps prior to low mood/ self-destructive behaviour. Breaking things down step by step.</i></p> <p><i>The word exactly used twice, possible detailing the detail to which chain analysis focuses.</i></p>

Eventual use of phone coaching.	<p>why'.</p> <p>Whereas now it's about you were sat on the couch but you were thinking this or-</p> <p>Yeah.</p> <p>Right okay. And what about- did you have any expectations of erm the phone coaching element or- ?</p> <p>Not really cos it's not something I'd ever experienced before. I was a bit nervous about it cos I know that I've got issues with phones so I was thinking like 'Ooh. I'm not the kind of person to just ring somebody when I've got a problem'.</p> <p>And now that you've been on the course does that still hold true? Do you not call SSS?</p> <p>I actually made my first call last week. Said he was quite proud of me for that cos I'd been quite scared of it for so long but I finally sent him a text and said 'can we do some phone coaching?'</p>	<p>No expectation with phone coaching, but nervous due to personal issues with phones. Tends not to call someone when she has a problem.</p>
Unlike other therapies.		
Practical use of DBT.		
Deep understanding/ready application		<p>Made first use of phone coaching. <i>Mentioned that therapist proud of her for using phone coaching – indicating to me how problematic it was for her to use phone coaching.</i></p> <p><u>Although phone coaching available, from beginning of DBT, it takes a while to eventually make use of phone coaching.</u></p>
Consolidated learning.		
Ability to soothe emotions.		<p>DBT different to previous therapies.</p> <p>DBT can be put into practice?</p>
Becoming skilful	<p>You spoke about your expectations, as a whole what would you say about how you've experienced DBT? What's it been like?</p> <p>It's been different definitely from what I've had before. Definitely.</p> <p>Cos I've done CBT before as well. I just remembered getting really frustrated because I knew it all but I just couldn't put it into practice.</p> <p>My overall feeling with DBT is that it's something that does actually seem to be sinking in.</p>	<p><i>'Sinking in'. Implying that DBT is being understood gradually. Sinking in; a further understanding as the weeks and months progress.</i></p> <p><u>The 12 month duration of DBT, twice a week, with homework, allows the tenets of DBT to be consolidated, learnt and applied?</u></p>
Achieve balance.		<p>DBT allows client to calm</p>

	<p>What is it about it that makes it sink in?</p> <p>I'm able to calm myself down first cos where the problems with CBT were was that it was 'right, analyse yourself'. But when you're that over the edge sort of thing, that emotional, you can't just-well at least for me, I can't just stop and pick up a pen and some paper and start analysing what I'm feeling. It's impossible. Where with this I can- there's techniques to help me calm myself down first so I can get to a point where I can then start using skills and stuff like that.</p> <p>That's interesting SSS. So something about the CBT, the thinking. If you're emotionally high as it were, the thinking is out the window?</p> <p>Yeah, it's not happening.</p> <p>But with DBT you can do things to self-sooth or whatever to-</p> <p>Yeah, just bring your level back.</p> <p>And then you can start buying yourself</p>	<p>themselves down first.</p> <p>DBT teaches techniques to calm self, which allows then for skills to be used.</p> <p><u>Calming before skill use.</u></p> <p><i>'Out the window'. My language has become colloquial. Why? Permit her to be at ease? She has been colloquial with me, so maybe this is me indicating that colloquialisms are okay.</i></p> <p><u>DBT permits equilibrium of emotions first??</u></p>
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Appendix P

Analytic Development from Emergent Themes to Super-ordinate Themes

Emergent Themes for participant 1

High expectations

Expecting life to be perfect.

Unrealistic expectations.

Cured

Last chance.

Slow recovery

Supportive

Debilitating Fear

Focus on unique problem solving

Not expecting it to be so supportive.

Non judging

Anxieties about starting the group

Understanding of self

Acceptance of self in group.

Becoming adept at problem solving using DBT

Fear of being disliked by others.

Developing skills.

Detailed step by step analysis.

Skills group helpful

Not alone

Life improved despite hard work

Support from other clients

Scared of being in the company of others in the group

Solidarity.

Understanding

Non judging and helpful Overwhelmed by DBT homework

Anxieties about being an inconvenience to the phone coach

Collective Wisdom

Acceptance and understanding.

