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A mixed method evaluation of change in young people attending Dialectical Behaviour Therapy for Adolescents (DBT-A)

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**A mixed method evaluation of change in young people
attending Dialectical Behaviour Therapy for Adolescents
(DBT-A)**

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for the Doctoral Programme in Clinical Psychology (Ph.D.) 2016

Declaration

I declare that this thesis is my own work and has not been submitted as part of another degree at the University of Limerick or any other academic institution.

Sarah Hardiman

April 2016

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Abstract

Background: Suicidal behaviour among adolescents is considered a significant public health concern. It is associated with an array of risk factors and complex mental health problems, in particular, Borderline Personality Disorder (BPD). There is a reluctance to diagnose BPD during adolescence given the absence of a stable personality structure. However, there exists a cohort of adolescents attending Child and Adolescent Mental Health Services in Ireland presenting with ongoing, pervasive difficulties and co-morbid psychopathology. Dialectical Behaviour Therapy for Adolescents (DBT-A), an adapted version of standard DBT, was developed with this cohort in mind. Given the relative recency of its development, research on the efficacy of DBT-A is in its infancy. Research to date examining the effectiveness of DBT-A has predominantly focussed on symptom reduction pre- and post- treatment using quantitative research methods and has shown promising results. Less is known about how or why changes in symptomatology have been found.

Method: This research used both qualitative and quantitative methods, i.e. mixed methods, to evaluate change in symptoms from beginning to end of treatment (quantitative phase) and examine the process of change through qualitative interviews. Quantitative data (n=30) were analysed using non-parametric tests comparing symptoms pre- and post- treatment. Interpretive Phenomenological Analysis (IPA) was used to examine the qualitative findings (n=6). The overarching mixed methodology utilised was the embedded design.

Results: Quantitative results showed significant reductions in depression, hopelessness, suicidal ideation, self-harming behaviour and anger from pre-treatment to post-treatment. The qualitative phase resulted in the emergence of five superordinate themes related to the process of change, namely, 'Then vs. Now', 'Skills Acquisition', 'Internal Processes of Change', 'Therapeutic Components' and 'Toward a Better DBT'. Findings indicated that the quantitative results supported previous research on the effectiveness of DBT-A using pre-post measurement design. The qualitative results both contextualised and expanded on quantitative findings.

Conclusion: Results from this research added to the quantitative literature on the evaluation of DBT-A and supports preliminary positive findings on the effectiveness of DBT-A. It also addressed a number of gaps in the existing literature on DBT-A, namely, providing insight into adolescents' experience of change, deconstructing the meaning of change, offering potential explanations of how change was made possible, and isolating therapeutic factors influencing the process of change through qualitative evaluation.

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CHAPTER 1: INTRODUCTION

1.1 Overview of the present study

The aim of the present study was to, firstly, evaluate the effectiveness of Dialectical Behaviour Therapy for Adolescents (DBT-A) using quantitative research methods and secondly, gain a deeper understanding of the processes governing therapeutic change as it relates to DBT-A. The quantitative phase focussed on symptom reduction and involved the researcher partnering with the National DBT Project, who are charged with the evaluation of DBT programmes rolled-out nationally. The researcher accessed pre-existing data collected by the National DBT Project for this phase. A subset of young people from the overall pool of participants attending DBT-A programmes nationally in 2015 were invited for a semi-structured interview. The qualitative phase attempted to deconstruct the young people's experience of change as it related to their engagement in DBT-A.

DBT-A was developed as a result of the promising findings for DBT in the adult population. It targets adolescents displaying suicidal behaviour¹ and traits indicative of Borderline Personality Disorder (BPD; Miller, Rathus, & Linehan, 2007). The delivery and evaluation of DBT has gained momentum in recent years through the National DBT Project, although a strong evidence base is yet to be established for this adapted version of the approach, DBT-A. In an effort to build an evidence base for DBT-A, research thus far has predominantly focused on quantitative evaluations utilising pre-post measurement designs to assess symptom reduction. There is one Randomised Control Trial evaluating the efficacy of DBT-A to date. While the research thus far has shown preliminary positive results, less is known about the various constituents of DBT-A which lead to positive outcomes. Furthermore, there is a notable dearth of qualitative research in the area. This research focused on the evaluation of DBT-A using mixed methods in an effort to obtain both a breadth and depth of understanding of effectiveness of DBT-A.

A number of key findings emerged from this research. The quantitative results showed significant reductions in symptoms related to depression, hopelessness, self-harming

¹ For the purpose of this thesis suicidal behaviour is an overarching term encompassing the following: suicidal ideation, suicide attempts, self-harming behaviour and completed suicide. Deliberate self-harm will also be used and can be understood as a descriptor for the overarching construct of suicidal behaviour.

behaviour, and suicidal ideation. This supports the body of research currently available on DBT-A. When comparing results of the two strands of the research, i.e. qualitative and quantitative, a number of similarities and differences were found. The qualitative results, on the one hand, expanded and contextualised the quantitative results and on the other hand, added new and valuable insights about the process of change which had not been captured quantitatively. This research attempted to deconstruct those elements which contribute to therapeutic change. Results showed that the process of change appears to involve a complex interplay of therapy related factors such as therapy techniques, type of therapy and therapist characteristics and non-therapy related factors which can be more broadly understood as external and internal factors.

1.2 Thesis Structure

An overview of the content covered in each chapter is outlined in this section. Chapter one refers to the current portion of the thesis.

1.2.1 Chapter two: Literature review

This chapter gives an overview of the development of the National DBT Project and its role in the current study. Relevant literature relating to the prevalence, manifestation, and risk factors associated with suicidal behaviour during adolescence is outlined. Definitional issues in relation to self-harm and the role of suicidal intent are highlighted. Adolescence as a developmental stage is explored with particular reference to debates in the literature about diagnosing BPD during this sensitive stage of development. The theoretical underpinnings of DBT-A are discussed along with a description of the format of DBT-A programmes. Relevant studies examining the efficacy of DBT-A to date are examined and evidence based practice issues are highlighted. Therapeutic change is explored and various models of change are presented. The chapter closes with the present study's research aims.

1.2.2 Chapter three: Methodology

This chapter outlines the methodology chosen to investigate the research questions and a rationale for the use of the embedded design. Detailed information on the mixed method procedures used in this research are provided. Information on the process of recruitment, demographic information of participants, and ethical precautions taken in the research are also outlined.

1.2.3 Chapter four: Results

This chapter presents the findings of the research. Quantitative and qualitative findings are presented separately first and then merged towards the end. This chapter includes the findings from detailed qualitative analysis as well as the researcher's interpretation of these results.

1.2.4 Chapter five: Discussion

The discussion chapter serves two main functions, 1) to marry the qualitative and quantitative findings in a coherent manner and 2) to relate the findings from both phases of the research to relevant existing literature. This chapter also presents the strengths and relative limitations of the present research study along with implications for clinical practice and recommendations for future research.

CHAPTER 2: LITERATURE REVIEW

2.1 Chapter Introduction

This chapter opens with a description of the National DBT Project to provide a context for how the current research developed. This is followed by an extensive exploration of the main areas of interest in this study, i.e. the manifestation of suicidal behaviour during adolescence, DBT-A as a treatment for this population, and the processes through which therapeutic change can be understood. In order to comprehensively address the research questions, information was gathered from a variety of sources. Given the study's focus on evaluating DBT-A, a review of the literature on the main inclusion criteria for the programme, i.e. self-harm, suicidal ideation, and emerging Borderline Personality Disorder (BPD) is provided. The prevalence, manifestation, aetiology and risk factors associated with suicidal behaviour during adolescence are discussed. Adolescence as a unique stage of development is explored including a discussion on the various issues linked with diagnosing BPD in this population. An overview of the theoretical underpinnings of DBT is presented and includes a summary of the structure of the DBT-A programme. To address the quantitative research questions, a systematic outline of research to date on the effectiveness of DBT-A is presented in tabulated form. The chapter closes with an exploration of the concept of change and how this is understood in terms of research and practice. As this research is the first to examine the processes of change relating to DBT-A, relevant findings relating to therapeutic change from a wider literature base are considered. The chapter, therefore, incorporates a style which is both systematic and exploratory in nature.

2.2 The National DBT Project

The National DBT Project originated from a small number of clinicians with a special interest in DBT. Initially two clinicians were trained in DBT and in 2010 rolled out a pilot programme in an Adult Mental Health Service (AMHS) in Co. Cork with thirteen participants. This pilot programme was evaluated using pre-post measures at three time points; before, during and six weeks following the intervention. As a result of the positive outcomes, the National Office of Suicide Prevention funded the training of three additional AMHS teams. At this stage four sites in the South of Ireland were delivering DBT programmes in AMHS. This cluster of four teams became known as the Endeavour Programme. Evaluation of the programmes by the facilitators continued until 2013, when the National DBT Project was developed. The National DBT

Project is funded by the National Office of Suicide Prevention and is charged with the investigation of the effectiveness of the intervention for clients, evaluation of the DBT implementation process at a national level and carries out a comprehensive economic evaluation comparing DBT versus treatment-as-usual. The National DBT Project is currently evaluating the intervention across both AMHS and Child and Adolescent Mental Health Services (CAMHS) countrywide.

The current research focusses on the investigation of DBT-A programmes delivered in CAMHS over a one year period (2015) in Ireland. This involved partnering with the National DBT Project to access pre-existing quantitative data collected as part of the national project. The DBT-A programme is currently delivered as a 16 week programme consisting of one hour of weekly individual therapy, a two hour weekly skills based group which a parent/caregiver attends alongside the adolescent, family therapy (where a need is indicated), and phone consultation which is available to the adolescent and the parent. Additionally, DBT-A therapists engage in weekly consultation meetings which are supportive and supervisory in nature to support the therapists in working with individual clients. The structure of DBT-A includes a pre-treatment phase which is aimed at familiarising the client to the DBT-A framework, building a therapeutic alliance between client and individual therapist and enhancing motivation to engage in treatment (Miller et al., 2007). The next section will explore the main inclusion criteria for enrolment in DBT-A, namely, chronic suicidal ideation and/or self harming behaviour indicative of emerging Borderline Personality Disorder.

2.3 Suicidal behaviour- epidemiology

Suicidal behaviour is an inclusive term which encompasses the following: suicidal ideation, attempted suicide and completed suicide (National Office of Suicide Prevention [NOSP], 2014; Miller, Rathus, & Linehan, 2007). Suicidal behaviour among adolescents is becoming a significant public health concern given the notable increase in prevalence rates and the significant associated health risks (Hawton, Rodham, Evans, & Harris, 2009). Nock et al. (2013) note that the first onset of suicidal behaviour usually occurs during adolescence.

A recent document published by the Department of Health entitled 'Connecting for Life' provides an overview of the current position of suicide prevention in Ireland (Department of Health, 2015). This national strategy, aimed at reducing suicide in Ireland, highlights that, in

general, Ireland's suicide rate is ranked number 21 of 31 European countries for which statistics were studied and included (Department of Health, 2015). When examined by age group, the suicide rate in Ireland for individuals aged between 15 and 19 years was ranked the fourth highest of the 31 countries studied in 2012 (Department of Health, 2015). This points to the vulnerability of adolescents in Ireland and establishes them as an at-risk group for suicide.

The National Self-Harm Registry of Ireland (NSHRI) is tasked with monitoring the occurrence of self-harm, including not only the number of incidences of self-harm nationally but also repeated admissions to hospital emergency departments as a result of self-harm (World Health Organisation [WHO], 2014a). While not all self-harm involves underlying suicidal intent, it is nonetheless identified as one of the strongest predictors of suicide in adolescents and substantially increases the risk of death in this cohort (Ougrin, Tranah, Leigh, Taylor, & Asarnow, 2012a). The main role of the NSHRI is to identify important demographic factors which can help to isolate at-risk groups and areas with the view to providing important information to services and practitioners concerned with the treatment and prevention of self-harm and suicidal behaviour (WHO, 2014a). Overall, in 2014, 11,126 deliberate self-harm presentations to hospital (made by 8,708 individuals) were recorded in Ireland by the NSHRI (Griffin et al., 2014). More than one in five of the total number of presentations made to emergency departments in Ireland in 2014 were due to repeat acts of self-harm (NOSP, 2014). Drug overdose was identified as the most common form of self-harm presenting to hospitals in Ireland in 2014, with 66% of cases presenting with drug overdose or self-poisoning (Griffin et al., 2014; NOSP, 2014). This was followed by self-cutting representing 26% of presentations and attempted hanging in 7% of cases (Griffin et al., 2014).

The NSHRI data is collated from hospital records and identifies only those individuals who present to hospital with self-harm; it does not account for those who receive support in community based services, nor does it include those individuals who do not seek professional help in any capacity. This is an important consideration, given that some studies have made reference to underreporting and potential underrepresentation of the issue of self-harm (Hawton et al., 2009; McMahon et al., 2014). McMahon et al. (2014) found that, of those adolescents who reported harming themselves overall, only 6% were reflected in hospital data. McMahon and colleagues describe the 'iceberg' of suicidal behaviour, with death by suicide representing the highly visible tip, followed by instances of self-harm resulting in hospitalization representing the middle and, at the base, self-harm that does not come to the attention of health services, remaining hidden and unknown.

Stallard, Spears, Montgomery, Phillips, and Sayal (2013) investigated the prevalence of self-harm in community based adolescents aged between 12 and 16 years over a one year period. Results from this study showed that 27% of the adolescents reported thoughts of self-harm and 15% reported actual self-harm occurring on at least one occasion (Stallard, Spears, Montgomery, Phillips, & Sayal, 2013). Less than one fifth of those engaging in self-harming behaviour had sought help for their psychological distress. This suggests that national statistics are likely to be underestimating the extent of the problem at a community level. Wilkinson (2011) proposes that the profile of self-harm is changing; once understood as a part of psychopathology, it has now become an epidemic in the general teenage population.

2.3.1 Profile of adolescent self-harm

A national audit on service delivery in Child and Adolescent Mental Health Services (CAMHS) in 2012-2013 reported that 25% of new cases referred to CAMHS included suicidal ideation or Deliberate Self-Harm (DSH) as the reason for referral (Health Service Executive [HSE], 2013). Depression and anxiety were identified as the most frequent primary issue for females presenting to CAMHS in 2012; this was closely followed by self-harm. Among those with a primary presentation of DSH, 77.5% were female and 22.5% male (HSE, 2013). However, more recent statistics garnered by the NSHRI note a change in the profile of self-harm with a significant increase in boys aged 10-14 treated in hospital for self-harm, demonstrating an increase of 44% in this cohort, from 34 to 49 per 100,000, compared to the previous year (Griffin et al, 2014). It is unclear whether this represents actual change in the way self-harm is manifesting or whether this is representative of a change in help seeking behaviour. Despite this difference, the peak rate of self-harm remained the same as previous years; 15-19 years old for females and 20-24 years of age for males (Griffin et al., 2014; NOSP, 2014).

Overall, there has been a concentrated effort made in recent years to develop a systematic national response to suicide and this is evidenced by the proliferation of national policy, registries and strategies concerned with self-harm, suicide and suicide prevention. Due to the increase in self-harm presentations to CAMHS in Ireland, concerted efforts are being made to discover and deliver an intervention that successfully reduces the various psychological and health risks associated with this behaviour. Consequently, it stands to reason that service providers and health professionals have a vested interest in understanding the subtle

complexities of the issue of suicidal behaviour in adolescents and evaluating treatment for this cohort.

2.3.2 Suicidal ideation

Suicidal ideation can be defined as persistent thoughts of death or dying, wishing to be dead, and thoughts of hurting oneself (Miller et al., 2007). In a large scale study on US adolescents, Nock et al. (2013) highlight that 89.3% of adolescents experiencing suicidal ideation met criteria for at least one DSM-IV diagnosis, the most prevalent being Major Depressive Disorder. Reinherz, Tanner, Berger, Beardslee, and Fitzmaurice (2006) found that individuals with suicidal ideation during adolescence were approximately twice as likely to have an axis I diagnosis when followed up in adulthood. Central to understanding the severity of suicidal ideation is the notion of intent, i.e. how dedicated an individual is in carrying out a plan. Miller et al. (2007) note that as the intensity and frequency of suicidal ideation increases, so too does the risk of suicide. Lui, Jones, and Spirito (2015) argue that while suicidal ideation is indeed a risk factor for subsequent suicidal behaviour, a substantial percentage of adolescents who experience suicidal ideation do not attempt suicide. Nock et al. (2013), on the other hand, note that approximately one third of adolescents expressing suicidal ideation will make a suicide attempt.

It is unclear what differentiates those individuals who experience ideation alone and those who progress to suicidal plans and attempts (Lui, Jones, & Spirito 2015). The relationship between suicidal ideation and Deliberate Self Harm (DSH) is complex and questions remain as to whether the two represent different levels of the same construct, with suicidal ideation acting as a prerequisite to self-harming behaviour, or whether DSH is a distinct concept. Laye-Gindhu and Schonert-Reichl (2005) highlight that the importance of suicidal ideation has been somewhat overlooked in the literature. The next section will examine in more detail the relationship between suicidal ideation, suicidal intent and DSH.

2.3.3 Deliberate self-harm

The way in which self-harm is conceptualised is variable across research studies which impacts on the development of a strong theoretical base for this phenomenon (Laye-Gindhu & Schonert-Reichl, 2005). Suicidal behaviour is used to describe varying levels of suicidality from thoughts of suicide to completed suicide. In some studies DSH has been included in the

definition of suicidal behaviour (Laye-Gindhu & Schonert-Reichl, 2005). The WHO (2014b) continue to cite the following definition of self-harm which was used in the WHO/EURO multicentre study: ‘an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences’ (Platt et al., 1992, p99, Hjelmeland et al., 2002).

Other definitions include behaviours initiated in order to cause harm to the self, e.g. self-cutting or jumping from a height, ingestion of a substance in excess of recommended or prescribed dosage, ingestion of a recreational or illicit drug that the individual regarded as self-harm, or ingestion of a non-ingestible substance or object (Madge et al., 2011; McDougall, Armstrong, & Trainer 2010; Griffin et al., 2014). Perhaps more simply, McDougall, Armstrong, and Trainer (2010) describe self-harm as a variety of behaviours that individuals engage in to deliberately harm themselves, usually carried out in hidden ways. In a qualitative study exploring the way in which adolescents talk about self-harm, Klineberg, Kelly, Standfeld, and Bhui (2013) note that adolescents often describe self-harm as a ‘private, inwardly focused expression of distress, often with reluctance to disclose and seek help’ (p7). Arkins, Tyrrell, Herlihy and Crowley (2013) note that self-harm can be broadly understood as a form of behavioural expression of personal distress.

Terms such as self-mutilation, self-injury, non-suicidal self-harm, self-cutting and parasuicide have been used interchangeably to describe what is thought to be the same construct (Laye-Gindhu & Schonert-Reichl, 2005; Wilkinson, 2011; Gonzales & Bergstrom, 2013). Differences in terminology for what constitutes the behaviours makes comparisons between studies difficult (Wilkinson, 2011). This is further complicated by the fact that some uses of the aforementioned terms include suicidal intent as part of the definitions while others refer only to those incidences of self-harm that are non-suicidal in nature (Gonzales & Bergstrom, 2013). McDougall et al. (2010) argue that while defining the construct of self-harm is undoubtedly important to guide practice, the utility of having a ‘one size fits all’ definition of self-harm is unclear, given the many different ways in which it can present clinically. Cloutier, Martin, Kennedy, Nixon, and Muehlenkamp (2010) suggest that self-harm should be classified in terms of suicidal and non-suicidal self-injury, although this categorization perhaps simplifies the construct, given the high co-occurrence of non-suicidal self-injury and suicide attempts.

Ougrin et al. (2012b) argue that non-suicidal self-harm and suicide attempts often happen in the same individual, making a distinction less clear. This is further compounded by the absence of a clear definition of what suicidal intent constitutes, how this is judged and who makes this judgement, i.e. professional and patient perception of suicidal intent can differ (Ougrin et al., 2012b). Hjelmeland et al. (2002) conceptualise intention as what the individual wants to achieve as a result of engaging in suicidal behaviour. The issue of the role of suicidal intent in non-fatal self-injury is complex and yet to be resolved. Ougrin et al., (2012b) propose that suicidal intent can be understood as occurring along a continuum with each pole identified as suicidal and non-suicidal, and the majority of self-harming adolescents lying somewhere in the middle, with mixed and changing levels of intent.

2.4 Aetiology of deliberate self-harm

Researchers and clinicians have attempted to isolate the factors which influence and help to explain suicidal behaviour during adolescence. A model known as the affect regulation model has been put forward to explain the function of self-harming behaviour (Zetterqvist, Lundh, Dahlstrom, & Svedin, 2013). This model posits that self-harm is used as a means of alleviating emotional pain, and decreasing negative affect and arousal (Klonsky, 2007). Other functions that self-harm is proposed to serve include; self-punishment, sensation seeking, anti-dissociation, anti-suicide, and as a way to influence interpersonal relationships in the environment (Klonsky, 2007). Anti-dissociation refers to the idea of wanting to feel again as a form of escape from feelings of unreality and numbness. The anti-suicide function suggests that self-harm is used as a way of managing suicidal urges without attempting suicide. Chapman, Gratz, and Brown (2006) propose a model for self-harm known as the experiential avoidance model whereby self-harm is understood as a strategy for avoiding unwanted and intense emotional arousal. This model outlines that self-harm results from a complex interplay of avoidance and an absence of appropriate skills to manage distress and regulate emotion. It proposes that self-harm occurs in a cyclical fashion whereby the individual experiences temporary relief from their intense emotions which reinforces self-harm as an effective management strategy, thereby becoming habitual over time (Chapman, Gratz, & Brown, 2006).

Laye-Gindhu and Schonert-Reichl (2004) suggest that self-harm is used to distract from loneliness, depression, feelings of emptiness or to express anger or punish oneself. Chapman and Dixon-Gordon (2007) isolate anger as the most frequent emotional antecedent to self-

harming behaviour. Scoliers et al. (2009) distinguishes two dimensions representing the reasons for adolescent self-harm, namely a cry for help and a cry of pain; the former describes reasons underpinned by interpersonal and communicative dynamics, whereas the latter focuses on inward directed reasons, such as a desire to escape emotional pain. In a study examining why people engage in para-suicide (defined as DSH, attempted suicide, and non-fatal suicidal behaviour), Hjelmeland et al. (2002) summarise four factors underlying the intent of parasuicidal behaviour, namely, care-seeking, influencing others, temporary escape, and final exit. Care-seeking and influencing others refer to an individual's desire to gain the attention from or punish others. Temporary escape describes an individual's desire for temporary pain relief or avoidance of difficult situations. Lastly, final exit, refers to an individual's intention to die, their expression of wanting to put an end to unbearable distress and a desire to make life easier for others.

2.4.1 Risk factors

There are numerous factors considered to be associated with the risk of self-harm specific to adolescence, including, and not limited to, family dysfunction, childhood sexual abuse, difficult peer relations, substance misuse, bullying, low self-esteem, impulsivity, perfectionism and psychological disorders such as depression, anxiety, eating disorders, disruptive disorders, and psychosis (Gratz, 2003; Fliege, Lee, Grimm, & Klapp, 2009; Ougrin et al., 2012b; Hawton et al., 2009; Madge et al., 2011). Results from a longitudinal study carried out by Reinherz and colleagues (2006) showed that individuals with suicidal ideation in adolescence reported more depressive symptoms, issues with peer relationships, and decreased family cohesion compared to participants in the study who did not report suicidal ideation. McDougall et al. (2010) isolate sexual orientation as a risk factor for self-harm during adolescence particularly for young people who do not feel safe in disclosing their sexual orientation and fear rejection as a result.

The WHO outline three strands of risk factors associated with suicidal behaviour, namely, societal/health systems, community and individual, although this is not specific to the adolescent population (WHO, 2014). Societal/health system risk factors include difficulty accessing health services, stigma against seeking help for suicidal behaviour, easy access to means of suicide, and inappropriate media reporting of suicide that sensationalises the act. Community risk factors were identified as war and disaster, acculturation, abuse, discrimination, isolation, violence and conflictual relationships. Individual risk factors are

identified as: previous suicide attempts, mental health issues, alcohol misuse, financial strain, chronic pain and history of suicide in the family (WHO, 2014). The risk factors for self-harming behaviour in the adolescent population are wide and far reaching. The next section will explore the unique features associated with adolescence as a developmental stage in an effort to contextualise factors influencing this at-risk population.

2.5 Adolescence

Given the dramatic increase in suicidal behaviour associated with adolescence, it is important to understand the unique features associated with this developmental stage. Adolescence is identified as a life stage governed by identity development, physical growth, emotional and cognitive development, and changes in social systems (McDougall et al., 2010). It is often represented as a time of upheaval, turmoil and psychological distress (Westen & Chang, 2000). One factor making adolescence a unique stage is the onset of puberty and the associated physiological changes which accompany this (Adams & Berzonsky, 2006). Westen and Chang (2000) note that shifting hormones causes change in motivational systems, particularly sexual motivation, which can increase the potential for aggressive drives. Another feature associated with adolescence is individuation from parents towards peers, who become central figures in the adolescent's social system (Adams & Berzonsky 2006). Westen and Chang (2000) note that the transition from childhood into more adult roles and responsibilities can be experienced as both exciting and anxiety provoking. Conflictual relationships, identity confusion, mood swings and a desire for increased autonomy are considered normative during this developmental stage (Westen & Chang, 2000). Adams and Berzonsky (2006) argue that increased levels of self-consciousness combined with impulsivity cause this population to be at risk for disproportionate responses to stress. In essence, experiences that could be classified objectively as minor can prompt perceived feelings of huge loss and rejection and consequently increase the risk for self-destructive behaviours and urges in this cohort (Adams & Berzonsky, 2006). Murray and Wright (2006) associate adolescence with disruptive and challenging behaviour, particularly for those in difficult family and social circumstances.

2.6 Borderline Personality Disorder in Adolescence

Suicidal behaviour in adulthood, particularly repeated episodes of self-harm, is often linked diagnostically with Borderline Personality Disorder (BPD; Haw, Hawton, Houston, & Townsend, 2001; Zetterqvist, et al., 2013). The utility and accuracy of diagnosing Personality

Disorder (PD) during adolescence has come under scrutiny, given the aforementioned complex challenges which encompass this stage of development. The diagnosis of BPD during adolescence is debated in the literature with arguments for and against making this diagnosis before adulthood. Prior to engaging in this debate, it is important to clarify the diagnostic criteria as they currently stand for a diagnosis of the disorder in adulthood.

In adulthood, BPD is understood to manifest as ‘a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts’ (American Psychiatric Association [APA], 2013). To obtain a diagnosis of BPD using The Diagnostic and Statistical Manual for Mental Disorders- fifth edition (DSM-V), an individual must meet at least five of the following: frantic efforts to avoid real or imagined abandonment; a pattern of intense, unstable close relationships marked by neediness, fear of abandonment, mistrust and oscillation between idealisation and devaluation of the other; identity disturbance; and impulsivity in at least two of the following areas; self-damaging, persistent and repeated suicidal behaviour in the form of self-harm or threats; affective instability; chronic feelings of emptiness; inappropriate, intense anger or difficulty controlling anger; and stress related paranoid ideation or severe dissociative symptoms (APA, 2013).

Additional requirements for making a diagnosis is that the aforementioned characteristics are stable across time and consistent across situations, that the personality difficulties cannot be better explained by an underlying physiological condition, e.g. head trauma, and lastly that the personality functioning and traits cannot be better understood as a reflection of developmental stage or socio-cultural factors. Grilo, McGlashan, and Skodol (2000) note that PD diagnoses demonstrate moderate stability with the potential for improvement over time. In a longitudinal study, Zanarini, Frankenburg, Hennen, Reich, and Silk (2006) found that 88% of a sample of 290 inpatients meeting the criteria for BPD were seen to be in remission within a 10 year period, with the highest number indicating remission at 2 year follow up. The stability of BPD over time has been called into question and this is highlighted by the finding that symptoms appear to wane as an individual gets older (APA, 2013).

The DSM-V outlines that early adulthood marks the most prominent and intense period of the disorder, with high levels of service utilization during this period (APA, 2013). It is proposed that the risk of suicide for this population is greatest in early adulthood with this risk gradually

dissipating with age (APA, 2013). Paris (2009), notes that many adults with BPD express experiencing symptoms for several years before receiving a diagnosis which supports the claim that the onset of BPD is likely to occur, at least for some, during adolescence. Some studies propose that self-harm and impulsivity during childhood and adolescence are predictive of a BPD diagnosis in adulthood (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2006; Miller, Muehlenkamp, & Jacobson, 2008). Stepp, Burke, Hipwell, & Loeber (2012) hypothesise that certain childhood disorders could be identified as precursors of BPD. For example, Attention Deficit Hyperactivity Disorder (ADHD) in childhood has a central feature of impulsivity or Oppositional Defiant Disorder (ODD) which is characterised by difficulty controlling anger and hostility.

Given the intense manifestation of the disorder in early adulthood, there is a surprising dearth of research on the precursors for the disorder during adolescence. While research exists on the developmental sequelae which represent the disorder in childhood, there is reluctance to diagnose the disorder during adolescence, given the absence of a fully formed stable personality structure until adulthood (Stepp, Burke, Hipwell, & Loeber, 2012). This results in a higher likelihood of adolescents who self-harm receiving a diagnosis of anxiety or depressive disorders (Zetterqvist et al., 2013). Miller, Muehlenkamp, and Jacobson (2008) suggest that using diagnostic criteria tailored for adults on an adolescent population creates issues with reliability and validity given the fluidity of the developmental process at this life stage and the tendency for the profile of borderline symptoms to shift during adolescence. Westen and Chang (2000) outline that personality difficulties are represented by different markers in adolescence compared to adulthood. Furthermore, the symptoms of BPD in adults mimic some of the expected and appropriate features of adolescent development, e.g. impulsivity, increased anger, identity confusion and conflictual interpersonal relationships (Miller et al., 2008). Winograd, Cohen, and Chen (2008) argue, however, that the levels of distress and high risk of suicide associated with borderline symptoms lie far outside the range of expected adolescent turbulence.

Establishing whether symptoms such as identity disturbance, mood swings, impulsivity and intense anger are reflective of a developmental stage or an underlying pathology appears to underlie the difficulty in ascertaining the presence of BPD in adolescence (Miller et al., 2008). The answer to this appears to lie in the pervasiveness and intensity of such symptomatology. In a study examining borderline symptoms in a sample of adolescents spanning a 20 year

period, Winograd and colleagues (2008) found that higher levels of borderline symptoms in adolescence were associated with longer term negative outcomes, demonstrating that such difficulties cannot be simply reduced to expressions of a temporary developmental phase. It is proposed that the presence of borderline symptoms during this stage can impact negatively on the developmental process, attainment of goals and impede an adolescent's ability to develop adult roles and responsibilities (Winograd, Cohen, & Chen, 2008; Stepp et al., 2012).

The developmental trajectory of BPD remains unclear and there is a need for longitudinal research to ascertain precursors and antecedents in order to develop continuity across diagnostic criteria (Grilo, McGlashan, & Skodol, 2000). There are arguments both for and against the diagnosis of BPD in adolescents, with one side questioning the utility and potential danger in diagnosing so early and the other arguing that it could influence service delivery and identify early risk factors associated with BPD (Westen & Chang, 2000; Miller et al., 2008). In spite of a lack of certainty surrounding the diagnosis and manifestation of BPD in adolescence, treatment approaches have nonetheless been developed with this particular population in mind. More specifically, Dialectical Behaviour Therapy for Adolescents was developed for adolescents who present with emerging BPD symptoms without having a formal diagnosis. The development of this treatment to specifically target adolescents who experience pervasive and intense emotional and behavioural disturbance offsets, to a degree, the position that diagnosis is paramount to developing appropriate services and treatment approaches.

2.7 Dialectical Behaviour Therapy- theoretical background

Dialectical Behaviour Therapy (DBT) was originally designed as a therapeutic intervention for adults with Borderline Personality Disorder (BPD, Linehan, 1993). Macpherson, Cheavens, and Fristad (2013) note that BPD is understood as a disorder of emotional regulation. Problematic behaviours such as self-harm are viewed as efforts to manage and regulate emotional instability (Macpherson, Cheavens, & Fristad., 2013). The dialectical philosophy underlying DBT views suffering as the result of polarized internal forces (Quinn, 2009). Quinn (2009) notes that these opposing forces can exist in an individual at the same time, i.e. a desire to live and a desire to die and that this creates conflict and distress. Using a DBT framework, suicidal behaviour and self-harm are conceptualized as a client getting 'stuck' in a polarized state of being (Miller & Smith, 2008). The behaviour is understood as a means of regulating

intense emotional states as well as a form of communication or help seeking (Miller & Smith, 2008).

Linehan's biosocial theory posits that symptoms of BPD develop when an innate vulnerable temperament is matched with an environment which does not fit the needs of this vulnerability (Linehan, 1993). This, in DBT, is termed an 'invalidating environment' (Miller & Smith, 2008). MacPherson et al. (2013) note that the experience of an invalidating environment for emotionally vulnerable individuals leads to an inability for such individuals to tolerate distress and label or regulate their emotions. The treatment is designed such that the therapist helps the client to navigate their difficulties by finding a balance between acceptance and change. The role of the therapist is to move with the client, to encourage change by maintaining an active stance in the therapeutic relationship while also exercising flexibility and acceptance (Miller & Smith, 2008). The main treatment goals of DBT are: to reduce life threatening behaviour, i.e. self-harm and suicidal behaviour, to reduce behaviours that compromise quality of life, to increase adherence to therapy, reduce therapy interfering behaviours and to increase behavioural skills (Miller et al., 2007). The therapy is grounded in a mixture of traditional behaviourism and Zen-Buddhism.

2.7.1 Dialectical Behaviour Therapy for Adolescents (DBT-A)

The central aim of DBT is to teach skills in emotional regulation and thus reduce self-harming behaviour. The therapy combines skills based group therapy, individual therapy and phone coaching (Linehan, 1993; Zervas, 2014; Quinn, 2009). The positive results from the body of research on the adult population has prompted the development and use of DBT for adolescents who exhibit similar difficulties with emotional regulation and behavioural difficulties (Miller et al., 2007; MacPherson et al., 2013). While DBT is, in the main, used as an approach for adolescents displaying emerging features of BPD, it has also been adopted for use with adolescents with eating disorders, externalizing disorders and mood disorders (Fischer & Peterson, 2015; Groves, Backer, Van Den Bosch, & Miller, 2012). The rationale for this more generalised usage is based on the component of emotional dysregulation, which is understood to underlie such disorders, which DBT targets. DBT-A has also been extended for use across a number of applied settings including inpatient and residential facilities (Katz, Cox, Gunasekara, & Miller, 2004). Given the fact that evaluation of the approach remains in preliminary stages, it is important that the objectives and uses of the approach are clearly laid

out so that it can be reliably evaluated (MacPherson et al., 2013). This research, therefore, aims to investigate DBT for adolescents who are referred to the outpatient programme for those characteristics associated with BPD, i.e. suicidal behaviour (self-harm or chronic suicidal ideation) and behavioural and/or emotional dysregulation.

The sixteen week programme consists of four core modules in the skills training group, namely distress tolerance, emotion regulation, interpersonal effectiveness and ‘walking the middle path’. Each module follows a similar structure of four sessions, with the first session consisting of an orientation to the module and core mindfulness skills and the remaining three sessions focussing on specific skills related to the module topic (Miller et al., 2007). Skills in acceptance, mindfulness, relaxation, self-soothing, positive communication, self-care and assertiveness are taught through group psycho-education, experiential learning, and homework practice over the course of the four modules (Miller et al., 2007). The individual therapy aims to support the client in generalising skills learned in the group and promote motivation to change (Kleim, Kroger, & Kosfelder, 2010). Target hierarchies are used to structure each session, starting with life-interfering behaviours, followed by decreasing therapy interfering behaviours, decreasing behaviours which interfere with quality of life, and increasing behavioural skills (Miller et al., 2007). Reinforcement strategies such as chain analysis are used to build awareness of a problem and establish the antecedents and consequences of a specific problematic event, e.g. an episode of self-harm. Diary cards are used to establish the nature and frequency of symptoms and problem behaviours between sessions. The therapist uses this as a guide to help structure that sessions target hierarchy. The phone consultation is provided as a forum for skills coaching, crisis intervention and relationship building between therapist and client (Miller et al., 2007).

Given the added component of family disharmony as potentially contributing to or maintaining maladaptive coping in adolescents, the DBT –A is modified to incorporate family involvement (Miller et al., 2007). In DBT terms, family issues are defined more broadly as part of the ‘invalidating environment’ which is generally understood as a factor associated with suicidal behaviour (Miller et al., 2007). The rationale behind incorporating parents into the treatment is so that they can act as ‘coaches’ to support the adolescent in generalizing the skills learned in the group aspect of the treatment (Daniel & Goldston, 2009; Uliaszek, Wilson, Mayberry, Cox, & Maslar, 2014). Furthermore, while the main focus of individual therapy is on addressing

issues the adolescent views as problematic, it can also be utilized as a forum to focus on difficulties in the family system (Uliaszek et al., 2014).

There is also the added module of ‘walking the middle path’ for the adolescent population, which gives the parent and teenager an opportunity to explore and balance the adolescent’s strive for autonomy with the parent’s need to provide supervision and discipline.(Rathus & Miller, 2000; Groves et al., 2012). The rationale for adding this module was to acknowledge the unique ‘dialectical dilemmas’ observed in the parent-child relationship (Rathus & Miller, 2000; Rathus et al., 2015). The treatment length was also reduced from one year to 16 weeks. This change was made in order to increase the likelihood of treatment completion, given that adolescents tend to complete a limited number of therapy sessions (Miller et al., 2007; Uliaszek et al., 2014). Other modifications included simplification of handouts and the use of teenager friendly examples and the option for phone coaching for parents as well as adolescents (Rathus et al., 2015).

2.8 DBT- A: Empirical research findings

Adolescents displaying suicidal behaviour are considered a difficult to treat group, making development of effective treatment for this cohort challenging (Brausch & Girresch, 2012). This is further complicated when considering suicidal adolescents with co-morbid diagnoses and severe and enduring mental health problems (Uliaszek et al., 2014). DBT-A has quickly become the treatment of choice for such adolescents displaying chronic suicidal behaviour/borderline traits with co-morbid diagnoses (Miller & Smith, 2008). Although DBT-A was initially developed to treat suicidal adolescents, its use has been extended to treat a range of diagnostic profiles across a number of treatment settings (Miller & Smith, 2008). For example, Fischer and Peterson (2015), conducted a pilot study assessing DBT for adolescents presenting with binge eating, purging, and suicidal behaviour. Results showed a significant reduction in frequency of objective episodes of binge eating, frequency of self-harm, and frequency of purging. However, the sample size in this study was extremely small with just seven participants completing the programme. Treatment duration in this study was 6 months using the full DBT-A structure with further modifications to content to incorporate psycho-education on Eating Disorders. Goldstein, Axelson, Birmaher, and Brent (2007) implemented a one year trial of DBT for adolescents with a diagnosis of Bipolar Disorder (BD). The programme utilized the group family skills training and individual sessions. However, rather

than offering each weekly, group skills training and individual therapy alternated and were offered on a biweekly basis. The rationale for extending the length of the programme was to facilitate the characteristic fluctuation over time in mood states associated with BD. Results of the study showed significant reductions in depressive symptoms, emotional dysregulation and suicidal behaviour from beginning to end of the therapy.

Nelson-Gray et al. (2006) also extended the use of DBT-A to non-suicidal adolescents meeting the criteria for Oppositional Defiant Disorder (ODD). The structure of DBT-A was modified using only the 16 week group skills training component of the therapy including the core DBT modules; emotion regulation, distress tolerance, interpersonal effectiveness and mindfulness. There were significant reductions in caregiver reports of ODD symptoms, externalising symptoms and improvements in interpersonal strength. Based on reports from the young people, significant reductions were found for internalising symptoms and depression but not externalising symptoms. The sample size used in this study was sufficient for statistical analysis (32 young people). However, the study lacked a control condition. The results of this study highlight differences in caregiver's report of their child's level of improvement regarding externalising behaviours, compared to the young person's self-report of same. The nature of externalising behaviour is that it is more objectively observable compared to internal psychological states which are more subjective in nature. These results highlight the utility in gaining the perspective of a loved one in offering another perspective. Similarly, Uliaszek, Wilson, Mayberry, Cox, and Maslar (2014) examined symptoms of psychopathology in adolescents presenting with borderline traits and externalising pathology. Caregiver's self-report symptoms, as well as caregiver's report of adolescent's symptoms and behaviours, were also measured. Interestingly, this study found no significant differences in adolescent's self-report of their symptoms but significant decreases were detected in caregiver reports of the adolescent's symptoms. Uliaszek et al. (2014) propose that the treatment could provide indirect intervention to participating caregivers, highlighting the utility of investigating this further. Currently, there is a paucity of literature that assesses caregiver's functioning following participation in DBT-A.

The expansion of DBT for adolescents across clinical populations has, in the main, involved varying degrees of modification of the original programme in order to cater for the needs of differing clinical presentations. Overall, results from such studies have highlighted positive results. However, the lack of homogeneity across clinical populations and the modifications to

the structure of DBT-A makes the development of a stringent evidence base difficult. In a comprehensive review of empirical outcomes, Macpherson et al. (2013) outline the need for homogenous samples targeting youth with suicidal/BPD features using stringent inclusion/exclusion criteria before examining different disorders. Key research studies examining the effectiveness of DBT-A for adolescents displaying borderline traits and/or suicidal behaviour, i.e. clinical presentations for which DBT-A was originally designed, are illustrated in Table 2.1.

Table 2.1: Summary of DBT-A research findings for adolescents with BPD symptoms and suicidal behaviour.