Confront the difficult

Gradual confrontation

Met someone with 'same thing as me'

Rules for staff and clients

An aversion to using the phone

Flattened hierarchy

Therapists giving examples of then they have needed to use DBT skills.

Sense of feeling unworthy about using the phone coach

Therapists giving examples of then they have struggled to use DBT skills.

Surprised at level of support

comfortable saying anything to the therapist

Acceptance

Perceptive Therapists

No longer feeling misunderstood

No demarcation between therapists and clients in the skills group
Understanding the difficulty of being confronted
Shared experience
Desire for consistency of staff members in DBT group
Sudden change is internalised. Self blame.
Understanding the links of behaviour and triggers.
Grounding in skills when emotional
Imposing on their time
Anxieties about being an inconvenience to the phone coach
Comprehensive coaching
Grounding in skills when emotional.
Voice of sanity.
Shared experience
Grounding in skills when emotional
Non judging
Life improving despite being difficult
Helped interpersonally
Challenging
Life improving - can now go outside.
No longer scared to go out
Sense of normalcy.
Live life and be happy
Sense of deserving to be happy
No longer feeling misunderstood
Control emotions
Lived advice
Lived advice
Sense of normalcy
Helped with practical things.
Helping to face difficult things.
Going out
Hope.
Understanding the links of behavior.
Non hierarchical
Instilled ambition
Rekindled hope.
Deserve to be Happy
Collective Wisdom
Control emotions sooner. Fix the emotions rather than act on them.
Awareness of emotions.
A place to share
Sense of normalcy.
Explore world
Sense of normalcy
Happy
Adaptive Coping

Understanding self
Personal insight
Balanced
Crises resolution
Therapists using the skills too
Not alone
Supportive
Three angels support in different ways.
Personal improvements
Supportive in the facing of difficulty.
Staff trying to help
Sense of being supported
Difficult to do the work set.
Distress caused by changes in group
DBT is hard
Personal insight into self
Personal improvements
Understanding self
Emotional Grounding to Reality

Super ordinate themes for Participant 1

Super ordinate theme	Emerging Theme	Quote examples
Optimistic	Expecting life to be perfect.	I thought that after the year I'd been here everything would be perfect, I'd have a job (<i>laughs</i>), I'll go to college (<i>laughs</i>) and er, which is a bit unrealistic of me erm but that is what I thought. I kind of had unrealistic expectations.
	Cured	
	Unrealistic expectations	
Anxiety about the skills group	Debilitating Fear	Absolutely Terrifying Like, we all erm with borderline we're just kind of, you automatically think no one's going to like you and they're just going to hate you forever for no apparent reason. I thought everyone might hate me. And that makes you scared of being around people.
	Fear of being disliked by others.	
	Scared of being in the company of others in the group	
Anxiety using the phone coach	Anxieties about being an inconvenience to the phone coach	feeling bad about asking for it (phone coaching)

	Sense of feeling unworthy about using the phone coach	I have a weirdness with phones
	An aversion to using the phone	
Non judging therapists	Non judging	<p>You get used to the fact that if you're going to say something that's really painful for you, they're not going to judge you and they are going to help you through it.</p> <p>no matter how crazy whatever it is you're admitting to or saying, they're not gonna judge you in any way, or, not even in their expression either. Er, which is good.</p>
	helpful	
	Apparent Verbal and facial acceptance of clients	
	comfortable saying anything to the therapist	
Therapists challenging avoidance	Confront the difficult	<p>you can't like avoid questions cos they know er, and it's like, you've got to prepare yourself to face what you're feeling and what it is you're thinking erm.</p> <p>they help you to face them slowly and help you to</p>
	Perceptive therapists	
	Gradual confrontation	

		understand why the emotion is there.
	Understanding the difficulty of being confronted	
Non hierarchical	No demarcation between therapists and clients in the skills group	They're part of the group as well so the rules still apply, erm, it's a mutual respect.
	Rules for staff and clients	
	Flattened hierarchy	We're all on the same level. No, 'I'm the therapist so you have to do this', which is what some people do but"
Supportive therapists	Therapists giving examples of then they have needed to use DBT skills.	"And they talk to you about situations like giving examples out of their life were they were in an emotional mind and this is what skill they did."
	Therapists giving examples of then they have struggled to use DBT skills.	"Say, if a therapist tells them, tells us about some of their experiences with being like using skills and where they've like not done it right or where they done it well. It kind of helps us to connect with them so we feel like they understand instead of just saying it and saying for us to do it when they're not doing it themselves."