Authors	Sample	Design	Time Points	Outcome Measures	Findings
Rathus & Miller (2002)	n= 29 (DBT) n= 82 (TAU) F/M= 27/2	Quasi- Experimental Outpatient	Pre-treatment Post-treatment (12 week treatment)	Beck Depression Inventory (BDI) Symptom Checklist-90-Revised (SCL-90-R) Scale for Suicidal Ideation (SSI), Life Problems Inventory (LPI), clinician record of suicide attempts & hospital admission	Significant reductions found for: SCL-90-R, LPI (within DBT group pre-post treatment). Significant difference found in severity, no. of admissions and completion.
Fleischhaker et al. (2011)	n= 12 F/M= 12/0	Pre-post Outpatient (Pilot Study)	Pre-treatment 4 weeks & 1 year post-treatment	Lifetime Depression Inventory for Child & Adolescents (DIKJ) Inventory of Life Quality in Children & Adolescents (ILC), Clinical Global Impression (CGI), Child Behaviour Checklist and Youth Self- Report (CBCL & YSR), Global Assessment of Functioning (GAF), SCL-90-R.	Significant reductions found for: GAF, CGI, SCL-90-R, CGI, YSR and DIK-J. Reductions in self-harm found during therapy and cessation of suicide attempts during and at both points post-treatment.
Hjalmarsson et al. (2008)	n= 27 F/M= 27/0 Age= 15-40	Pre-post Outpatient	Pre-treatment 6 months 12 months	Karolinska Affective and Borderline Symptom Scale- Self- Assessment (KABOSS-S), SCL-90-R, Comprehensive BPD- Treatment Outcome Assessment (BPD- TOA), GAF, Diary Cards.	Significant decreases found for: subscales of SCL-90-R; KABOSS-S; para-suicidal behaviours

Table 2.1 Continued: Summary of DBT-A research findings for adolescents with BPD symptoms and suicidal behaviour.

Authors	Sample	Design	Time Points	Outcome Measures	Findings
Mehlum et al. (2014)	n= 77 DBT= 39 EUC= 38 Age= 12-18	RCT Outpatient	Pre-treatment 9, 15, 19 weeks (19 week treatment)	Suicidal Ideation Questionnaire (SIQ), Short Mood & Feelings Questionnaire (SMFQ) Beck Hopelessness Scale (BHS), Borderline Symptom Checklist (BSL), Montgomery-Asberg Depression Scale (MADRS).	Significant reductions for: self-harm frequency, depression, suicidal ideation (both within and between groups); hopelessness & borderline symptoms (within only)
James et al. (2008)	n= 16 F/M= 16/0	Pre- post Outpatient	Pre-treatment Post-treatment 8 month follow up	BDI, BHS, GAF, episodes of self-harm.	Significant reduction in: frequency of self-harm, depression and hopelessness. Significant Improvement in general functioning.
Katz et al. (2004)	n= 62 DBT/TAU F/M= 52/10	Quasi- experimental Inpatient	Pre-treatment Post-Treatment 1 year follow up	BDI, Kazdin Hopelessness Scale for Children (KHS), Reynolds Suicidal Ideation Questionnaire-Jr (SIQ), Lifetime Parasuicide Count (LPC), hospital records of admissions.	Significant reductions in: suicidal ideation, para-suicidal behaviour, depressive symptoms (within group). Significant between group difference in behavioural incidents.

TAU= Treatment as Usual. EUC= Enhanced Usual Care. F/M= Female/Male

The most significant study of DBT in the adolescent population to date points to the first and only Randomized Control Trial (RCT) comparing the treatment efficacy of DBT-A and Enhanced Usual Care (EUC) for adolescents engaging in self-harm (Mehlum et al., 2014). This study has a number of strengths including the presence of a comparison group, the random allocation of participants, the use of independent interviewers blind to treatment allocation, and a sufficient sample size (77 in total; Mehlum et al., 2014). Results of the study indicated that DBT was superior to EUC in the following domains: Reducing frequency of self-harm, diminishing the severity of suicidal ideation, and ameliorating depressive symptoms. There were no significant differences between groups in number of sessions attended (Mehlum et al., 2014). However, following analysis, treatment intensity was found to be a partial mediator to outcome. This is an important limitation in this study, as the EUC group did not receive multi-family skills training which influences the comparability of the two groups.

While RCTs are considered the ‘gold standard’ for treatment evaluation, Fitzpatrick-Lewis, Ciliska, and Thomas (2009), note that replicating a controlled environment in community settings is impractical and unmanageable. The majority of the studies outlined in table 2.1 evaluating DBT-A use pre-test post-test measurement designs, some of which use control groups and others using within group designs. A number of methodological shortcomings in these studies are worth noting including; a lack of randomization to groups which could lead to selection bias; differences in the severity of presentations across groups; and differences in treatment modalities i.e. the presence of group based intervention in the DBT group (Quinn, 2009). Another limitation in many of these studies relates to small sample size and in some cases the absence of a control group which diminishes the validity of generalized claims about the effectiveness of treatment. In the study by Katz, Cox, Gunasekara, and Miller (2004), a number of potential confounding variables are evident, including the care received as a result of hospital admission by nursing staff, as well as pharmacotherapy, which were not controlled for in the study (Quinn 2009).

Thus far, research on DBT-A has focused predominantly on the evaluation of symptoms over the course of treatment. Less research has been conducted on the effectiveness of the various therapeutic components of DBT-A. Rathus, Campbell, Miller, and Smith (2015) studied the treatment acceptability of the added skills module ‘walking the middle path’ and found high levels of treatment acceptability. ‘Walking the middle path’ skills were also rated highly among participants, with validation skills perceived as the most beneficial. Miller, Wyman, Huppert,

Glassman, and Rathus (2000) conducted an analysis on suicidal adolescents' perceived usefulness of skills. Adolescents engaging in DBT were found to rate skills highly in terms of usefulness, with distress tolerance and mindfulness skills ranked the highest in this group. Type of skill was correlated with various problem areas related to borderline traits, namely, confusion about self, impulsivity, emotional instability, and interpersonal difficulties. However, no correlations were found. The group skills training component of DBT has frequently been delivered and evaluated as a stand-alone treatment, particularly in the adult population (this has also been the case for a small number of studies in the adolescent population; Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2014). Soler et al. (2009) conducted an RCT comparing standard group therapy and DBT skills training in a population of adult outpatients with BPD in an effort to assess whether DBT skills group was sufficient in observing improvements in symptoms and superior to standard group therapy. Results showed superior results for the skills training group over standard group therapy in terms of treatment dropout and greater reductions in psychiatric symptoms. Conversely, Andion et al. (2012) compared two groups of a similar cohort; one receiving individual DBT sessions alone and another receiving both skills group training and individual sessions. They noted results indicating no significant difference between groups and suggested that individual sessions are sufficient to show improvement in symptoms.

Methodological limitations exist in many studies evaluating various components of DBT making it difficult to draw strong conclusions in this regard. Larger control trials are needed to establish effectiveness of various components of DBT. There is a paucity of research isolating effective components specific to DBT-A. Another area which has received little attention in the literature on DBT-A relates to the evaluation of the underlying processes responsible for change in symptoms over time. Given the sparsity of research on change and DBT, the next section extends its exploration of therapeutic change to a wider literature base, including various models of change related to all therapy.

2.9 Therapeutic change

It is widely acknowledged that the overarching goal of therapy is to facilitate a process of growth and positive change (Carey, Mansel, & Tai, 2015). A number of definitions exist to describe therapeutic change, many of which focus on functionality and wellbeing (Kazdin & Nock, 2003). The following definition of therapeutic change by Rogers (1957) describes the

process of psychotherapeutic change as ‘change in the personality structure of the individual, at both surface and deeper levels, in a direction which clinicians would agree means greater integration, less internal conflict, and more energy utilizable for effective living; change in behaviour away from behaviours generally regarded as immature and toward behaviours regarded as mature’ (p95).

In DBT, change is understood to occur through a process of what are referred to as acceptance and change strategies (Miller et al., 2007). BPD is understood to have developed through the exposure to an ‘invalidating environment’, causing polarised states of being, and symptoms are understood as behaviours which interfere with a desired way of living (Linehan, 1993). It is proposed that equipping clients with skills to enhance their quality of life and diminish life threatening behaviour contributes to a process of change. The internal processes of change, however, do not seem to be addressed in the DBT philosophy in the same way as other therapeutic approaches. Perhaps this is because DBT is behaviourally based as opposed to process based. In a study examining potential mechanisms of change related to DBT, Lynch, Chapman, Rosenthal, Kuo, and Linehan (2006) conceptualise patient change as helping the client to engage in functional, life enhancing behaviour despite the presence of intense emotion. This conceptualisation of change seems to focus on the role of therapist in supporting the process of change. Less appears to be known about particular patient characteristics which affect participants’ ability to make change when engaged in a DBT programme.

2.9.1 Models of change

Various models have been developed in an effort to conceptualise the underlying elements responsible for successful outcome in therapy. It has been proposed by many researchers that common factors can be attributed to the process of change, regardless of therapeutic orientation (Carey et al., 2015). The idea of common change principles is driven by two factors; 1) the fact that many individuals suffering with mental health difficulties recover without therapeutic input, 2) hundreds of forms of therapy exist, it is unlikely that each has its own unique mechanisms of change (Messer & Wampold, 2002; Kazdin, 2007; Carey et al., 2015).

Goldfried (2014) proposes a list of common principles which support the endeavour of therapeutic change including; the therapeutic alliance; positive expectation of change; increasing client’s awareness; corrective experiences; and ongoing reality testing. According

to Goldfried's model, the therapeutic alliance serves the purpose of increasing engagement in therapy tasks, positive expectations of change provide belief in the therapeutic process, thus keeping the client engaged, and increasing client's awareness helps the client gain deeper understanding of self. Corrective experience is proposed to provide a client with a model of healthy relating through validation and attunement and ongoing reality testing promotes evaluation and reflection of ongoing patterns (Goldfried, 2014).

Grawe (1997) proposes four basic mechanisms of change, based on a review of RCTs focussing on therapeutic intervention and change. The four mechanisms are identified as follows: Mastery, which describes learning to cope with difficult situations; clarification of meaning, referring to the unearthing of unconscious motives in understanding ones behaviour and experience; problem actualization, which refers to how the problem is experienced emotionally in the therapy; and resource activation, which denotes the active use of the client's abilities and resources to produce therapeutic change (Mander et al, 2013). Castonguay and Beutler (2006) propose three core principles to frame the process of change, namely, participant factors, relationship factors and technique factors. Participant factors refer to client and therapist characteristics that exist within the person and are qualities which can be observed outside of psychotherapy, e.g. gender or attachment style. Relationship factors refers to the quality of the therapeutic interaction and encompasses factors such as therapeutic alliance, empathy and management of countertransference. Technique factors comprise those elements of an approach which are considered most likely to be associated with efficacious outcomes.

Other models of change focus on prerequisites which enhance the likelihood of therapeutic change and factors. Hanna (2002), proposes that therapeutic change hinges on seven precursors, namely, hope, awareness, a sense of necessity to change, the willingness to experience anxiety or difficulty, confronting issues, the exertion of will or effort, and the presence of social support. Expanding on Hanna's idea of the willingness to experience anxiety, Leiter and Kuiper (2008) propose that high intolerance to uncertainty impacts upon a client's ability to face any aspects of therapy which focus on change. This intolerance to uncertainty is proposed to cause discomfort for those clients when they are faced with the unfamiliarity that change brings.

2.9.2 Researching change

This section shall move from models of change to how and why it is important to research change. Castonguay and Beutler (2006) note a dichotomy within the field of psychology between those who rely on objective, empirically supported treatments and those who place value on subjective and interpersonal processes as accounting for change. Shifting the focus from between group analysis, e.g. comparing a control group to a treatment group, to ‘within person’ analysis, provides a landscape for understanding the underlying intricacies of how an intervention is working, as opposed to establishing a causal relationship alone (Kroner & Yessine, 2013, p322). Grawe (1997), distinguishes the question of *whether* a therapy is effective from *how* it is effective, labelling the former as conservative and the latter as progressive. Kazdin and Nock (2003) note the job of therapy research as understanding how change can be produced on a broader level rather than merely via therapeutic techniques, i.e. viewing change in the context of functioning at a social, emotional and behavioural level, as opposed to simply removing symptoms.

Measuring change based on predetermined variables negates the complexity of the process of change at an individual subjective and experiential level. Kazdin and Nock (2003) note that measuring change on *a priori* grounds is not sufficient to fully illustrate the impact of change in an individual’s everyday functioning. They add that there are a vast array of factors which can influence whether an individual experiences positive and desired change. Some such factors can be related to specific aspects of a therapeutic intervention and others can relate to external factors occurring in a person’s life, which are in turn effecting internal change (Kazdin, 2007). This highlights that change is an all-encompassing process that can be *influenced* by therapy but perhaps not *caused* by therapy alone.

2.9.3 Advantages of researching change

Research on mechanisms of change can help to elucidate how and why treatment is working, as well as what components of treatment are useful (Kazdin and Nock, 2003). Understanding why a treatment is working can not only help to maximise treatment effects but can also isolate those features of a treatment which are most critical in creating change; an important consideration in the generalisation of treatment in clinical practice (Messer & Wampold, 2002; Kazdin & Nock, 2003; Kazdin, 2007). Understanding processes which effect change can direct which content areas should be the focus of an intervention (Kroner & Yessine, 2013), enhance

patient allocation to treatment (Trompetter, Bohlmeijer, Fox, & Schreurs, 2015), and enhance generalization of treatment effects from research to practice (Kazdin, 2007).

In the absence of knowing what particular processes or mechanisms of a therapy produce change, it is difficult to develop and deliver optimal treatment programmes (Kazdin & Nock, 2003). This may also influence pre-treatment factors, i.e. identifying suitability. Suitability is generally established based on particular inclusion criteria or particular elements/symptoms of a clinical presentation. However, while individuals may have similar clusters of symptoms, their capacity to gain benefit from a therapy can vary dramatically. Blatt, Zuroff, Hawley, and Auerbach (2010) note that one of the main obstacles in research on the process of change is the assumption that all clients enter treatment as a relatively homogenous group with greater similarity than difference. They point to the importance of assessing pre-treatment personality factors and how this impacts on an individual's ability to benefit from therapy and produce change (Blatt, Zuroff, Hawley, & Auerbach, 2010). Factors which influence an individual's ability to gain benefit from therapy are wide and varied. The next section focuses specifically on potential factors influencing those individuals with a diagnoses of BPD in benefiting from therapeutic intervention.

2.9.4 Change and BPD

The area given perhaps the most attention in the literature is the therapeutic alliance which many studies have isolated as the most significant factor associated with treatment outcome (Messer & Wampold, 2002). The characteristic difficulties establishing and maintaining relationships indicative of BPD threatens the development of a strong therapeutic alliance given that this is also a highly relational process (Castonguay & Beutler, 2006). Kazdin (2007) notes an association between the strength of the therapeutic alliance and positive outcome in treatment. Based on the role of the therapeutic alliance on outcome, and the difficulty with relationship formation inherent in BPD, this group are potentially at risk of poor outcome in treatment (Castonguay & Beutler, 2006). Castonguay and Beutler (2006) suggest that as a result of this, the therapeutic alliance is given particular attention when working with this unique group.

Castonguay and Beutler (2006), specifically explore change as it is researched in personality disorder with relation to the aforementioned factors; participant, relationship and technique.

They derived that the focus of the research with this population tended to be on changes in behaviours or symptoms, deviating from therapeutic work with other groups which commonly focused on self-concept, view of others and complex relational difficulties. They posit that this slight bias in the focus of change research possibly skews the research findings in the direction of symptom reduction as the main change construct compared to process based factors.

2.10 Summary

In spite of the positive outcomes in the studies examining symptom reduction and functioning for those exposed to DBT-A, this research is in the early stages of development for this population (Macpherson et al., 2013). Overall, the research shows promising results for DBT-A in terms of reduction in symptoms of psychopathology and problem behaviours for the adolescent population. However, there is notable variation across the research studies in terms of the delivery of DBT-A in terms of treatment duration, intensity of treatment, modes of treatment and setting in which it is delivered (Tormeon et al., 2014). This makes comparison between studies difficult. There is a need for more RCTs with control comparisons starting with Waitlist Controls (WLC) or Treatment as Usual (TAU), conducted by diverse research groups, and assessing functioning at long term follow up (Macpherson et al., 2013). Mehlum et al. (2014), suggest that future research needs to focus on what the active constituents in DBT-A are, and refining treatment to target specific symptom domains such as self-harm or suicidal ideation, rather than broad ranges of behaviours. The evaluation of particular clinical components of the adapted programme to determine those aspects of DBT-A which are deemed most effective for parent/adolescent is also recommended (Macpherson et al., 2013). There is a noticeable dearth of qualitative and mixed method research in the area which has led to an over-reliance on quantitative studies in ascertaining the effectiveness of DBT-A. Less is known about how or why this approach is working or what is accounting for the changes which have been established in quantitative research (Mehlum et al., 2014). This research study attempts to fill some of the aforementioned gaps and add to the literature on DBT-A in a meaningful way. This research aims to marry quantitative investigations of symptom reduction with qualitative explorations of the potential mechanisms of change.

2.11 Research Questions

Quantitative

Hypothesis: Participants of the DBT-A programme will show a reduction in symptoms from beginning to end of therapy in self-harming behaviour, suicidal ideation, depression, hopelessness and anger, as assessed by the Suicidal Ideation Questionnaire, Beck Depression Youth Scale, Beck Hopelessness Scale, State Trait Anger Expression Inventory, and therapist recording of self-harming behaviour.

Qualitative

Research question: What are adolescents' experiences of the process of change as it relates to their engagement in the DBT-A programme?

CHAPTER 3: METHODOLOGY

3.1 Chapter introduction

This chapter provides a description and definition of the overall research design utilized, followed by a rationale for the selection of this methodology. Next, the type of mixed method design chosen, the embedded design, is described, along with a visual diagram of how it is applied to the current research study. A description of Interpretive Phenomenological Analysis (IPA) is given, as this is the approach used in the qualitative phase of the study. Information on participants for both quantitative and qualitative phases of the study is provided, along with ethical issues in the research. Procedures for data collection and analysis are explained in detail for both phases, along with a discussion of reliability and validity.

3.2 Research design

This research utilised a mixed method design, i.e. the application of both qualitative and quantitative methods of enquiry (Doyle, Brady & Byrne, 2009). As previously discussed research to date on the efficacy of DBT-A has predominantly focused on symptom reduction from the beginning to end of treatment (Rathus & Miller, 2002; James, Taylor, Winmill & Alfoadari, 2008). This has involved, in the main, the utilization of quantitative methods of enquiry. Less is known about how or why DBT-A may be effective, or what is accounting for the changes which have been established in quantitative research (Mehlum et al, 2014). Rather than separately presenting quantitative investigations, i.e. symptom reduction, and qualitative explorations, i.e. aspects of programme that have contributed to change, the aim is to marry both quantitative and qualitative enquiries, given the interconnectivity between the two. The rationale for the introduction of qualitative methods is to both contrast and complement quantitative methods (Todd, Nerlich, McKeown, & Clarke, 2004). Creswell and Clark (2011) state that research problems best suited to mixed method design include those in which one source of data does not sufficiently answer the research question, where results require further explanation, and where a primary method needs to be enhanced by a second method.

3.3 Mixed method research

Mixed method research has been referred to as the third methodological wave (Doyle et al., 2009). Teddlie and Tashakkori (2012) coin the term ‘methodological eclecticism’ to describe mixed method research, i.e. the integration of the most appropriate qualitative and quantitative techniques in order to comprehensively investigate a phenomena (p777). Mixed method research is grounded in the philosophy of pragmatism, advocating for this aforementioned eclecticism. Underpinning the philosophy of pragmatism is the notion that the practicalities of research outweigh paradigm debates between qualitative and quantitative schools of thought, giving the best opportunity to thoroughly answer the research question.

The use of mixed method research has gained significant momentum in health care research in recent years (Doyle et al., 2009). While there is a degree of agreement about mixing methods, there are still ongoing debates about how this should be done (Guével, Pommier, & Jourdan, 2015; Teddlie & Tashakkori, 2012). A number of models have been identified within mixed method research in an effort to answer the complex questions relating to how and when to use mix methods (Terrel, 2012). To address concerns relating to consistency and structuring, Creswell and Clark (2011) propose six major mixed method research designs, namely, the convergent parallel design, the explanatory sequential design, the exploratory sequential design, the embedded design, the transformative design and the multiphase design. Determining the most appropriate mixed method design to fit the research question requires a number of key considerations, including the level of interaction between the qualitative and quantitative strands, the level of priority given to each strand, the timing of both strands (i.e. concurrent vs. sequential), and the stage at which the methods are mixed (Terrel, 2012; Guével et al., 2015; Creswell & Clark, 2011).

3.4 Rationale for methodology

The strengths of quantitative research include its generalizability, its credibility among stakeholders, and the transformation of human phenomena into numerical values (Johnson & Onwuegbuzie, 2004). It allows for testing and validating already constructed theories in relation to human behaviour as well as statistical analysis which is objective and free of the researcher (Doyle et al., 2009; Steckler, McLeroy, Goodman, Bird, & McCormick, 1992). The weaknesses of the approach, which to a degree reflect the strengths of qualitative research, include a) the focus on hypothesis testing rather than hypothesis generation and b) the fact that

the researcher chooses categories for assessment which may not encapsulate the totality of an individual's experience, leaving the potential to miss important information (Johnson & Onwuegbuzie, 2004; Creswell & Clark, 2011). Johnson and Onwuegbuzie (2004) argue that a full differentiation between cause and effect is not possible, given the subjectivity of all human experience.

Qualitative research can be used to contextualise quantitative results to gain a greater understanding of the intricacies of human experience outside of testable hypotheses (Doyle et al., 2009). While qualitative data is not generalizable in the same way as quantitative methods, the case for its use is to provide a rich and in-depth perspective of the complexities of an experience, to assist in giving numerical data a context, and to discover from the perspective of the service user what elements of an intervention are most helpful in achieving individual positive outcomes (Starks & Trinidad, 2007). More simply, quantitative tells us 'if', while qualitative tells us 'how or why' (Terrel, 2012).

It is argued that combining the strengths of both quantitative and qualitative methods allows for the integration of epistemological, ontological and methodological perspectives, leading to a more complete analysis and adding value to the study and evaluation of complex interventions (Doyle et al., 2009; Guével et al., 2015; Creswell, Fetters, & Ivankova, 2004). Depending on the way in which methods are mixed, a number of benefits have been identified for use of this approach. For example, the use of qualitative methods first can aid hypothesis generation as well as support instrument development by identifying items of importance for quantitative testing (Doyle et al., 2009). In addition, using mixed methods allows for a number of different research questions to be answered using a variety of methods that best suit each research question (Creswell & Clark, 2011). Mixing methods also allows for the use of qualitative methods to corroborate quantitative findings, a process also known as triangulation (Jick, 1979; Bryman, 2006). Equally, results from quantitative and qualitative data may contradict each other; a contradiction which would remain unknown if only one approach was employed (Creswell & Clark, 2011).

While there remain unresolved issues in relation to epistemology, philosophy, and integration of data analysis within mixed method research, arguments for its adoption are strong. Todd, Nerlick, McKeown, and Clarke (2004) note that the mixing of methods can produce results that are more 'understandable, more credible, and easier to use in the context of everyday beliefs

and practices' (p83). Johnson and Onwuegbuzie (2004) argue that mixed method research bridges the gap between purist qualitative and quantitative research. In this way it offers a way of exploring and understanding phenomena that maximises on the strengths of both approaches (Morgan, 1998). It is proposed that the combination of approaches will help the development of more effective interventions through an in depth and layered understanding of an intervention's complexity, both through establishing linear relationships between cause and effect and through exploratory investigation of experience at an individual level.

3.5 The embedded design

The mixed method design considered to best address the research questions in this research is known as the embedded design. The sequential explanatory method, a two phase model in which data are collected sequentially, was also considered for this research (Ivankova, Creswell, & Stick, 2006). However, this was ruled out, as this design involves the investigation of one research question, through the use two methods, as opposed to the examination of two research questions addressed separately. This research design also warrants a longer time frame in which to conduct the research given the sequential nature of data collection and analysis, which was unfeasible given the time frame for this study.

The underlying premise of the embedded design is that one type of data is insufficient in answering questions about an intervention (Creswell & Clark, 2011). It is considered appropriate when a researcher has two questions that each require different types of data. One data set, usually qualitative, is embedded within a larger quantitative data set, and takes on a secondary role in the study (Doyle et al., 2009). Usually the data sets are given unequal priority, with one identified as predominant (Creswell & Clark, 2011). A number of factors guided the selection of this design, including time orientation (both sets of data were collected within the same time frame) and sample relationship (participants for the qualitative phase are nested within the overall sample of participants for the quantitative phase; Collins, Onwuegbuzie, & Jiao, 2007). The research also proposed two separate research questions, each requiring different methods of enquiry to be appropriately addressed. The qualitative data in this research is embedded within a wider national quantitative project. In this way, the quantitative data is predominant. However, it should be noted that this researcher had greater involvement in the qualitative phase of the research and this will be reflected in the depth of analysis of the qualitative results.

An overview of the embedded design as it relates specifically to this study is detailed in Figure 3.1 below. Quantitative methods are represented by the large square to the left and given the abbreviated label of QUAN, written in capitals to reflect that it is the predominant method in the study. Qualitative methods, given the abbreviated label Qual, shown as a circle, are nested within the square to show that it is embedded within the quantitative dataset. Data collection and analysis of the quantitative and qualitative strands occur separately with the qualitative data being collected after the quantitative data. The findings are merged at the interpretation stage which is represented in the box in the bottom left of Figure 3.1.

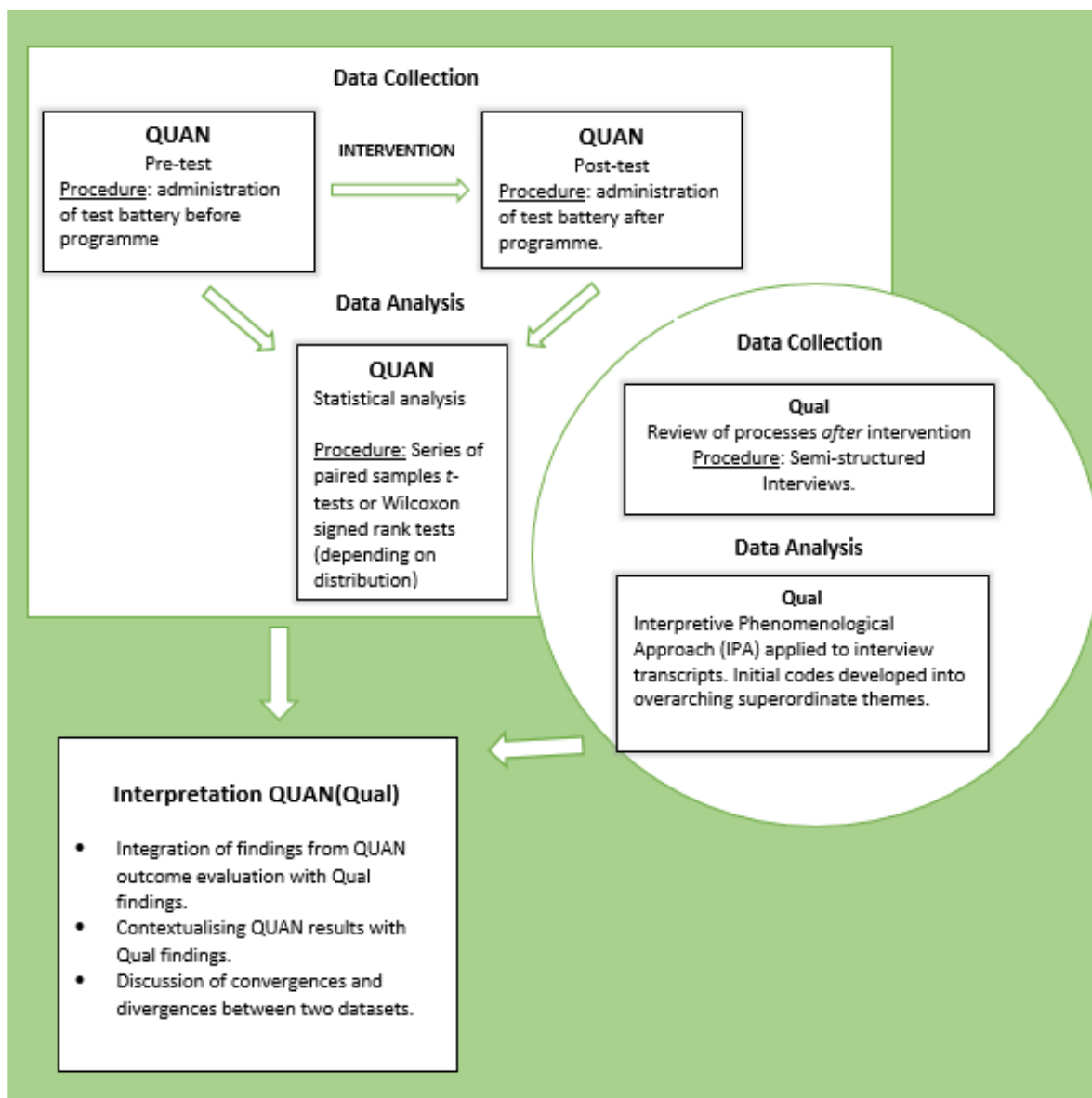


Figure 3.1: A visual model of the stages of data collection, analysis and interpretation of quantitative (QUAN) and qualitative (Qual) datasets.

3.6 Interpretive Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA) was chosen as the method of analysis for the qualitative data. As previously discussed, the process of change is idiosyncratic in nature and while there are inevitable similarities in the way that individuals experience change, it is ultimately a highly personal experience. The qualitative research question is centred on the way that change is experienced and, therefore, warrants an approach that would examine the subjective lived experience of this phenomenon in an in-depth manner. IPA is based on a combination of phenomenology and hermeneutics, in that the approach strives to get as close to the personal experience of the participant as possible (phenomenology) while also acknowledging that once a researcher is introduced this becomes an interpretive process (hermeneutics; Smith, Flowers & Larkin, 2009).

3.7 Participants

Quantitative

A total of thirty seven adolescents were initially enrolled in DBT-A in Ireland in 2015 and thirty successfully completed the programme. The DBT-A programme was delivered across seven sites nationally, including three sites in the South, two sites in the East, and two sites in the West of Ireland. The initial stage of recruitment involved liaison with the project lead and coordinator of the National DBT Project. A proposal of the research questions and aims was presented and subject to ethical approval, access to the sample of participants was granted by the manager of the National DBT Project. As part of their enrolment in DBT-A, all participants agreed to take part in the evaluation that is part of the National DBT Project. Therefore, quantitative data was collected and available for all participants engaged in DBT-A nationally for 2015.

Qualitative

For the qualitative phase of the research, participants were recruited from three of the seven sites delivering DBT-A nationally. The researcher accompanied the National DBT Project researchers to each site on the last session of DBT-A when post-intervention data collection was due to take place. A verbal description of the research was presented to each group of potential participants along with information leaflets, consent forms, and an 'opt in' sheet, with a space for the name and phone number of the parent of the adolescent or, alternatively, the adolescent's own name if over 18 years (see Appendix A). It was explained that providing contact details on the 'opt in' form gave permission to be contacted by the researcher to arrange

a suitable time and date for a research interview. Of the fourteen participants who were approached about the research, nine opted in. Upon follow up, three decided they no longer wished to take part and six agreed to attend for interview.

3.7.1 Inclusion Criteria

Participants were required to have been enrolled in and completed the DBT-A programme in 2015 to be included in this research study. Inclusion criteria for enrolment in DBT-A were set out by the National DBT Project and they are as follows:

1. Between/including the ages of 14-18 years.
2. Demonstrating emotional and/or behavioural disturbance/emotional dysregulation.
3. Persistent patterns of deliberate self-harm with deliberate self-harm behavior or a suicidal act having occurred with the last 16 weeks or chronic suicidal ideation.
4. The client and their guardian will have discussed their emotional dysregulation with their clinician or a member of the team and will have expressed an interest in, and commitment to, the 16 week programme.

3.7.2 Exclusion Criteria

A number of exclusion criteria were established by the National DBT Project team for participation in the research evaluation. These included:

1. The presence of an active psychosis.
2. Severe developmental delays, cognitive impairment or learning disabilities (exceeding the mild range).
3. The presence of mental health issues including, but not restricted to, drug dependence or eating disorders that are at such a level that would impede engagement with any of the modalities of DBT.

3.7.3 Demographic Information

Quantitative

At Time 1 (initial stage of treatment), the sample comprised 8 males and 29 females. A total of thirty participants completed the programme. All seven participants who dropped out of the programme were female. The average age of participants was 15.7 (SD= 1.07) with a range of

13-17 years². The average age of participants was the same for the sample at Time 1 (n= 37) and when calculated for only those participants who completed the programme (n= 30). Data pertaining to type and frequency of suicidal behaviour (n=34) showed that 62% of participants engaged in more than one type of self-harm, 38% in more than two forms of self-harm and 23% in more than three forms of self-harm. In terms of type of self-harm, 82% of the sample engaged in cutting and 23% had overdosed. Threatening self-harm was found in 48% of the sample and 32% of participants displayed dysregulated eating. Other forms of Deliberate Self Harm (DSH) included burning, eye scratching, and punching walls and were found in 23% of individuals. As previously mentioned, many participants engaged in multiple forms of self-harming behaviour, i.e. it is possible for one individual to engage in cutting, burning and dysregulated eating. Of those who completed, twenty six presented with DSH and four with Suicidal Ideation (SI) as the primary presenting problem at pre-treatment. The existence of a co-morbid diagnosis was identified in 63% of the sample and 50% of participants at Time 1 were on psychotropic medication. Co-morbid diagnoses ranged from anxiety disorders, mood disorders, Attention Deficit Hyperactivity Disorder, Autistic Spectrum Disorder, Conversion Disorder, Reactive Attachment Disorder, Obsessive Compulsive Disorder, Eating Disorders and disordered alcohol use. Of those who completed the programme, 23% had at least one inpatient admission prior to enrolment and 43% had been to the Accident and Emergency (A&E) department. One participant in this sample had both an inpatient and A&E admission, and is therefore represented in both percentages. Overall, 53% of participants had been admitted to inpatient services or A&E as a result of their suicidal behaviour.

Qualitative

Table 3.1 overleaf provides information relating to the six participants who took part in the qualitative interviews. This includes age, presenting issue, whether a comorbid diagnosis exists, and whether participants had previously had inpatient admission. Participants were aged between 16-17 years old. The sample consisted of four individuals presenting with DSH and two with SI, four of the six were given comorbid diagnoses and three had experienced at least one inpatient admission. The co-morbid diagnoses included Obsessive Compulsive Disorder, secondary psychotic illness, depression/anxiety and queried eating disorder.

² Further information relating to cultural background and ethnicity of participants was sought but was not available as this information had not been included in the initial data collection phase.

Table 3.1: Participant information

Participant Pseudonym	Age	Presenting Issue*	Comorbid Diagnosis	Prior Inpatient Admission
Ruth	16	DSH	Yes	No
Ben	17	DSH	No	No
Maria	17	DSH	Yes	Yes
Karen	16	DSH	No	Yes
Rachel	17	SI	Yes	Yes
Greg	17	SI	Yes	No

*Note: DSH= Deliberate Self-Harm, SI= Suicidal Ideation

3.7.4 Setting

Interviews took place in three separate locations, reflecting the three selected services delivering DBT-A. Two of the locations were the CAMHS services in which participants attended for DBT-A. The third CAMHS service did not have room availability to facilitate interviewing. Therefore, it was decided that the interviews for participants linked into that service would be held at the DBT National Project headquarters, which is based in an adult mental health service building. This provoked some ethical issues which will be described in section 3.8.

3.8 Ethical Issues

Ethical approval was sought and granted from the Clinical Research Ethics Committee, Cork. The ethics application gave an overview of the project's aims and objectives along with comprehensive information on how participants and their information would be safeguarded, which was led by the Psychological Society's Code of Ethics (Psychological Society of Ireland, 2011). A letter requesting access to quantitative data collected by the National DBT Project researchers accompanied the application, citing the National DBT Project ethics application.

Particular ethical considerations included; the age of the participants (under 18 years), confidentiality, the vulnerability of this population and the potential sensitivity of the research question. The following precautions were put in place in light of the aforementioned considerations:

- Explicit expression of the opportunity to opt out at any stage of the interview.
- The opportunity for participants to share their experiences of the interview with the researcher as a form of debriefing following the interview.
- Written and verbal explanation of the limits of confidentiality and the specific actions that would take place should information of concern arise in the interview, i.e. the development of a safety plan to contact parents and relevant professionals to ensure their personal safety.
- Any participant who was no longer engaged with CAMHS and who expressed concern for their safety would be offered a once off appointment with their original CAMHS therapist.

A number of ethical issues arose in the process of organizing and conducting the research interviews. One such issue related to setting. When arranging the location of interviews of participants from one CAMHS service, it came to light that there was limited room availability and that an alternative premises would need to be sought to conduct the interviews. This provoked questions relating to the suitability and convenience of using a different location. It was decided that the National DBT Project headquarters would be used for convenience given its short distance from the CAMHS service in question. However, this premises was also an adult mental health service and prompted the issue of the potential risks of bringing an under 18 year old into a service for adults with mental health issues. To address this, the researcher explicitly informed the parents and participants where the interview would take place, met the participant at the CAMHS service, and accompanied them to and from this premises.

Another issue arose in the process of an interview with one particular adolescent who expressed suicidal ideation when discussing her experiences. This was managed by following the aforementioned precautions set out in the ethics application. A plan was drawn up between the interviewer and participant to walk back to the CAMHS service at the end of the interview where she had an appointment with her DBT clinician. The statement was quoted to the clinician who made a note of it and took over clinical responsibility. This particular ethical dilemma highlights the ‘real world’ issues which can arise when conducting applied research.

3.9 Procedure

Quantitative

The quantitative phase of the research involved accessing pre-existing data collected by the National DBT Project team. The data was collected by the National DBT Project team, pre- and post-treatment, and was subsequently collated and inputted into an excel file. Each response item was entered into an allocated cell on the spreadsheet. Columns represented questionnaire items and rows were representative of each participant's item response. Each item response had a numerical code depending on the questionnaire's rating scale. The excel spreadsheets contained data collected for all DBT-A programmes over a 2 year period.

Data pertaining to the seven sites delivering DBT-A in 2015 (n= 37 participants pre-treatment, n= 30 participants post-treatment) was then extracted from the National DBT Project excel spreadsheets by the researcher and imported directly into a new SPSS file. Only data relating to the questionnaires named in the next section (3.10) were extracted and inputted into SPSS.

Qualitative

A total of six participants attended for a semi-structured interview. The structure of each interview was roughly the same: to begin, the researcher welcomed, thanked and attempted to build rapport with the participant. The research project and its rationale were explained, along with a verbal explanation of the limits to confidentiality and the procedures that would be followed if anything of concern arose during the interview. Participants were then given an opportunity to ask any questions they might have about the current research study. The interviews opened with a broad question relating to their overall experience of engaging in the DBT-A programme. This then led to more specific questions relating to their experience of the process of change, how they felt this occurred and what factors they felt influenced making positive change or created obstacles in making desired change. The interviews ranged in duration from 40-59 minutes with an average of 48 minutes. The length of the interview depended on the adolescent's ability to reflect on and articulate their experiences and the researcher's judgment of data saturation.

A journal containing memos and reflective notes, details of research meetings, and emerging questions was kept by the researcher from the outset of the research project. Memos contained reflections which arose throughout the research process including the experience of the interviewer, the experience of analyzing the data from coding to developing themes, issues

arising in the process of data analysis, and impressions left by the interviewee (see Appendix B). A research field note template was utilized separately during the interview stage to capture significant elements of this process (Salmon, 2011, see Appendix C & D). This framework was used immediately after each interview to document important aspects of the interview process including a summary of the interview, the key points made by the participant, a description of the participant's presentation and the setting in which the interview took place, the researchers feelings throughout the interview and any significant phrases or words expressed by the participant. This was then used later to aid data analysis.

3.10 Instruments

Quantitative

The quantitative phase of the research utilized data which had been collected by the DBT national research team. As mentioned previously, the National DBT Project is an implementation project with an economic focus. A comprehensive battery of instruments is, therefore, used to assess each treatment target related to DBT, i.e. quality of life interfering behaviours, life threatening behaviours, and adherence to therapy, as well as measures focusing on service utilization. Not all instruments in this broad battery were applicable to the research questions in this study and therefore only those instruments which were considered linked to the research question were used. Some questionnaires which may have been appropriate, e.g. DBT Ways of Coping Checklist and the Borderline Symptom Checklist, were omitted due to a lack of standardization with the adolescent population, which provoked concerns relating to validity and reliability.

The following instruments were included in the study (see Appendix E):

- *The Beck Depression Inventory- Youth (BDI-Y).*
- *The Beck Hopelessness Scale (BHS).*
- *The State Trait Anger Expression Inventory (STAXI).*
- *The Suicidal Ideation Questionnaire (SIQ).*
- The National DBT Project- Client Record Form (only those sections pertinent to this study are included in Appendix E).

Beck Depression Inventory- Youth

The BDI-Y is a 20 item self report questionnaire designed for children and adolescents aged 7-18 years. Items are rated on a four point likert scale ranging from 0 (*never*) to 5 (*always*). The questionnaire assesses thoughts, feelings and behaviours associated with depression. *The Beck Depression Inventory* (BDI) for adults is a well-established psychometric tool for the measurement of depression. The instrument has been adapted for use with children and adolescents. Beck, Beck, Jolly and Steer (2005) note alpha coefficients between .91 and .95 for the BDI-Y in a clinical sample of adolescents showing strong internal consistency. Test-Retest reliabilities are between .83 and .94 for the BDI-Y in a clinical sample of adolescents (Beck et al., 2005).

Beck Hopelessness Scale

The BHS is a 20 item questionnaire developed to measure negative attitudes to the future. It is a self-report measure with true/false response options. Participants respond true or false for each item depending on whether or not they endorse that item. While the BHS is not normed for the adolescent population, it has been used in clinical populations aged 13 to 80 years. Statistical analysis showed no statistical correlation between age and the BHS, indicating that adjustments to scores based on age are not necessary (Beck & Steer, 1993). Beck and Steer (1993), the originators of the BHS, note strong internal consistency with Kuder-Richardson (KR-20) reliabilities between .87 and .93.

State-Trait Anger Expression Inventory

The STAXI is a 35 item self-report questionnaire which measures state anger, trait anger and anger expression (Del Barrio, Aluja, & Spielberger, 2004). It consists of the following subscales; Anger State, Anger Trait, Anger Expression and Anger Control. Anger State refers to transient reaction to a present situation and Anger Trait refers to a disposition relating to a tendency toward intense expressed emotion (Del Barrio et al., 2004). Anger Expression examines angry feelings toward others or the environment which is outwardly expressed (Anger Expression-Out) as well as angry feelings that are suppressed (Anger Expression-In). Anger Control refers to preventing the expression of anger and/or suppressing anger by calming down. The STAXI shows good internal consistency with coefficient alphas ranging from .77 to .94 in a clinical sample (Brunner & Spielberger, 2009).

Suicidal Ideation Questionnaire

The SIQ is a six item questionnaire which was developed by the National DBT Project team to assess thoughts about suicide. While this is an unstandardized measure, it was deemed important for inclusion given that chronic suicidal ideation is one of the main inclusion criteria for enrolment in DBT-A.