	Surprised at level of support	I didn't expect it to be so supportive as it is.
Feeling understood within the group	No longer feeling misunderstood	<p>'It's erm meeting other people with the same condition as you. It's like I've never ever met anyone with the same thing as me. And it's like especially with borderlines you have to- we feel like we're being misunderstood all the time by everyone and like when you finally meet a group of people that no matter how weird whatever you're going to say is they'll be like 'yeah, I get that as well'. And it's like, just the fact that you're not alone anymore.....'</p> <p>'I think also sharing the experience with other people like, I've always said that, it's like a massive one for me.'</p>
	Acceptance	
	Shared experience	
Learning from other clients.	Lived advice	you can bounce things off more people and say 'Oh, do you do this when you feel like that?' and they're like 'I'll do this instead' and

		you'll be like 'I've never thought of that, I might try that' and like we all help each in that way because there's more people,
	A place to share	there's more minds together to erm, you know, help with skill.'
	Collective Wisdom	
Development of self	Personal insight into self	it's helped me understand my thought process with chain analysis where he does chain analysis with me in a situation I've not handled well. Erm, going through each thought, each urge erm, and knowing the point where you can use your skills to sort of break the cycle that goes round. Erm, an, erm...
	Personal improvements	<p>'It's, it's helped like, like, for practical things like, like I said, the going out. That's something normal people do and like, I was never able to do that until, like, I came here'</p> <p>It's helped me to speak more, erm, which is a big</p>

		<p>step to me</p> <p>‘It’s helped me be more social in my day to day life with people that I don’t know because if I, I practice talking to them here with skills and I can, I try it outside as well which is like I never did before really.</p>
	Understanding self	<p>“I understand what’s wrong with me a lot more. I understand my emotional reaction a lot more.</p>
Crises resolution	Emotional Grounding to Reality	<p>‘for me it’s like a voice of sanity in like a really like stormy and crazy reality’. It’s, it’s broke the cycle of panic in my head. Erm, best of all it reminds me of skills.’</p>
	Not alone	<p>‘Er, it meant that in situations where I was on my own outside and I was panicking that, er, I’d be able to deal with it skilfully whereas if I hadn’t rang I would have just panicked and kept on panicking.</p>
	Adaptive Coping	<p>It stopped, just stopped me from, like doing what I</p>

		normally do to cope which is, like, more destructive things. It's like coping in the right way. That's what it sort of taught me, like.
Self Focus	Focus on unique problem solving	Erm.....it's helped me understand my thought process with chain analysis where he does chain analysis with me in a situation I've not handled well
	Becoming adept at problem solving using DBT	Erm, going through each thought, each urge erm, and knowing the point where you can use your skills to sort of break the cycle that goes round.
DBT is challenging	Hard work	Erm. It's very hard work, erm, it's, it's-
	Life improved despite hard work	As hard as it is, it's made my life quite a bit better than it was, erm...
	Overwhelmed by DBT homework	Erm. The amount of homework you get, the amount of sheets, diary sheets
Need consistency with therapists.	Desire for consistency of staff members in DBT group	one of the people that we started off with, in the skills people, erm, like, the first group we had said 'Oh, this

		is me, this is ccccc. We're both gonna be here til the end of the year' if, when we had a break, she left and didn't say anything, she left for a better job and that set everyone in the group off, erm,
	Distress caused by changes in group	we had people walking out and people crying just because she, you know, we didn't think we was good enough.
	Sudden change is internalised. Self blame.	And it's like, this is why she left cos, you know we're bastards and, erm, that set everyone off. And just something little like that, that can really, really trigger people with borderline.

Super ordinate themes from all participant interviews.