The National DBT Project- Client Record Form

The Client Record Form was also developed by the National DBT Project and is used as part of their battery of measures relating to participants enrolled in DBT-A. This form is given to clinicians to fill out about their DBT-A clients (each client's respective individual therapist is responsible for filling this out). This form collates demographic information, i.e. age, gender, educational level of participants, and other practical details such as contact information. Included in the Client Record Form is information relating to diagnosis, service utilization and details of self-harming behaviour. It was decided by the National DBT Project team that clinicians should record the type and frequency of self-harming behaviour on behalf of the young people, given the vulnerability of this population and in order to protect the participants from any potential distress this could cause. Those parts of the Client Record Form deemed important for this research were utilized, e.g. demographic information, type and frequency of self-harming behaviour, presence of comorbid diagnosis, and previous inpatient admission.

Qualitative

The interview schedule (see Appendix F) was developed based on the literature to date on DBT-A, as well as relevant research articles relating to the development of an interview schedule (Jacob & Ferguson, 2012). In particular, the protocol outlined by Smith, Flowers, and Larkin (2009) was utilized, the focus of which is on developing open ended and expansive questions that help to elicit a flow of dialogue, capturing the participant's lived experience. As part of this process, the researcher also consulted the Participant Satisfaction Questionnaires completed by parents and adolescents from the previous year of enrolment (2014, which was the first year of the delivery of DBT-A). The Participant Satisfaction Questionnaire (PSQ) is a brief questionnaire developed by the National DBT research team to evaluate the participant's and their caregiver's level of satisfaction with the DBT programme (See Appendix G). Of particular interest was the second section of the questionnaire which includes three qualitative questions relating to helpful and unhelpful aspects of the programme, along with any additional comments about the personal experience of DBT (see Appendix G, Q. 6-8). The PSQ was

referred to in the initial stages of the research to give the researcher a deeper understanding of the potential mediating factors of DBT-A, as reported by the participants of the programme, as well as those aspects of the programme which created potential obstacles in making desired change.

3.11 Data Analysis

Quantitative

The researcher extracted all relevant data from the central excel file belonging to the National DBT Project. Figure 3.2 represents the steps involved in the quantitative data analysis.

Firstly, the SPSS file was prepared and relevant data was entered for each variable, pre- and post-intervention. A series of tests were conducted to establish whether normal distribution could be assumed. The data were then subjected to a series of Wilcoxon signed-rank tests.

The Wilcoxon signed-rank test is the non-parametric equivalent of the *t*-test and is used when data is collected under two separate conditions but from a single sample of participants (Howitt & Cramer, 2014). It uses ranks and compares the medians of two conditions, e.g. before and after an intervention, and is useful in assessing change over time (Howitt & Cramer, 2014).

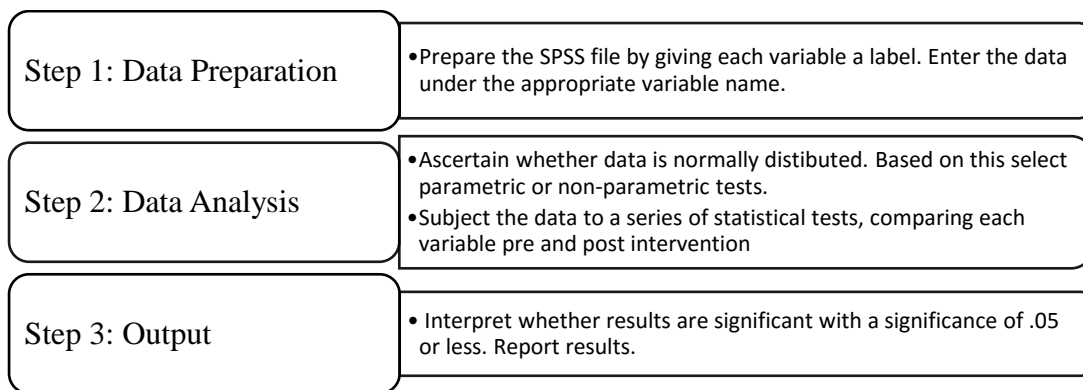


Figure 3.2: A visual outline of the steps involved in quantitative data analysis (Howitt & Cramer, 2014).

Qualitative

Using IPA as the framework, data was analysed using the following steps:

1. Familiarization with the data: the interview transcripts were read and re-read by the researcher. To enhance engagement with the data, the interviews were also listened to while reading the transcripts. This helped the researcher to develop a sense of the essence of each interview as told by the participant and enabled the detection of subtle changes in tone and punctuation expressed by the participant.
2. Initial noting: the transcripts were then subjected to detailed coding. Descriptive, linguistic and conceptual codes were developed, i.e. a description of content, the presentation of content (use of metaphors, repetition, pauses, tone, laughter and other significant linguistic factors), and finally, questions that the content provoked. The latter, conceptual codes, are deemed an important step in moving the analysis from purely descriptive to interpretive (Smith, et al., 2009). The researcher hand coded the data at this stage as this encouraged greater flow and connection with the data. The three different types of codes were represented by different coloured ink (descriptive codes: black, linguistic codes: red, conceptual codes: green).
3. Developing emergent themes: this involves a shift from working with the original transcript to working with the initial noting. The researcher attempts to reduce the detailed codes to manageable chunks of meaningful information without losing their meaning or complexity. This stage requires the researcher to break away from the data slightly to explore the connections, patterns and relationships between exploratory notes (Smith et al., 2009). At this stage, all initial notes were imported into an excel spreadsheet and possible emergent themes and superordinate themes were identified for each interview (See Appendix H).
4. Searching for connections across emergent themes: the emergent themes are listed and similarities and differences are highlighted. Superordinate themes are developed through a number of processes including the examination of emergent theme function, context and frequency, collating related themes (subsumption), and connecting themes that focus on difference (polarization). This process involved the researcher examining the emergent themes across all interviews. Mind maps were created to aid this process and create visual representations of the first stages of theme development (see Appendix I). Themes were also physically arranged using sticky tabs to support the process of data refinement (see

Appendix H). From this, the themes were either subsumed, i.e. collapsed into an overarching theme, or separated into more appropriate themes.

3.12 Validity and Reliability

Debates about the definition, understanding and application of validity and reliability have arisen between qualitative and quantitative schools of thought (Smith et al., 2009). Traditional definitions of validity and reliability refer mostly to quantitative research and arguments have been raised in relation to the applicability of such definitions to qualitative research, given the differences in the aims and objectives of the two research methodologies. A major goal in quantitative research is to produce findings that are generalizable to wider populations and circumstances (Winter, 2000). Questions that are pertinent to validity in quantitative research design include; are we measuring what we think we are measuring, is there a relationship between cause and effect and can we generalise to other groups and circumstances? In quantitative research, broadly speaking, validity refers to accuracy and reliability refers to replicability (Winter, 2000).

In qualitative research, concepts such as commitment and rigour, sensitivity to context, and coherence and transparency are used to describe the process of validation (Yardley, 2000; Smith et al., 2009). These principles refer to the degree to which the research is grounded in relevant theory, is respectful and representative of the participant's perspective and world view, displays in-depth engagement with the topic, adopts thorough data collection techniques and in-depth analysis, provides clear and powerful arguments and is transparent in terms of the method and presentation of data (Yardley, 2000). Issues relating to validity and reliability are somewhat complicated when mixing qualitative and quantitative methods within one study. Conducting valid mixed method research requires the researcher to adhere to guidelines on validity and reliability from each school of thought separately. Difficulties can arise during the process of integration when the researcher makes inferences about both datasets, combining results into one coherent whole (Collins et al., 2007). Some such difficulties have been offset by the development of models and typologies to describe and instruct particular ways of mixing methods.

In this study, validity and reliability for the quantitative strand were managed through the use of standardized measures where possible. Interpretation of results of unstandardized

questionnaires, which were considered important to address the research question, was done so with caution. For the qualitative phase, the researcher adhered to the guidelines for IPA as set out by Smith et al. (2009). The selection of an appropriate mixed method design, the embedded design, assisted the process of integrating findings by providing a specific model to work from.

CHAPTER 4: RESULTS

4.1 Chapter introduction

This chapter outlines the results of quantitative and qualitative analysis. Each phase is presented separately initially and merged at the end. Firstly, the results of statistical analysis are presented for each variable under investigation along with psychometric characteristics of the measures used in the study. The second phase, results of the qualitative analysis, are presented in the style of superordinate and subordinate themes. An overview of each superordinate theme is provided with descriptions of the subordinate themes. Themes are supported by contextual examples in the form of quotes from the original interview transcripts. The quantitative and qualitative findings are then merged using a mixed method analysis strategy known as side by side comparison, illustrating the ways in which the two sets of data relate to each other.

4.2 Quantitative Results

Quantitative data analysis was carried out using the “Statistical Package for Social Sciences, SPSS 23.0”. A number of tests were conducted to ascertain whether the data for each variable were normally distributed including, histograms, Probability-Probability plots (P-P plots) and the Kolmogorov-Smirnov tests (K-S tests; Field, 2009). The results of the graphs and plots were visually checked and it was confirmed through the K-S test results that the majority of data could not be regarded as normally distributed. Therefore, analysis was carried out using non-parametric tests, more specifically, the Wilcoxon signed-rank test.

Table 4.1 below illustrates the psychometric characteristics of each questionnaire used in this study, namely, The Beck Inventory- Youth (BDI-Y), the Questionnaire of Suicidal Ideation (QSI), the Beck Hopelessness Scale (BHS) and the State-Trait Anger Expression Inventory (STAXI). See section 3.10 for in-depth explanations of these measures. The Median (Mdn) and Interquartile Range (IQR) are reported given that the assumption of normality was violated. Reliability tests were conducted to measure internal consistency, i.e. the degree to which all items of a questionnaire are measuring the same construct (Howitt & Cramer, 2014). Internal Consistency was measured using Cronbach’s alpha (α). Reliability co-efficients range from zero to one with higher reliability represented by values closer to one (Field, 2009). Reliability co-efficients at or above .7 are generally regarded as acceptable (Howitt & Cramer, 2014).

Table 4.1 indicates that all but one scale achieved alpha levels of .7 or above demonstrating good reliability.

Table 4.1: Characteristics of psychological measures pre and post treatment

Scale Name	N	Mdn		IQR		No. Items	Cronbach's α	
		T1	T2	T1	T2		T1	T2
BDI-Y	30	34.5	28	14	16	20	.906	.930
QSI	30	11.5	4	10	11	6	.904	.965
BHS	30	15	10	8	9	20	.930	.906
<u>STAXI</u>								
Trait Anger	30	24.5	24	7	10	10	.872	.873
State Anger	30	14.5	13	6	7	10	.914	.950
Anger Expression-Out	30	10	9	4	3	5	.633	.652
Anger Expression-In	30	11	11	4	4	5	.864	.830
Anger Control	30	10	12	4	4	5	.745	.784

N= Number of participants, Mdn= Median, IQR= Interquartile Range, T1= Time 1, T2= Time 2

4.2.1 Results from statistical analysis

A total of nine Wilcoxon signed rank tests were conducted to compare symptoms at T1 (pre-treatment) and T2 (post-treatment) across five different measures (see Table 4.2). Four of the five measures yielded significant results, with one of the five subscales on the fifth measure showing a significant result. The frequency of self-harm significantly reduced from T1 to T2 ($Z=-3.162$, $p = 0.002$, $r = -.52$). Depression levels as measured by the BDI-Y were significantly lower post-treatment ($Mdn = 28$) compared to pre-treatment ($Mdn = 34.5$), $z = -3.45$, $p < .01$, $r = -.45$. Depression scores at T1 fell in the severely elevated range and reduced over time to the moderately elevated range at T2. A significant reduction was observed for hopelessness (using the BHS) before treatment ($Mdn = 15$) and after treatment ($Mdn = 10$), $z = -3.02$, $p < .01$, $r = -.39$. It is notable that, in terms of clinical range, this change represents a drop from the severe range of hopelessness to the moderate range. A significant reduction was also found for suicidal ideation (measured by the QSI) before ($Mdn = 11.5$) and after ($Mdn = 4$) treatment, $z = -3.66$, $p < .01$, $r = -.47$. Four of the subscales for anger on the STAXI, namely, state anger, trait anger, outward expression of anger and inward expression of anger indicated non-significant results. A significant increase was found for Anger Control, $z = -2.77$, $p < .01$, $r = -.36$.

Table 4.2: Results of the Wilcoxon signed rank tests for each measure

Variable	<i>N</i>	<i>Z</i>	<i>Sig. (p)</i>	<i>Effect Size (r)</i>
Self-Harm Frequency	30	-3.16	.002*	-.52
BDI-Y	30	-3.45	.001*	-.45
QSI	30	-3.66	.000*	-.47
BHS	30	-3.02	.003*	-.39
STAXI				
Trait Anger	30	-0.61	.544	-.07
State Anger	30	-1.32	.187	-.17
Anger Expression-Out	30	-2.27	.018	-.31
Anger Expression-In	30	-1.61	.108	-.21
Anger Control	30	-2.77	.006*	-.36

Note: * $p < .01$

4.3 Qualitative Results

The qualitative results are presented in the form of superordinate and subordinate themes. Following comprehensive coding and collating into themes, a total of five superordinate themes emerged from the analysis of the six interview transcripts. An example of a coded transcript can be seen in Appendix J. The prevalence of themes across participants can be seen in Appendix K. It should be noted that not all participants who attended for interview experienced change as a result of the intervention. This resulted in a number of divergences across the interview data. For those who acknowledged their achievement of change, the goal of the interview was to develop a personal narrative of what changes they noticed and the processes responsible for change. For those who did not experience change, the goal of the interview was to identify the obstacles they faced in making change, explore their understanding of change, describe the personal impact of not making change and pinpoint factors they felt may have helped to make change possible.

4.4 Overview of Superordinate Themes

Table 4.3 overleaf represents each superordinate theme and their relative subordinate themes. The first superordinate theme, ‘Then vs. Now’ represents participants description of their lives, personal circumstances and issues prior to enrolment in the DBT-A programme compared to after. A description of the changes they noticed in themselves and in their relationships following completion of the programme is provided. The second superordinate theme, ‘Internal

Processes of Change’, refers to internal processes influencing participant’s ability to make change including readiness and motivation, attitude to recovery and belief in change. ‘Skills Acquisition’, the third superordinate theme, describes the personal impact that “*knowing what to do*” had on participants, the application of skills to specific situations, the integration of skills to everyday life and specific skills which were identified as useful for participants. The fourth superordinate theme, ‘Therapeutic Components’, refers to specific elements of DBT-A which influenced participant’s ability to engage and gain benefit from the intervention, as well as particular components of the therapy which influenced the process of change. The last superordinate theme, ‘Toward a Better DBT’ encompasses participants expression of elements of the therapy they did not find useful and their suggestions for improvement based on their personal experience of DBT-A.

Table 4.3: Summary of Superordinate and Subordinate themes

Superordinate Theme	Subordinate themes
Then vs. Now	New Self <i>“Family life”</i>
Skills Acquisition	<i>“Knowing what to do”</i> Application & Integration
Internal Processes of Change	Readiness and Belief Motivation
Therapeutic Components	Attitude to Intervention Mode of Therapy
Toward a Better DBT	<i>“The Elephant in the Room”</i> Room for Improvement

4.5 Superordinate Theme: Then vs. Now

This superordinate theme represents ‘what’ changed in participants' lives without reference to the underlying process of ‘how’ change happened. Participants talked about how their lives differed from the beginning to the end of the programme and in this way created a kind of landscape of their personal experiences of change. This superordinate theme encapsulates participants' description of their experiences before entering into DBT-A and descriptions of how they are different now compared to before. It looks at the transition from old ways of being to form a ‘new self’ encapsulating both changes in how they relate to themselves and others.

4.5.1 New Self

Many participants described a new found sense of self. They referenced changes in mind-set and the development of a positive outlook on life. Some participants noted a shift in psychological symptoms and behavioural change. An increased sense of control and ability to manage also emerged as participants described their ‘new self’.

Many participants gave simple descriptors of their ‘new self’ as happier, less distressed and more stable without reference to why this was the case:

“I don’t appear as distressed as I used to...” (Maria, p16)

“I think people noticed that I was like happier and more upbeat towards, like, the end of it...” (Greg, p10)

Ben simply stated *“I’m just a much more stable together person”* as he outlined the differences he notices in himself compared to before *“my life used to be so dramatic all the time... but now I’m just...it’s this different sort of sense of like calmness”*. Maria expressed that before the programme she felt an absence of control in her life *“I didn’t have no control or no understanding of what was going on”*. Here she gives the impression of being lost and disconnected from herself and the circumstances she found herself in. She later describes a feeling of power and feeling better able to manage her difficulties.

While some participants did not elaborate on the basis for their ‘new self’, others directly attributed a reduction in suicidal behaviour as contributing to a sense of contentment:

“...I haven’t had suicidal thoughts in weeks, in weeks, in weeks, I’ve just been a lot happier in myself.” (Rachel, p14)

“I’m not as down about it [self-harm] anymore...just not having those secrets or not having to worry about keeping the secrets.” (Ruth, p15)

Ruth talks about the negative cycle of self-harm and her fear of returning to that place in her life:

“...like back to, like, keeping secrets and self-harming and getting upset from self-harming and then self-harming because I’m upset and that circle, kind of.” (Ruth, p13)

A willingness to develop a positive outlook and actively seek out happiness were identified as important changes for some participants. There is a sense from participants of becoming more decisive in their own lives, and actively choosing their paths in life. Participants impressed as having a new sense of empowerment and resilience which seemed to drive a keen desire for a new way of being:

“...realising, like, I actually have power over these things. I’m not this helpless victim of myself like that’s, em... and just kind of growing from that all the time.” (Ben, p8)

“I guess I’d be more kind of willing to see, like, the bigger picture about things and like if, like I have a bad day, I know like it’s not the end of the world...I’m not as negative about things...there’s no point moping about it, you might as well get on with life...” (Ruth, p5)

“I’m not looking for negative things, I’m not seeking that out anymore, I’m just kind of going through life and taking all the beautiful bits in, being mindful in a way of all the nice things that are going on around me too so.” (Ben, p6)

Rachel describes how increased self-reflection helped her to gain awareness of her psychological symptoms and consequently develop a new perspective on her difficulties:

“I didn’t realise how often I would actually feel down or I would actually feel suicidal...it put things in perspective I suppose...” (Rachel, p6)

Developing a stronger sense of self and becoming connected with self appeared important in the transition from ‘old self’ to ‘new self’. Many participants described the development of characteristics suggestive of strength and competency:

“I felt more educated on life, or on how people behave and think, or how you are supposed to react to people... so I could speak about it more confidently and without as much worry that was a very big impact on me.” (Rachel, p18)

“I notice that I am kind of more assertive, yeah...my interactions with people around me have improved...before I would have taken on a lot and then it would make me more unwell doing all these different things that I wasn’t really able to do.” (Maria, p12)

Reflection

In developing this theme, I considered the subtle difference between simply describing change compared to explaining how change occurred. As my research question relates to processes of change, I wondered about the utility of a theme which centres on description. However, in acknowledging this potential bias and as I moved through the research process, I realised that having a theme based on description of change set an important backdrop for themes which focused on underlying processes. In a way, I feel this theme set the scene for me in developing themes which involved deconstructing more complex narratives.

4.5.2 “Family life”

A change in home life and familial relationships emerged as significant for many participants. This subordinate theme focuses on how familial relationships changed over time from somewhat problematic to more grounded and settled. Many participants spoke about difficulties in parental relationships and the consequences of this before entering the programme. Ben referenced a dearth of skills within the family in managing relational difficulties eventually leading to devastating consequences on his wellbeing:

“...we didn’t really know how to handle the problem, as opposed to the problem in itself...everything just kept blowing up and getting incredibly intense...and I ended up in, I took a, like, a fatal overdose of paracetamol and stuff and, em... ended up in the hospital.” (Ben, p3)

Similarly, Maria noted difficulties in family relationships prior to the programme which manifested as unresolved anger:

“...at the start of the programme there was a lot of left over anger...and there was the anger on my parents' part, which kind of fuelled both sides...” (Maria, p15)

Participants expressed an increased ability to manage conflict at home and how this strengthened the parent-child relationships. It seems that both parent and child learned how to repair ruptures in the relationship more effectively, leading to a more relaxed home environment. There is a sense of participants gaining a greater awareness of themselves in their interactions with their parents and, as a result, becoming better able to manage and take responsibility for their part in a difficult interaction. Parent’s ability to manage conflict and communicate appropriately also appears important in this relational process:

“...we’re so chilled out now, my Mum and I, it’s just better, we used to fight a lot, we, we still don’t see eye to eye on everything...but we kind of, I think there’s more to a relationship anyway than having the same opinions.” (Ben, p18)

“I guess before, like, if I asked to meet up with friends, like, it might just turn into an argument but this time I like tried to like stay calm...and, like, not, like, just flip out over something, get in a strop.” (Ruth, p9)

“I actually think my mother benefited from it more than I did. I mean it helped her interact with my sister and all that kind of jazz, so just kind of everyday stuff...” (Greg, p8)

“...using DBT we did more pleasant activities together and we learned to get along better and discuss things more openly.” (Maria, p15)

Maria describes how an increased awareness of the impact of her behaviours on others has strengthened relationships in the family and helped to develop a more pleasant home environment:

“My mother notices huge changes in me, how I interact with people around me, em... how I, they’ve become kind of less scared because my behaviours don’t kind of spill over like they used to into different areas of family life.” (Maria, p14)

Maria’s use of the word “*spill*” represents a lack of containment and how this produced fear in others and perhaps in herself too. She gives the impression that her behaviours were in a way contaminating family life and that learning to develop greater self-awareness and solidity within herself helped her to contain her experiences without acting them out behaviourally leading to greater serenity in the family unit.

Reflection

I became very aware of my preconceptions relating to attachment in developing this theme. Before conducting this piece of research, I was curious about how parental involvement in the treatment would impact on outcomes. I hypothesized that this was a potential ‘ingredient’ of DBT-A’s success, and wondered why this had not been addressed in the literature. I was cautious not to over-state the importance of this and to allow the data to emerge fluidly.

4.6 Superordinate Theme: Skills Acquisition

The first superordinate theme, ‘Then vs. Now’ provides a backdrop of participants' descriptions of themselves before and after the DBT-A programme. Many participants reflected on a new found sense of solidity, competency and self-awareness and how this positively impacted on their relationship with themselves and relationships within the family. Acquiring skills emerged as an important factor in the development of a ‘new self’ and in producing desired change in their lives. Participants talked about skills in a variety of ways. Many outlined exactly how they used skills to manage challenging situations, others described how having strategies and “*solutions*” to problems was a transformative experience and directly impacted on their

sense of self-efficacy. Participants also made reference to specific skills which they found useful for themselves personally and also in how they related to others.

4.6.1 “Knowing what to do”

Participants connected acquiring skills with “*knowing what to do*”. Many participants identified empowerment, increased confidence and a sense of self-efficacy as positive by-products of learning new skills. For some, it had a profound impact on their sense of self and contributed to the transformative process of their new self-identity:

“...it just changed the way I interacted with everyone, it changed everything I did...it made me feel more powerful kind of, more in charge.” (Maria, p17)

“I feel like saying I felt more like ‘a psychologist’ but I felt more like I knew what I was saying and I didn’t have to worry about what I was saying.” (Rachel, p17)

Maria references a “*sense of mastery*” through practicing skills pointing to a sense of accomplishment and a feeling of having greater control in her life. Similarly Rachel’s analogy of feeling more like “*a psychologist*” shows how acquiring skills and knowledge increased her confidence and belief in her own ability, developing a stronger sense of self as a result.

Participants seemed to benefit from having a framework to refer to in challenging situations. In a way, this provided them with a scaffold to support them in coming to a resolution of particular difficulties. “*Knowing what to do*” seemed to bring with it a sense of relief:

“I think that was the biggest thing for me was that I kind of... it just gave me all these solutions for being in problem situations, em... kind of learning.” (Ben, p6)

“Before I wouldn’t really know like what to do if a situation came up...but now, like, with, like, my skills, I kind of know how to deal with things better...” (Ruth, p9)

“It made life easier.” (Rachel, p17)

4.6.2 Application and Integration

The application of skills to specific situations and the integration of skills to everyday life emerged as important aspects in the utilization of skills. The way in which skills were applied varied with some participants describing purposeful use of skills and others integrating skills without conscious thought:

“I don’t sit down every day and remember to use my DBT skills, but I think subconsciously it helped me.” (Rachel, p14)

“With things like self-harm, I did use the skills beforehand to avoid self-harm.” (Maria, p12)

“...the kind of emotional regulation made sure that when you’re in that conflict situation and you’re highly emotional, that you can kind of pull yourself back down and think reasonably...” (Ben, p21)

Many participants talked about the impact that having skills had on their lives in terms of wellbeing, coping, and prevention. The meaning that various skills held for participants seems quite idiographic:

“So it would help in that it teaches you skills to cope when you’re unwell, but also how to stop you from becoming more unwell.” (Maria, p13)

“A huge thing was Mindfulness... I learned just to notice those thoughts and that was a big change, like just noticing my thoughts instead of acting out on them.” (Maria, p17)

“...you’d learn from the DBT that you’re not responsible for other people’s feelings so I found that very, very helpful and that took a big weight off my shoulders.” (Rachel, p17)

Generalisation of skills from the therapy room to everyday life resonated with many participants. Ruth expressed that the more realistic she felt a skill was, the more useful she felt

it would be “...*the more realistic it [the skill] was, the way we could see how we could actually like use this in life like they were the better ones*”. Karen, on the other hand, expressed displeasure at the genericity of the examples for skill use “*All the examples used were like, ‘Oh, when I was babysitting’, and I’m kind of like, no, but, like, why can’t you say one night when I was feeling really bad and I was making a plan to kill myself, when could I apply this skill?*”

Participants gave examples from their lives of instances when they applied skills and named specific skills they found useful. The successful application of skills seemed to be dependent on the types of issues participants were experiencing. Some participants expressed clear application of skills and how applying skills helped the particular situation they found themselves in:

“The skills around interpersonal effectiveness, em... and, like, emotional regulation and stuff helped... just, it helped my home life so much.” (Ben, p20)

“...well, especially the sticking to your values part, I found that I came away from interactions feeling better about myself.” (Maria, p11)

“...not being responsible for how other people feel, I had to use it the other day in a very big way.” (Rachel, p6)

Others made broader comments about the utility of skills without specifying their application:

“...validating people’s emotions and how to... yeah, to talk to someone if they are, like, upset or distressed...that was actually very useful.” (Greg, p7)

“...like, you know if you’re asking something from your parents, like, I think they’re handy...” (Ruth, p2)

“I found surfing the wave useful...” (Rachel, p19)

Rachel expressed that while skills can be useful, the application of skills can be difficult particularly when *'in the heat of the moment or really distressed'*. Maria, on the other hand, explained how she managed skill use when distressed:

"...you kind of figure out whether you're in the right state of mind to use skills and if not, you use the tip skills like splashing your face with water..." (Maria, p6)

Maria appeared to have in-depth knowledge of the skills, what behaviours they were useful in treating and the behaviours they were not effective for, as well as preventative skill use. She gave the impression that she had experimented extensively with the skills for a variety of problem behaviours:

"It was more helpful for self-harm than vomiting, it made no impact on things like auditory hallucinations, they came and went but it did stop me making the situation worse..." (Maria, p27)

Reflection

The theme of 'Skills Acquisition' emerged with a degree of ease. Many participants spoke with clarity and conviction about how they used skills to make change. I wondered about whether to merge this theme with 'Therapeutic Components', however, it arose with such frequency and importance, I decided to make it a stand-alone theme. The development of the subordinate themes required further reflection. I felt as though the importance of skills was two-pronged; on one hand learning and integrating skills to everyday life was significant, and on another level, there seemed to be an underlying process relating to a sense of self-efficacy and mastery which I felt should remain separate.

4.7 Superordinate Theme: Internal Processes of Change

Once participants described their changed selves and new ways of being, they were invited to examine how such changes came about. Many participants used the interview setting as a forum to engage in a process of self-examination as they were encouraged to pinpoint how change was made possible. Some participants expressed a struggle with explaining how they made changes while others appeared more able to reflect on this process. While describing change

seemed like a more natural process, unpacking the ‘how’ of change posed greater challenges for many participants *“trying to pinpoint on the change is very difficult”*.

The process of reflecting how change was achieved led participants to engage in an in-depth dialogue of the factors from within themselves which they felt made change possible. They described the parts of themselves that they felt contributed to their ability to gain benefit from therapy, or indeed stopped them from gaining benefit from the intervention. This superordinate theme includes participants' attitudes and beliefs about change and recovery, and their sense of readiness and motivation to change.

4.7.1 Readiness and Belief

As participants delved deeper into their experience of change and discussed how they conceptualised their own ability to make changes, readiness and belief that change is possible emerged as significant features. The idea of readiness to make change seemed to evoke the idea of participants' willingness to take a leap of faith into recovery. Some participants talked about being in the right *“headspace”* to make changes and engage in therapeutic intervention:

“I think I was a lot better than I had ever been in my life, like coming into DBT at that point was like the best point in my life for me.” (Ben, p2)

Conversely, other participants eluded to the fact that they didn't feel ready within themselves to make changes and viewed themselves as an obstacle to making change:

“See the thing is, I don't know if I was ready or even, like, dedicated enough to implement the changes necessary to solve it, so I don't really think it was the therapy.”
(Greg p12)

“...I feel like I am the obstacle, because for everyone else, they can do it, but I'm here questioning it and not just doing it...” (Karen, p7)

Many participants spoke about themselves as being obstacles in their own recovery, pinpointing particular personality characteristics, a lack of desire to change and not feeling ready within themselves. Some participants talked about the discomfort associated with making

change and how they gravitated towards familiarity in spite of the negative consequences this held for them. Both Ben and Greg talked about readiness in this way, both speaking from different stages in their personal journey. Greg acknowledged his difficulty in making changes and how this related to his desire to stay in the comfort of sameness:

“I don’t really think I was able to or dedicated enough to keep with the changes that would help, or it’s like I’d fall into a pattern that I would become pretty comfortable with, even though it was causing a lot of problems.” (Greg, p13)

Ben, on the other hand, described his transition from the comfort of staying in a “*sad space*” to actively seeking out happiness:

“...just before DBT happened, I had kind of finally reached that place where it was like you know being happy is great and I want that and I’m going to look out and I’m gonna search for things in life that are gonna bring me there and make me feel that way.” (Ben, p4)

Ben’s use of the word “*finally*” suggests a long journey of recovery. His expression of “*searching*” for happiness suggests a type of new exploration and a new way of interacting with the world. Participants’ attitude toward unfamiliarity and novelty matched with their willingness to move outside their comfort zone appears to influence their ability to break unhealthy life cycles and ultimately make significant change.

Participants' belief in change also emerged as an important factor in the process of making desirable change:

“I believe all of it, and I believe that, like, it’s not a waste of time, like they’re [therapists] doing this to help me” (Ben, p3)

“...it’s not like going through it is going to solve all my problems so eh, I just try to make the most out of it and just thankful I was there. I don’t regret doing it.” (Greg, p11)

“I don’t really believe that anything can change, like my medication isn’t really working, they’re saying they’re hearing that but I don’t believe that...it’s either this for the rest of my life or suicide” (Karen, p17)

There is a sense of disillusionment from some participants as they talk about not expecting change to happen for them and not believing change is possible. This hopelessness about change seems to directly link to Karen’s suicidality. She appears to be resolved to the fact that her life will either stay as it is or result in suicide. Karen portrays a sense of disenchantment about the possibility of being helped by others, viewing her problems as unfixable *“in reality no one can actually fix it”*. Ben, on the other hand, speaks in an upbeat manner about his belief in therapy and his view of others as essential to recovery. Greg, like Karen, speaks to his lack of belief that his problems can be solved through the process of therapy. Participant’s belief in therapy appears to be intertwined with their belief in change which is not surprising considering that the goal of most therapies is to support a process of change and transformation.

4.7.2 Motivation

Motivation as a construct was explored in two different ways by participants. Firstly, participants explored motivation in terms of their desire to change and whether this desire remained throughout the course of treatment. In this way, participants explored the process of internal motivation. The second way in which motivation was examined was through the notion of external motivators, i.e. elements outside of themselves that motivated them to make change. Many participants discussed the impact of wanting to change versus not wanting to change, placing this on a continuum of motivation. Wanting to change was identified as a key element influencing one’s ability to change:

“...it was just that bit about not wanting to change it, it just impacted on, like, being able to change it.” (Maria, p20)

“I’m not really sure I wanted to make those kind of lifestyle changes, I was pretty used to how I was living and doing things. Yeah and even though I obviously knew my mood and health was suffering for it but kind of sticking with those things was difficult.” (Greg, p13)

Participants engaged in a dialogue around their personal experience of change and how this process produced ambivalence about change. Some participants described motivation as a fluid and fluid variable rather than a fixed construct. Through self-reflection, participants identified change as an active process, but also one that produced ambivalence:

“...throughout the programme, there were some behaviours at the start that I wanted to change and as the programme went on I didn’t want to change them.” (Maria, p19)

“I was thinking, well if she [participant’s mother] wasn’t checking would I still be self-harming so I just kind of decided okay, look, like, because I wanted to recover, obviously, but at the same time, like, I wanted to self-harm, like, it was kind of a question, like, for me annoying, so, like, I had to decide, so obviously I want to recover and stop.” (Ruth, p13)

For Ruth, parental monitoring of her behaviour (self-harming) led her to reflect on whether she wanted to continue the behaviour or engage in recovery. Making an active decision to change seemed to underlie Ruth’s motivation even though this was initially prompted by external monitoring. Participants made reference to the presence of external motivators to varying degrees, serving multiple purposes in their path of recovery:

“...the fact that I had someone else going with me also kind of forced me to go in a way...if you’ve got someone doing something with you it’s easier to just continue.” (Greg, p5)

“I was like, ‘I’m just going to do it to humour them’...it was mainly for other people that I did it, just to say that, like, yeah, I’ve done DBT, yeah, can we try something that actually works for me?” (Karen, p4)

“...he [psychiatrist] was telling my Mom to, like, check every night to see if I had new cuts, so, like, I didn’t really have much choice but to stop because of that anyway...” (Ruth p13)

Having others as external motivators was viewed both positively and negatively by participants. Some saw the support of loved ones as positive motivators. Ruth expressed

ambivalence toward the involvement of outside professionals. However, this appeared to be a stepping stone to her development of internal motivation. Karen, on the other hand, seemed to suggest that being motivated by others affected her ability to authentically engage with therapy resulting in her “*going through the motions*” without experiencing genuine relief or recovery. Some participants explained that their motivation to engage in therapy reduced as time went on, explained by the presence of ongoing mental health issues and feeling overwhelmed by the programme’s intensity:

“...the later on it went, though, I kind of found myself, like, struggling to get in but it’s like I do that with a lot of things, just anxiety related stuff, kind of, like, stick with one thing.” (Greg, p1)

“...it was just quite difficult to keep going...just a bit fed up and lacking motivation...em... it was kind of launched straight into the next thing, there was a lot of kind of feeling overwhelmed by all the information.” (Maria, p18)

“I have my OCD and it’s quite severe and at times I would have found it difficult to stay in the group or to stay there for the full two hours because my head could have been bad.” (Rachel, p8)

Participants gave the impression that engaging in therapy requires perseverance and ongoing commitment. The process of making change seems to develop in stages with levels of motivation changing at different points in the recovery process. Participant’s difficulty staying engaged in the programme is likely to be linked to their attitude and desire to change at that point in time.

Reflection

I reflected on my work as a psychologist in clinical training while developing the theme ‘Internal Processes of Change’. As I analysed the data I was reminded of clients I have worked with throughout training, particularly those who demonstrated difficulty making change. I thought about how the mental health system can react to clients who are ‘stuck’ and reminisced about clients I have seen negatively impacted by the systems response to ‘poor outcomes’. I became aware of my strong feelings to incorporate the voice of those

participants who struggled to make change and to honour their experiences of mental health services. I also felt as though this required a degree of balance and a need to intersperse the range of experiences that arose in the interviews. I was challenged by the opposing experiences of participants and spent much time reflecting on how I could capture such a wide range of experiences, from those who spoke positively about their readiness for change to those who spoke of their fear of change to those who experienced hopelessness about change.

4.8 Superordinate Theme: Therapeutic Components

The fourth superordinate theme, ‘Therapeutic Components’, focuses on elements specific to the therapy which participants commented on. Participants tended to engage in both descriptive and reflective narratives about the DBT-A programme, including how they experienced the various elements of DBT-A, specific components they found useful or not, their understanding of the purpose of particular elements and their views about how the programme was delivered. In setting this scene, participants also explored their attitude toward the intervention, how they felt about DBT in general and their expectations prior to entering the programme.

4.8.1 Attitude to Intervention

Participants' attitude toward the intervention emerged as important as they explored their views of particular therapeutic components. The pathway into the DBT-A programme varied across participants. Some participants had previous experience of DBT in an inpatient setting and others had no exposure to the approach prior to enrolling in the outpatient programme. Some participants described their enrolment as part of a process of exploration while others expressed feeling obligated to engage:

“I kind of just went to just try something different, something that was coming up and yeah, I had no goals, nothing that I specifically wanted to get out of it.” (Greg, p4)

“I said I’d give it a shot and yeah, no, it was, it was incredible, like I got so much out of it, I was so happy.” (Ben, p3)

“...it felt like I wasn’t really given a choice, it was kind of like DBT is you know the thing for people like you...there wasn’t, like, ‘If you don’t want to do that we can do this’.” (Karen, p2)

The language used by Ben and Greg in the above example suggests a degree of openness to the approach. Through his use of the phrase “*give it a shot*”, Ben gives an impression that he was open and prepared to engage with the programme. Greg’s reference to trying something different suggests a willingness to experience something new. Karen, on the other hand, embraced a less explorative stance towards the programme “*I feel like I’ve done this before and what’s the point*”. She described the impact that this had on her “*I was just really upset about it because I was, like, I don’t feel like I’m going to get anything out of this*”.

Some participants approached the programme with less direction and structured planning compared to others as exemplified in the following examples:

“I didn’t really set into the course with, like, I’m going to tackle this specific thing or I’m definitely going to make these changes.” (Greg, p11)

“I had a target hierarchy of things I wanted to work on, like self-harm, purge vomiting, that kind of stuff and, em... just suicidal thoughts and all that” (Maria, p5)

Part of participants’ attitude toward the programme related to their vision of what the intervention would mean for them. Ben talked about the meaning that DBT-A held for him as “*a sort of goodbye in a way to CAMHS since I’m almost 18*”. Ben gave the impression that he wanted to maximize his benefit of the programme as part of his plan to individuate from lengthy engagement with mental health services. Engaging in DBT-A seemed to symbolize a poignant stage in this process of individuation. As Ben spoke about this, there was a sense that DBT-A was, in a way, a finale; his last step before entering the world as an adult, no longer needing the support of mental health services to function effectively:

“I’m probably not going to get referred to adult services because, like, because of my personal choice...it was important for me to have something I think to kind of equip me to go out in the world myself, because it has been, like, four years I’ve been in counselling.” (Ben, p2)

A fit between the needs of the participant and what the programme offers emerged as important. For some participants, like Ben, who wanted a set of life skills, the overall aims of DBT-A and modules within it fit their needs:

“...the interpersonal effectiveness was very helpful for me personally because I had a lot of difficulties with my family...” (Maria, p27).

For one participant in particular, a lack of fit between DBT-A and what she felt she needed at the time was identified:

“...I was, like, ‘How is this going to help me?’, it was more like, em... practical and functional stuff and I’m kind of, like, I will function all you want but it’s my head that’s messed up.” (Karen, p10)

While the issue of fit did not seem to arise for other participants in the same way, it emerged as quite a significant feature of Karen’s interview about her experiences of DBT-A specifically and indeed engagement with mental health services more generally *“the mental health system, they are like, once you fit in here like that’s okay”*. She described how she felt perceived by professionals as *“uncooperative”* as a result of not having *“blind faith”* in the approach. In a way, Karen seemed to position herself as an outsider in her descriptions of how she engaged with the programme:

“I do believe that it’s a proven like it’s a very effective treatment...for like 90% of people and I feel like I always end up in one of those really small percentages.” (Karen, p12)

Karen’s use of *“always”* in the above example could suggest that not fitting is a familiar experience for her. There is a sense of aloneness as she pitches herself as so different from others.

4.8.2 Mode of Therapy

DBT-A consists of a variety of therapeutic modalities including individual therapy, a skills group and phone coaching. This is one of the unique features of DBT compared to traditional

therapies which tend to offer singular modes of therapy, e.g. individual therapy, separate from group therapy. In DBT, each mode of therapy is interlinked. The focus of the interview was to establish the young people's unique experiences of change and what they felt contributed to same. As part of this discussion, all participants referenced the specific modes of therapy. Some participants engaged in descriptive narratives of what they found useful about the three formats; individual, group and phone. Others delved deeper into the meaning that these components held for them and how they contributed to their personal process of change.

Individual sessions are structured in such a way as to target particular behaviours which are viewed as problematic and to encourage the generalisation of skills learned in the group to real life scenarios. Participants expressed a range of experiences of the individual therapy component of DBT-A:

"...the one on one helped a lot as well, [DBT therapist's name] kind of helped me unroot where, like, a lot of my problems are stemming from" (Ben p6)

"...a resolution to my problems would kind of be found in the individual sessions with my therapist and stuff. We just kind of talk about it and try to find a way then to overcome those problems..." (Ruth, p14)

"It was more like targeting the symptoms and not getting to the root... not looking at why do you have anxiety you know? It was just how can we stop it and, like, what can we do to prevent it?" (Karen, p13)

"I did find it beneficial to have somewhere that you can kind of just open up, because otherwise you are just keeping things locked in and you get frustrated about things..." (Rachel, p8).

As shown in the examples above, the meaning and way in which participants used individual sessions varied. Some participants viewed the individual therapy as a space to explore their issues, others used it to problem solve current issues in their lives and others described it as a core aspect in their process of change. These differences are particularly stark in the examples given by Karen and Ben. Ben references using the individual sessions to unearth his "core" issues to help him to understand that *"loneliness was causing a lot of negative actions in my*

life". Conversely, based on her experience, Karen described the individual sessions as symptom focused without looking deeper into the question of "why" she experiences psychological distress. Rachel, on the other hand, gives the impression that the individual therapy allowed for a sort of cathartic expression. Her use of the term "locked in" provokes a feeling of her being trapped by her difficulties and the benefit she got from opening up and expressing her concerns.