Participant 1

Optimistic

Anxiety about the skills group

Anxiety using the phone coach

Non judging therapists

Therapists challenging avoidance

Non hierarchical

Supportive therapists

Feeling understood within the group

Learning from other clients

Development of self

Crises resolution

Self focus

DBT is challenging

Need consistency with therapists.

Participant 2

Skills Group Anxiety

Difficulties surrounding using the telephone coach

Dynamic nature of group causing anxiety

Dealing with the stress of coping with the workload.

Hard work to keep on top of work load

Non judging DBT staff

Lowered Expectations

Adjustment of expectations

Use of DBT benefiting life

Permanence of learning

Reducing life-threatening behaviours

Immediate resolution of a crises

Application of skills to self

Transformational

Participant 3

Anxiety about starting the group

Phone coaching anxieties

Developed skills to achieve goals

Control of life endangering behaviours.

Transformational

Personal application of DBT

Clients feel considered by therapists

Measured therapy determination

Participant 4

Skills group anxiety
Unsettled by Group dynamics
Helpful therapist factors
Sense of being understood
Learning from other group members
Optimistic
Development of skill for aiding with the achievement of personal goals
Permanence of skills
Really difficult despite expectation of difficulty
Group dynamics are unsettling
Transformed
Non judging relationship with therapist
Challenging avoidance

Participant 5

Pessimism
Challenging Therapists
Increased learning from other group members
Development of skill for improved daily living
Better control of strong destructive emotions
Transformational
DBT skills become permanent
Crises Resolution
Shared understanding

Participant 6

Skills Group Anxiety
Anxieties concerning the phone coaching
Non judgmental
Non hierarchical
Supportive
Shared understanding
Learning from other skills group members
Improving skills for managing life-threatening behaviours.
Personalised problem solving
DBT requires effort
Permanence of learnt DBT skills

Development of Emergent Themes, Super-ordinate themes, and Master Themes

<i>Master Themes</i>	Clustering of Sub Themes	Emerging Themes
Therapeutic Group Factors	Shared Understanding	Feeling understood within the group
		Sense of being understood
		Shared understanding
	Learning from Others	Learning from other clients
		Increased learning from other group members
		Learning from other group members
		Learning from other skills group members
Therapist Factors	Non-judging	Non judging therapists
		Non judging DBT staff
		Non judgmental
		Non judging relationship with therapist
	Challenging avoidance	Therapists challenging avoidance
		Challenging Therapists
		Challenging avoidance
		Measured therapy determination
	Non-hierarchical	Non hierarchical
		Non hierarchical
	Supportive	Supportive therapists
		Supportive

		Clients feel considered by therapists
Personal Change	Development of skills for achieving practical personal goals	Use of DBT benefiting life
		Development of skills to achieve goals
		Development of skill for improved daily living
		Development of skill for aiding with the achievement of personal goals
		Development of self
	Increased control of strong emotions and life-threatening behaviours	Better control of strong destructive emotions
		Improving skills for managing life-threatening behaviours.
		Reducing life-threatening behaviours
		Control of life endangering behaviours
	Transformational	Transformational
		Transformed
	Permanence of skills	Permanence of learning
		Permanence of skills
		Permanence of learnt DBT skills
		DBT skills become permanent
Challenges to be Overcome	Anxieties about starting the Skills group	Anxiety about the skills group
		Skills Group Anxiety
	Difficulty using phone coaching	Anxiety using the phone coach
		Difficulties surrounding using the telephone

		coach
		Phone coaching anxieties
		Anxieties concerning the phone coaching
	Dynamic group composition	Dynamic nature of group causing anxiety
		Group dynamics
		Group changes (with the staff too) can happen once clients feel settled
		Need for consistency from therapists.
	Hard work	Hard work to keep on top of work load
		Dealing with the stress of coping with the workload.
		DBT is challenging
		DBT requires effort
		Really difficult despite expectation of difficulty
		Hard work to keep on top of workload
		Dealing with the stress of coping with the workload.
	Personalised Problem Solving	Application of skills to self
		Personal application of DBT
		Self focus
	Crises resolution	Crises resolution
		Crises Resolution
		Immediate resolution of a crises

		Personalised problem solving
Opposing Expectations	Optimistic	Optimistic
	Pessimistic	Lowered Expectations
		Pessimism