As previously mentioned, DBT-A is structured such that the different modes of therapy are interconnected. Some participants compared their experience of the group with their individual sessions and others expressed the importance of the connectivity between the components:

"...if you didn't have someone to go talk to about it after [the group], I think that might have been more damaging. Then you know you'd be losing something"
(Rachel, p9)

"...in the group it was just kind of learning about the skills but the individual sessions, yeah, em... that kind of helped more, because that was, like, focused on a thing, so, like, we'll say if it's self-harming.." (Ruth, p6)

In the example above, Rachel talks about the importance that the individual sessions held for her as a kind of safety net for issues that arose in the group sessions. She gave the impression that the individual sessions provided her with a sense of security. She references "losing something" as though not having the individual therapy would be a loss for her. While Rachel references the interconnectivity between the two modes of therapy, Ruth expresses a preference for the individual therapy as it provided a more personal space for her to focus on specific issues. Rachel expands on her experience of the usefulness of the individual sessions in keeping her engaged and motivated in the programme more generally " *...I thought it was very beneficial to have the one on one, it kept you on track...* ".

The aim of the group component is to teach skills in such a way as participants can role play and engage in experiential learning with each other in a group setting. A number of features of the group arose as important for participants. The value of group learning was evident to

varying degrees for participants. Some participants talked about the value of shared experience and the importance of developing safety and rapport in the group:

“...it was just kind of nice to have a place where you could voice and everyone else was understanding and, yeah, had similar experiences and all that.” (Greg, p1)

“I think it’s a really nice thing when you create this open atmosphere so that everybody feels like they’re valued and someone else can understand the stuff they are going through.” (Ben, p10)

The power of group work can be seen through this process of normalization and exposure to others sharing similar difficulties. Ben describes getting to know others through sharing their experiences of adversity as a *“unique situation”*. There is a sense from some participants that an important aspect of the group was in developing connections with others and learning from each other:

“it’s like two hours a week where you specifically kind of have to talk about the difficulties in your life like and try to get better together, I just I learned so much from people and how hard they were trying” (Ben, p10)

“we just had a good time like in learning and talking and whatever we did...it was light-hearted and enjoyable and it was just one of the few times...most of the time I would spend just, like, by myself...so actually getting up and going somewhere once a week, I know it doesn’t really sound like much, but for me it was like I guess a breath of fresh air, socially, to just go somewhere and do something so..” (Greg, p5)

As shown in the above examples, the meaning the group held was as important as the content of the group sessions. Greg’s description of the group as *“a breath of fresh air”* signifies that connecting with others seemed to bring him a sense of relief and light-heartedness. He qualifies this in his expression of it not sounding *“like much”* showing that while this could be perceived as a simple thing, for him it is profound. Many participants talked about how group cohesion developed through trust and respect of each other:

“...everyone is very vulnerable and fragile in the group...people were respectful for each other but you were still, you had your own opinions.” (Rachel, p10)

“I think [name] opened up and then I felt like I could open up and then everyone started opening up and the homework got a bit more personal.” (Ben p13)

“...just talking in front of the group I just thought that was the worst, like at the end it was okay because, like, you know you’re after getting to know each other, but at the start I hated it.” (Ruth, p7)

There is a sense that group members journeyed together, developing trust and navigating through their self-conscious feelings from beginning to end. Trust is an integral part of feeling safe to open up in the group setting. While many participants expressed their experience of the group as positive and in some cases reparative, Karen describes how her anxiety stemmed from a feeling of being misunderstood in the group:

“I had really bad anxiety as well, so kind of talking in front of people wouldn’t kind of be my thing...but it was kind of, ‘cos I could kind of see people just did not grasp what I was trying to say” (Karen, p20)

Karen describes how feeling misunderstood by others led her to “*grin and bear it*” and close off from open expression within the group. The difference in group member’s perception of the same intervention points to the individuality of this experience.

Style of facilitation emerged as another important feature of the group. Participants talked about how the delivery of the group added to the overall benefit they gained from it. Characteristics of the facilitators, the style of teaching, the creation of a pleasant environment and a balance between providing direction and allowing space are emphasised in the following examples:

“...all of them made everybody feel comfortable and open and made sure that everyone respected everyone else and just created a really nice atmosphere and without that ... em... I mean, what do you have then, you know...?” (Ben p24)

“...it was taught through, like, games and through... yeah kind of, it was very interactive...that helped us, like, open up to each other and feel more comfortable talking to each other...” (Greg, p6)

“...they would just kind of encourage you...like it depends, like, if I didn't have, like, a resolution to my problem, then they would help, which was good and then if I had, like, sorted out, then they would just move on, which was grand...” (Ruth, p6)

“...the group was very, very nice, eh.. it was a nice set up, they did it very well actually, I liked the snacks, it was kind of a distraction, em... there was a little break in between, which we were very glad to have, it was just enough” (Rachel, p9)

Facilitators seemed to have a particularly important role in the development of group cohesion. Ben describes the facilitators as *“the gel of the group”* which symbolises the importance of their role in keeping the group together and creating safety among group members.

In terms of structure, some participants mentioned the presence of their parent in the group. Participants gave mixed reviews about the utility of having their parent present:

“...the parents definitely do help, I think. Also, just... I mean, it's obviously different for some people, but I found it helped” (Greg, p11)

“It was sometimes difficult to discuss things in the group with my mother there.” (Maria, p15)

“It was hard at times, I suppose, but it was nice to know that she was getting the same knowledge as me, so at least we could kind of work on that...” (Rachel, p22)

Given participant's developmental stage and the characteristic desire for autonomy associated with adolescence, it is understandable that having a parent present would cause ambivalence. While some found it a useful support, others found it led to a degree of censorship in the group.

Other structural components discussed by participants included phone coaching. There was a general consensus that while the availability of their therapist by phone was a useful concept,

it was generally not utilised. It seemed that the idea of having this support in and of itself was enough and provided a sense of security among some participants:

“I didn’t really use the phone coaching that much. I think I just used it once, actually, but I mean it’s nice as an option.” (Greg, p3)

“I rarely used the phone consultation because I hadn’t experienced therapy like that before where you can just, like, phone someone and, em... so I didn’t really use it...I was kind of I was worried about bothering people” (Maria, p3).

“I was very shocked at the start... to be able to phone someone you know all day long and then go to this course and have one on one, I found it very helpful knowing that you could, even if I didn’t use it...I didn’t really want to bother people” (Rachel, p6)

In the above examples, participants gave the impression that talking on the phone was somewhat unfamiliar and as a result prompted feelings of self-consciousness. The idea of not wanting to burden their therapist also emerged in discussions about phone coaching. This provoked a sense of trepidation about reaching out for support. It seems that the process of reaching out was difficult for some participants.

Reflection

The various modes of therapy is a unique feature of DBT-A and one that created a curiosity in me. Prior to engaging in this research, I wondered whether or not the versatility of this therapy was the key to its success, rather than any one component within it. I was aware of my wonderings about this at the stage of conducting the interviews to analysing the data. I found that the young people’s impression of the different components were quite individual in terms of their preferences and that for the most part there was a consensus that having different forms of therapy was useful.

4.9 Superordinate theme: Toward a Better DBT

The last superordinate theme encompasses participants expression of negative elements of the programme and their suggestions for improvement based on their personal experience of DBT-A. The subordinate theme ‘Room for Improvement’ arose less frequently than other themes and is perhaps more mechanical than other themes presented. Participants tended to speak in concrete and matter of fact terms when expressing their suggestions for improvement. This subordinate theme is less connected with the research question which focuses on therapeutic change but was deemed important to include as a means of honouring the voice and opinion of the participants. Furthermore, participant’s contributions in relation to specific useful (or ineffectual) elements are considered important when evaluating the effectiveness of the intervention overall.

4.9.1 “*The elephant in the room*”

The manual for delivering the group component of DBT-A suggests that self-harm and other problematic behaviours should not be addressed in the group and should instead be targeted in the individual therapy. The aim of the group is to teach skills and provide a space for experiential learning. The rationale behind not talking about suicidality directly in the group relates to the theory of “contagion effect” whereby one person’s expression of suicidality elicits urges in another person (Miller et al., 2007) The idea, therefore, is to safeguard group members through directing them to individual therapy to discuss any aspect of their suicidality. The value and importance of self-disclosure was named by a number of participants. These participants spoke about their desire to share more and talk in greater detail about their difficulties in the group.

“...they didn’t really touch on, liken more of, like, why the teenagers were in there in the first place and, like, how the skills would help.” (Ruth, p11)

“...maybe if we discussed a little bit about ourselves at the start of the group, not giving our whole, you know, life story or whatever, or going into detail about a problem, but just a little bit.” (Maria, p9)

The examples above demonstrate participant’s desire for greater connection with each other. Perhaps this leads back to the idea of cohesion and the power of sharing.

“they [facilitators] said try not to speak about it [self-harm] because you could trigger someone else...but they’re going to hear about it anyway, so we may as well hear about it in a safe environment and like how to get over it.” (Ruth, p11)

“..I think that it would’ve been more helpful if they told us things to leave out of the group and what things were okay” (Maria, p9)

“no one mentioned the word suicide there ever or even, you know, like, killing yourself ... I felt like they were just avoiding the elephant in the room...DBT is designed for people with like BPD, eating disorders, people with like suicidal tendencies, urges, ideation and you know that’s a big deal and it was just not mentioned” (Karen, p15)

As exemplified above, many participants spoke passionately about the issue of self-disclosure. Karen, in particular, expressed a feeling of being “*censored*” by this rule in the group. The feeling of not being able to talk about important issues impacted negatively on some participants. In the examples below, Maria describes a feeling of confusion about what was acceptable in the group, which at times resulted in a reluctance to share in the group. Karen describes how this reinforced her feelings of isolation and separateness from others in the group:

“I wasn’t sure what we were able to talk about and what we weren’t...as a result, I didn’t talk as much in the groups as I ... I didn’t talk about the things I would have liked to have talked about in the group...” (Maria, p13)

“...like, no one named it and it was kind of, like, okay, maybe no one else is like that, maybe I’m just like... then the self-doubt comes in.” (Karen, p19)

Participants seemed to be affected negatively by not talking about in a direct manner about their difficulties. Ruth also talked about disclosure, adding that “*...without mentioning something, like you can’t accept it or understand it.*”

4.9.2 Room for Improvement

This theme looks at participants suggestions for change including specific elements they felt were unhelpful and additional elements they feel would be useful. Two participants noted a desire for greater flexibility in the individual sessions:

“...if something happened we didn’t just talk about it, we had to go through the chain and we had to through the behaviours and we had to go through the solutions and we had to work everything out, when maybe I hadn’t sorted it out in my head just yet.”

(Maria, p18)

“...you couldn’t talk about it only in DBT terms but I’m, like, no I need someone to talk to, I need someone to give me advice and I don’t need any DBT at the moment, everything doesn’t fit into DBT and they try to do it and it just didn’t...” (Karen, p13)

A number of participants expressed displeasure at one module in particular which focused on changing other people’s behaviour. This seemed to provoke debate in their group around the morality of attempting to train behaviours out of others:

“...changing other people’s behaviours, that topic in it. I think most people got angry with it to be honest with you, it felt unethical...” (Rachel, p25)

“...trying to control another person’s behaviour when maybe sometimes it’s more important to accept the behaviour” (Maria, p24)

Two participants made suggestions about the presentation of information, desiring more concise and accessible information on the various skills:

“I think what would be very helpful would be a little notebook, just little summaries, even if you wanted to write one yourself...the ones you found useful or else all of them in a little notebook that you can carry around with you or have with you, I thought that would be helpful.” (Rachel, p17)

“I found it easier, em... the way it was simplified in the inpatient setting and maybe for adolescents maybe it’s harder to get through all that information, I don’t know.”

(Maria, p26)

In the above example, Maria references how the simplification of information is important, based on her developmental stage. In a way, it seems like participants have a desire to carry DBT with them as a memory aid and perhaps this is symbolic of holding on to their time in the programme.

Reflection

I had some reservations about this theme as it did not directly address the research question. However, I felt that participants’ expression of elements of the therapy they did not find useful, provided important information about DBT-A. I became aware of my own feelings of frustration at the tendency for outcome research to focus on proving positive outcomes when there is such valuable information in knowing what does not work well. I was aware of my own critical bias toward providing balanced perspectives about intervention effectiveness, and my own impressions that the perfect intervention does not exist. I felt it was necessary to represent the young people who had provided information on elements of DBT-A they found created obstacles for them.

4.10 Merging quantitative and qualitative findings

Mixed method analysis requires a process of merging data from both strands of the research. The previous sections have presented the results of separate data analysis which took place for each strand, i.e. quantitative results followed by qualitative results. The quantitative data in this study represents the overarching phase of the research. The purpose of the qualitative phase is to build on the quantitative data and provide a more in-depth analysis of the phenomenon under study, in this case the underlying processes of change. Although the quantitative data represents the primary dataset, it should be noted that the collection of the quantitative data was not managed by the researcher which allowed for a deeper and more time consuming analysis of the qualitative data. The next stage of analysis involved amalgamating the results of both phases to determine the ways in which the secondary data (qualitative) support or enhance the primary data (quantitative; Creswell & Clark, 2011). The way in which the data are merged

depends on the particular mixed method design being used. Side by side comparison is a data analysis strategy for merging data and is used to visually represent how findings from two separate analyses relate to each other (Creswell & Clark, 2011). Figure 4.1 below gives a side by side comparison of how the qualitative and quantitative data relate to each other. Examples of how the qualitative data corroborated and diverged from the quantitative data are shown. The themes connected with the quantitative results included 'Then vs. Now' and 'Skills Acquisition'. Many other themes which emerged in the qualitative phase could not be directly mapped onto the quantitative findings. A more detailed examination of the ways in which the results from both strands converge and diverge will be presented in the next chapter.

Quantitative Variable	Qualitative Themes
<p><u>Depression (BDI-Y):</u> Significant reduction from beginning to end of treatment.</p>	<p><u>Theme:</u> New Self <i>“I’m not as down about it [self-harm] anymore”</i> <i>“I’m not looking for negative things, I’m not seeking that out anymore”</i></p>
<p><u>Suicidal Ideation (QSI):</u> Significant reduction from beginning to end of treatment.</p>	<p><u>Theme:</u> New Self <i>“...I haven’t had suicidal thoughts in weeks, in weeks, in weeks, I’ve just been a lot happier in myself.”</i></p>
<p><u>Hopelessness (BHS):</u> Significant reduction from beginning to end of treatment.</p>	<p><u>Theme:</u> New Self <i>“I guess I’d be more kind of willing to see like the bigger picture about things and like if like I have a bad day I know like it’s not the end of the world”</i></p>
<p><u>Self-Harm (Client Record Form):</u> Significant Reduction from beginning to end.</p>	<p><u>Theme:</u> Skills Acquisition <i>“With things like self-harm I did use the skills beforehand to avoid self-harm.”</i></p>
<p><u>Anger (STAXI):</u> Significant increase in Anger Control i.e. ability to stay calm and control angry feelings.</p> <p>No significant differences in state, trait or outward expression of anger from beginning to end of treatment.</p> <p>No significant difference in inward expression of anger.</p>	<p><u>Theme:</u> Skills Acquisition <i>“...the kind of emotional regulation made sure that when you’re in that conflict situation and you’re highly emotional that you can kind of pull yourself back down and think reasonably...”</i></p> <p><u>Theme:</u> Family Life <i>“...we’re so chilled out now, my Mum and I, it’s just better, we used to fight a lot”</i> <i>“I like tried to like stay calm...and like not like just flip out over something, get in a strop.”</i> <i>“...before I would have kind of blown up out of nothing, I wouldn’t have known how handle em I think DBT kind of gave me a lot of skills to handle that better, and to be able to like walk away and come back em accept things...”</i></p> <p>No data available on inward expression of anger for qualitative phase.</p>

Figure 4.1: A visual illustration of side by side comparison of quantitative and qualitative findings.

CHAPTER 5: DISCUSSION

5.1 Chapter Introduction

This chapter provides a detailed discussion of the main findings in the study. For the purpose of clarity, the research questions are reiterated along with a short outline of the purpose that the two different phases of the research served. In addition to the amalgamation of results from both sets of findings, the results are also presented within the context of relevant literature. The strengths and limitations of this study are acknowledged along with recommendations for clinical practice and future research. The chapter closes with a reflection on the research process.

5.2 Review of the research questions

The research to date on the efficacy of DBT-A has focussed predominantly on the use of quantitative methods investigating symptom reduction (Quinn, 2009). This research sought to combine the strengths of both qualitative and quantitative research methods to gain both a breadth and depth of understanding about the effects of DBT-A and the associated processes of change. The quantitative phase aimed to assess whether there were differences in symptoms from beginning to end of treatment, across a number of assessment tools measuring levels of depression, hopelessness, anger, suicidal ideation and frequency of self-harming behaviour. The qualitative phase aimed to delve deeper into participants' personal experience of the DBT-A programme and deconstruct the meaning of change and their perception of the processes responsible for change.

5.3 Summary of research findings

This section will provide a summary of the quantitative and qualitative research findings. The results from each phase will be integrated through a process of comparison. These results will also be examined in the context of relevant literature.

5.3.1 Participant profile

Descriptive results from the quantitative phase of this research showed that 86% of adolescents were engaging in one or more types of self-harm, pre-treatment, 63% had received comorbid diagnoses and 50% were on medication. The manifestation of self-harm during adolescence has been extensively researched and shown to be associated with depressive disorders, eating disorders, anxiety disorders, psychosis and externalizing disorders (Hawton et al., 2009; Madge et al., 2011). Hawton et al. (1999) found that adolescents engaging in repeated self-harm showed significantly higher levels of depression, hopelessness, impulsivity, and anger compared to those with a single episode of self-harm. Suicidal Ideation (SI) during adolescence has been linked with more depressive symptoms, difficult peer relationships and family disharmony when compared with adolescents not reporting SI (Reinherz Tanner, Berger, Beardslee, & Fitzmaurice, 2006). The profile of participants in the current research study are representative of the complex presentations found in self-harming adolescents more generally.

5.3.2 Symptom Reduction

The main focus of the quantitative phase of the research was to assess symptoms and ascertain whether they reduced over the course of treatment. Results of the quantitative data showed significant reductions in levels of depression using the BDI-Y from beginning to end of treatment. A significant reduction was found for hopelessness and suicidal ideation as measured by the BHS and the QSI respectively when comparing pre-treatment to post-treatment scores. Participants' hopelessness scores moved from the severe range to the moderate range. A reduction in the frequency of self-harming behaviour was also found. A significant increase in anger control as measured by the STAXI was found. The state, trait, outward and inward anger expression subscales did not reveal any significant changes from beginning to end of treatment.

Research to date on DBT-A shows promising results in terms of symptom reduction over the course of treatment. A number of studies, examining change in symptomatology pre- and post-treatment for suicidal adolescents displaying borderline traits, showed significant results (see James et al., 2008; Hjalmarsson, Haver, Perseus, Cederberg, & Ghaderi, 2008; Fleischhaker et al. 2011). Other research used quasi-experimental designs using control groups to compare treatment efficacy of DBT-A with Treatment as Usual (TAU; see Katz et al., 2004; Rathus & Miller, 2002). However, there exists a number of methodological shortcomings in the aforementioned studies, including selection bias, small sample sizes, comparability of groups

and an absence of randomised procedures. The most stringent research conducted on DBT-A relates to the only RCT which was conducted by Mehlum et al. (2014). The results indicated superior results for DBT-A compared to Enhanced Usual Care in terms of treatment retention and level of psychopathology post-treatment, although treatment intensity was found to be a partial mediator to outcome which puts into question the comparability of the two groups.

Results of the current research study are in line with the results reported in the general DBT-A literature which show promising results through the evaluation of pre- and post-treatment symptom reduction. The current research study is perhaps most comparable with the work of James, Taylor, Winmill, and Alfoadori (2008) who examined similar constructs pre- and post-treatment, using the BDI and BHS, as well as reported episodes of self-harm. However, the sample size in that study is considerably lower (n= 16) than in the present study. The present study also examines anger as a construct relating to suicidal behaviour.

5.3.3 Then vs. Now

The theme ‘Then vs. Now’ is most strongly linked with the quantitative results. This theme encompassed participants’ description of their difficulties before and after treatment. It examined ‘what’ changed in the lives of the clients from beginning to end of treatment. Participants noted reductions in levels of anger, depression and hopelessness and many described gaining a new perspective on life. An increased ability to manage intense emotional states accompanied participants’ discussion of symptom reduction. These findings support and expand on the quantitative research findings, more particularly, the significant results from the following measures: BDI-Y, BHS, STAXI (Anger Control). It is important to note, however, that this theme mapped onto the quantitative results only for those participants who expressed successfully making change in their lives. Those who did not experience change did not discuss how their life differed before and after treatment.

The meaning that reduced psychological distress held for participants was captured in the subordinate theme ‘New Self’, where many participants described that symptom reduction was accompanied by a transformation in their ways of interacting with themselves, others and the world. Higginson and Mansell (2008) conducted a similar study examining mechanisms of psychological change for individuals who had experienced recovery. One superordinate theme in this study was entitled ‘new self versus old self’, encapsulating how individuals’ perceptions

and beliefs about themselves changed as part of a process of recovery. The study focused on individuals who experienced recovery from psychological difficulties. Findings from the present study show similar results, however, only for those participants who reported change.

Quantitative results also mapped onto the subordinate theme 'Family Life', in particular results from the STAXI, i.e. increased control of anger. Participants contextualised how their increased ability to manage their anger and communicate more effectively changed their familial relationships. Anger has been established as a frequent emotional antecedent to self-harming behaviour (Chapman & Dixon-Gordon, 2007). Family dysfunction has also been established as a risk factor for self-harming behaviour in adolescents (Hawton et al., 2009; Madge et al., 2011; Wilkinson, 2011). Rathus et al. (2015) conducted a study examining the treatment acceptability of 'walking the middle path', which is the additional module in DBT-A focusing on conflict resolution in family life. Part of this study's evaluation involved the administration of open ended qualitative questions. Participants in this study reported that the skills module helped them to develop healthier familial relationships across a number of dimensions including reducing arguments at home, improving communication, increasing efficacy in managing conflict, and increasing clients' ability to see from the perspective of their loved one. The findings from the current study corroborate these findings.

5.3.4 Skills Acquisition

Symptom reduction also tapped into the second superordinate theme, 'Skill Acquisition', where many participants described their new found ability to manage their symptoms. In the subordinate theme 'Application and Integration', participants explained the process of applying and integrating skills to reduce various symptoms and problem behaviours. They referenced that the acquisition of skills supported a process of self-awareness and reflection. For some, this allowed them to pre-empt the onset of various symptoms and intervene before they intensified. This superordinate theme helps to expand and explain the 'how' of the quantitative reductions in anger, depression, and self-harm for many participants. Neacsiu, Shireen, Rizvi, and Linehan (2010) found that DBT skills use mediated a decrease in suicide attempts and depression and an increase in control of anger over time. However, this was conducted with an adult population receiving standard DBT. Nevertheless, the qualitative results in this research supports the idea that skills utilization can act as a mediator within the process of change. Other studies examining the utilization of DBT skills indicate positive correlations

between skills use and reduction in symptoms related to BPD in the adult population (see Lindenboim, Comtois, & Linehan, 2007; Stepp, Epler, Jahng, & Trull, 2008).

The subordinate theme “*knowing what to do*” also helps to explain how symptom reduction was achieved and in this way contextualises the quantitative results. Many participants talked about how having skills and “*solutions*” made them feel more in control of their lives and increased their sense of self-efficacy. Acquiring skills and developing a sense of mastery over their lives emerged as an important feature in the process of change. This is reminiscent of Grawe’s (1997) model of change which proposes four overall mechanisms responsible for therapeutic change. The first of these mechanisms is mastery and learning to cope with difficult situations (Mander et al., 2013). The experiential avoidance model proposes that self-harm results from an avoidance of unwanted emotion matched with an absence of appropriate skills to manage distress and regulate emotion (Chapman et al., 2006). Brausch and Girresch (2012) note that self-harm can be understood as resulting from a mixture of poor coping and reduced skills in problem-solving. Reisner (2005) proposes that therapists helping clients to attribute their improvement to themselves in order to enhance their sense of self-efficacy can support the process of therapeutic change. In DBT-A, emphasis is placed on the teaching of skills and a central role for DBT-A therapists is to support their clients to actively utilise skills and encourage their effort at attempting to develop a better quality of life. Results from the current study isolates skills acquisition as a core therapeutic component in the process of ameliorating negative symptoms and supporting the process of change.

5.3.5 Internal Processes of Change

The superordinate theme ‘Internal Processes of Change’ could not be mapped onto or directly related to the quantitative results. This is most likely because, at this stage in the interview, participants started to move from a descriptive stance to deeper reflections of ‘how’ change came about. In this way, these qualitative results add new and valuable insights to the quantitative findings. As participants described their experiences of change or indeed obstacles which prevented them in making change, they reflected on internal processes which enhanced their ability to make change.

The subordinate themes ‘Readiness and Belief’ and ‘Motivation’ emerged as important precursors to participants’ engagement in a process of change. Carey et al. (2007) investigated

processes of change qualitatively in a sample of adults engaging in a variety of treatment programmes. In their study, readiness and motivation incorporated the idea of ‘hitting rock bottom’, a realisation that avoiding the problem was not going to solve it and a determination to tackle the issue (Carey et al., 2007). In the present study, the idea of ‘hitting rock bottom’ emerged as significant for just one participant. This is most likely explained by participants’ age and the likelihood that their symptoms of psychopathology are, at least comparatively speaking, not as longstanding as would be expected in the adult population. Instead, in the present study, readiness represented participants’ willingness to face their issues and make active decisions to move out of the comfort of a “*sad space*” and into a more fulfilling life. This idea of willingness to change emerges in the model of change developed by Hanna (2002) which views therapeutic change as hinging on seven precursors, namely hope, awareness, a sense of necessity to change, the willingness to experience anxiety or difficulty, confronting issues, the exertion of will or effort, and the presence of social support. The finding in the present study relating to belief that change is possible also maps onto the ‘hope’ precursor in the aforementioned model.

These results show that the ability to gain benefit goes beyond the techniques employed as part of this intervention; for some, it is also determined by internal/psychological factors including, readiness to engage, attitude toward therapy, belief about change, and the acknowledgement that recovery is difficult. While these internal processes were identified as being important, specific elements of the intervention were also isolated as contributing to change. It is possible that the process of change involves a complex interplay of both therapy and non-therapy related factors.

5.3.6 Therapeutic Components

The superordinate theme ‘Therapeutic Components’ encapsulates participants’ attitudes towards DBT-A and their impression of the various modes of therapy. Participants delineated a number of potential mechanisms within DBT-A which could contribute to the reduction in symptoms detected in the quantitative phase of the study.

The subordinate theme ‘Attitude toward Intervention’ encompassed therapeutic fit, attitude toward DBT-A, and openness to engaging with the programme. These emerged as important factors which impacted either positively or negatively on participants’ engagement. This

subordinate theme could not be mapped onto the quantitative findings. There has been a concerted effort to identify particular populations for which DBT-A is effective in treating and this is represented by the evaluation of DBT-A across a range of settings and a variety of diagnostic profiles (see Nelson-Gray et al., 2006; Goldstein, Axelson, Birmaher, & Brent 2007; Fischer and Peterson, 2015). However, there is a dearth of research examining populations or particular characteristics of a disorder that DBT-A is less effective in treating. For some participants in this study there was a high level of treatment acceptability and for others the approach seemed less effective. Research examining the differences between presentations DBT-A is effective in treating versus those whose needs the treatment does not meet requires further investigation.

The second subordinate theme, 'Mode of Therapy' encompasses participants' impressions of the different types of therapy offered by DBT-A, i.e. skills training group, phone consultation and individual therapy. Some research exists examining the effectiveness of skills training as a stand-alone treatment in the adolescent population and preliminary findings show positive results (see Uliaszek et al., 2014; Nelson-Gray et al., 2006). The use of group skills training as a stand-alone treatment has been more comprehensively studied in the adult population. Results, in the main, are promising (see Valentine et al., 2014; Soler et al., 2009). On the other hand, Andion et al. (2012), compared standard DBT with individual DBT sessions only, and found no significant difference between groups, suggesting that individual sessions are sufficient to show improvement in symptoms.

It is unclear whether one mode of DBT therapy is superior to another, or whether an interplay of individual, phone and group modes of therapy are responsible for outcomes. In this research, participants varied in terms of their preference for different modes of therapy, although there was a general consensus on the need for the individual therapy among those who experienced change. Variability was found in the way participants used the individual sessions, with some using the individual therapy as a supportive forum to talk about their difficulties, others using it as a means of generalising skills and others using this space to unearth the core of their issues. The way in which the programme was delivered and facilitators' style were also deemed important by many participants. Participants considered the group component in terms of group processes, shared experience and group learning. Burlingame, Fuhriman, and Johnson (2001) outline six principles underlying the development of cohesion in a group, namely, pre-group preparation, early group structure, leader interaction, feedback, leader modelling and member

emotional expression. The first two principles relate to the pre-treatment phase in DBT-A, which aims to prepare clients for their engagement with the programme. In this research, however, participants did not mention the pre-treatment phase in their interviews. Participants did discuss the usefulness of emotional expression by members and facilitator style as important factors in the group component.

5.3.7 Toward a Better DBT

The superordinate theme ‘Toward a Better DBT’ relates to intervention development. The Participant Satisfaction Questionnaire is administered to participants following their completion of DBT-A and was used in this research to familiarise the researcher with aspects of DBT-A participants tended to find useful or not and inform the interview schedule. While this questionnaire includes open ended questions relating to helpful and unhelpful elements of DBT-A, the semi-structured interview provided a space for participants to explore their experiences in greater depth. In this way, participants could move beyond simply naming aspects they found unhelpful, and explain why this was the case as well as expressing the impact that identified negative elements had on them.

The subordinate theme “*the elephant in the room*” relates specifically to participants’ desire for increased self-disclosure in the skills training group. The DBT-A group component is considered a skills training group as opposed to a psychotherapeutic process group. However, the natural occurrence of group cohesion and bonds developing between group members left participants with a greater desire for increased connection to others and a desire for suicidal behaviour to be directly named and addressed in the group. There is a paucity of research examining the processes underlying the various therapeutic components of DBT-A. While some research exists examining the effectiveness of the skills training group, there is an absence of literature examining important group processes. Burlingame et al. (2006) note that emotional expression by group members is considered an important aspect of group cohesion and this principle is supported in the current research study. The subordinate theme ‘Room for Improvement’ encompasses participants’ suggestions for improvement based on their experience in the programme, including greater flexibility in individual sessions and more concise DBT materials. These will be referenced in greater detail in section on implications for clinical practice (5.6).

5.4 Limitations of the study

This study used a pre-test post-test measurement design to examine change in symptoms over time. There was no control group in this study, making it difficult to confirm that differences can be attributed to treatment. Having a control group allows for the manipulation of one group over another with a similar population, thus allowing for more valid claims to be made about the effectiveness of a treatment group (Howitt & Cramer, 2014). Given the time constraints of this research, the researcher also did not have access to a third follow up time point which assesses stability of change over time. Given that this study is not a RCT, it cannot be said with 100% certainty that the intervention *caused* any of the changes observed. However, the qualitative phase of the research attests to the fact that many participants experienced improvement as a result of the DBT intervention, which adds weight to the quantitative findings, despite the lack of control group.

A limitation in the study relates to sample size. Using IPA requires in-depth procedures of analysis and emphasises the idiographic nature of human experience. Therefore, a sample size of six is considered generally sufficient when using IPA. However, the interviews appeared to capture a wide spectrum of responses about the experience of change. While there were some obvious links across the entire dataset, there were also a number of divergences in participant responses. While some divergences represented opposite sides of the same construct, others remained in isolation, impacting on the possible representativeness of those results. Another limitation which perhaps relates to the issue of the qualitative sample size was that participants were signed up to take part in the National DBT Project as part of their enrolment in DBT-A. This meant that participants were asked to complete a large battery of measures at the beginning and end of the programme. This prior commitment to research participation may have affected participants' desire to opt in to any further research endeavours. Participants were also selected on an opt-in basis which arguably could produce a degree of social desirability, although this did not appear to be a major issue in the current research.

Participants' engagement with the National DBT Project could be considered both a strength and limitation in the study. Firstly, the presence of the National DBT Project meant that the researcher had access to a relatively large volume of data which had already been collected. Given the time constraints for completion of this research, this made the use of mixed methods possible in a practical way. On the other hand, in order not to over-burden participants, it was

not possible to add any supplemental questionnaires, which meant that the researcher did not have control over the choice of the assessment measures used.

A further limitation relates to the self-report measures used in the study, which are limited by factors such as distortion in self-perception and demand characteristics (Kleim et al., 2010). The researcher in this study took a conservative approach and, as a result, a decision was made to exclude measures used by the National DBT Project which were either unstandardized or not normed against the adolescent population (with the exception of the QSI). This resulted in the exclusion of data which may have provided further information on the symptomatology of this group. The sample size for the quantitative phase was also relatively small, with 37 participants at time one (pre-treatment) and 30 at time two (post-treatment). Small sample sizes increase the likelihood of Type I and Type II errors in the results, particularly in a convenience sample, and therefore, the results in this study should be interpreted with this in mind (Field, 2009).

Another limitation in this study is that participants were enrolled in different DBT-A programmes across the country. Concerted efforts are made by the developers of DBT to deliver a streamlined intervention of DBT-A. All professionals receive the same training and detailed manuals are made available for treatment delivery. Facilitators are also provided with access to supervision with external DBT trainers. Despite these efforts to maintain stringency in the delivery of the approach, there is a possibility that the results are confounded by virtue of the different clusters from which the sample was gathered. One way to address this is to increase sample size. However, this was not possible in this research as the sample was purposive and represents a full population of participants in DBT-A in Ireland.

5.5 Strengths of the study

This research possesses a number of key strengths, one of which relates to sample. The sample used in this research represents all of the young people enrolled in DBT-A nationally in 2015. In this way, the research captured a full population of participants in an Irish context which has important implications for comparisons of DBT-A in other countries. The sample used in this research also represents a particularly vulnerable and at-risk population in a number of ways. A large portion of the sample had received at least one co-morbid diagnosis, highlighting the complexity of this client group. Adolescence, in general, as a developmental stage is associated

with an increased desire for autonomy, experimentation and a greater likelihood of engaging in risky behaviours (Oldershaw et al., 2009). Therefore, adolescence in and of itself represents a vulnerable stage of development with increased risk for the development of problematic behaviours and psychopathology (Murray & Wright, 2006). This developmental vulnerability matched with the complexity of this client groups' presentation points to a particularly hard to reach group. As a result of this, particular care was taken in the development of ethical precautions to safeguard the participants from any further distress. This was also considered when developing the interview schedule and during the course of the interviews. The researcher maintained a reflective stance with participants, made particular efforts to build rapport and develop safety and a level of comfort with each participant prior to the interview. Due consideration with relation to probing was also given so as to ensure that probing related only to what participants had started to discuss themselves.

The use of an in-depth type of analysis (IPA) for the qualitative phase of the research is also considered a strength. This type of analysis, though quite detailed and time-consuming, allowed for an in-depth analysis of participants' experiences. It gave the researcher flexibility in the development of the interview schedule, framing broad questions and allowing the participant space to create a narrative of their experiences of DBT-A. The focus that IPA places on the idiographic experience of the participant gave the researcher scope to make sense of each individual's story before DBT, their pathway into it and their journey through the programme. This approach fit with the research question and this is demonstrated in the depth of the findings and the variation in the perspectives of the young people across interviews.

Another strength of this research is the use of mixed methods which allowed the researcher to examine the phenomenon of change comprehensively, utilising the strengths of both methodologies. Using quantitative methods allowed for the collation of a larger amount of data, incorporating all individuals who had engaged in DBT-A nationally for 2015. It made the quantification of a complex array of symptomatology related to suicidal behaviour possible. It allowed for the testing of hypotheses and added to the existing body of literature which examines important psychological constructs related to suicidal behaviour in adolescents. The quantitative results also gave a snapshot of the levels of distress and the extremity of symptoms experienced by the young people before engaging in DBT-A. They provided a profile of the type of presentation which tended to be referred for DBT-A, namely, co-morbid multi-problem presentations, young people who had extensive engagement with services prior to engagement

in DBT and those at the upper end of psychological distress. This is important when considering factors such as capacity to change and likelihood of experiencing change.

The qualitative phase, on the other hand, heard from the participants about their individual journey before engaging in DBT, the intricacies of their experience of change and the essential constituents and ingredients which made change possible for them. The qualitative findings helped to contextualise the quantitative results through participants' discussion of their problems before DBT-A and the impact that a reduction of symptoms had on their wellbeing. The qualitative results also expanded on the quantitative results, highlighting important aspects of the underlying idiographic process of change which was not captured in the quantitative data.

It has previously been highlighted that an advantage of using mixed methods is that it can detect contradictions between results of qualitative and quantitative analysis. By using both approaches, there is a greater possibility of developing a more comprehensive and in depth understanding of a research problem. The results of this research has shown that important elements related to investigating effectiveness were detected in the results of both methods employed. However, while there was some overlap, a number of differences arose across the results. For example, quantitative results yielded important factors influencing improvement, a reduction in self-harm, a reduction in suicidal thoughts, a reduction in depressive symptoms and anger. Some, but not all, participants interviewed corroborated these findings. This shows that the avenue through which change occurs is a highly idiographic experience.

This research not only adds to the literature on DBT-A but also adds to the literature on therapeutic change. Previous research suggests that there are commonalities in the process of change across all therapeutic approaches. This research has attempted to separate factors influencing change which can be attributed specifically to the therapy, e.g. techniques, models, those factors which relate to therapy generally and factors completely distinct from therapy which influence change, e.g. intrinsic motivation and readiness. The superordinate theme 'internal processes of change' tapped into the idea of how each young person managed to make desired change and what got in the way of making change. Overall, this emerged as a complex interplay between core factors within the self and external factors which included specific elements of therapy and other factors surrounding general life circumstances.

5.6 Implications for clinical practice

Recommendations for clinical practice are based on the young people's expression of aspects of the programme they did not find useful and various suggestions for improvement they made. Some participants expressed a desire for greater disclosure and to address suicidal behaviour directly in the group. This is an important consideration given the negative impact some participants expressed due to a feeling of being censored in the group by not being able to talk directly about their issues. While DBT-A has a clear rationale for not directly addressing suicidal behaviour in the group, it is nonetheless an important finding that some participants did not find this useful. In the future delivery of DBT-A, perhaps this is something that clinicians could remain cognisant of when delivering the group intervention and feeding back their view of this to those responsible for the overall delivery of DBT-A.

Readiness and motivation also emerged as important pre-requisites to successful therapeutic engagement and making change. The pre-treatment stage of DBT-A involves preparing the client for the programme, providing information on what to expect from the programme and familiarising the client with their individual DBT therapist. The purpose of this stage is, at least in part, to enhance motivation to attend the programme. Perhaps a greater emphasis on clinicians' objective assessment of the client's readiness to engage in an intervention which is designed to target behaviour change is needed. This also points to the theme relating to therapeutic fit between the client and the approach. While many clients will present with similar clusters of symptoms, factors influencing clients' ability to gain benefit can vary. This is something to be considered in the pre-treatment phase of DBT-A and may impact on the assessment of suitability and selection of participants for the programme.

The speed of technological advances experienced by this generations' adolescents, and their subsequent familiarity with various forms of communication via applications and social media sites, opens the possibility for development of new and innovative ways to disseminate therapeutic aids. The development of a DBT application for smart phones is proposed as a useful way for adolescents to access information on skills via their device. The finding relating to phone consultation also relates to this point. Adolescents expressed apprehension at phoning their therapist out of fear of being a burden and self-conscious feelings regarding talking on the phone. Perhaps part of this issue can be explained by adolescents' greater familiarity with written and visual forms of communication, such as text messages and picture messaging.

Another recommendation is to develop a means of communicating that the adolescent is comfortable with, such as texting rather than phoning, although this would need to be managed with caution, with clear instructions of how this would work.

There is evidence to suggest that individuals with a diagnosis of BPD can be viewed as a problematic client group in adult mental health services. Given that DBT-A has been developed for adolescents with emerging traits of BPD, it is possible that this subgroup could be perceived in a similar vein. It is therefore of even greater importance to access the experiences of this group in a transparent and direct way. It is recommended that a space is made available for the young people to voice how they are finding the programme while they are still engaged in it. Providing a structured space for the young people to express their experience in the midst of their enrolment could help to address any difficulties with the programme early on and thus give an opportunity for such issues to be addressed and resolved, it could aid a process of clarification and empower the young people to feel that their experience of the programme is valuable and useful in its overall evaluation.

5.7 Recommendations for future research

There is a noticeable dearth of qualitative research on DBT-A. The role out of DBT-A in Ireland is in its infancy, with 2015 representing the second year of delivery of the programme nationally for some teams and the first year of delivery for other teams. The popularity of the approach is growing and its roll-out is gaining momentum in Ireland; it is thus imperative that the effectiveness of DBT-A continues to be explored. There is a need for more RCTs using control groups with comparable treatment intensity, using homogenous samples and which assess functioning over the long-term.

It is of equal importance to incorporate the client's voice in the evaluation of DBT-A in Ireland, through qualitative interviews. There has been a predominant focus on quantitative methods to investigate DBT-A, which is evident in the literature on DBT-A more generally. It is unclear why this is the case. It is possible that quantitative methods have been given precedent because DBT-A as an approach is relatively new, leading to a focus on creating an evidence base where the use of larger pools of data are considered more powerful. This is understandable given that 'gold standard' treatments tend to have a strong quantitative research base, including multiple RCTs, to prove their effectiveness. It is also conceivable that an effort to garner the support of

various stakeholders and national funding bodies has driven the development of a strong quantitative research base.

While attempting to fill the gap in qualitative research in this area, this research examined one group's perspective, i.e. adolescents. The views and experiences of clinicians who are involved in rolling-out the programme would be considered useful, particularly since DBT-A is an adapted version of the adult DBT programme. Clinicians' insights into components which are deemed useful in working with this cohort, along with any issues in rolling-out the programme, would add to the literature. As mentioned, the adaptations in DBT-A compared to traditional DBT require further examination both quantitatively and qualitatively. The findings from the qualitative phase in this research, while not generalizable in the same way as the quantitative results, have provided important information on elements of the programme considered particularly useful for adolescents, e.g. conflict resolution and interpersonal effectiveness. Skills which tap into developing more effective communication, resolving conflict and effectively getting one's needs met, are likely to be particularly applicable to the adolescent population. This research has shown that using skills to strengthen familial relationships and reduce disharmony in the home were important for adolescents. Further examination of the modules which are particularly applicable to the lives of adolescents would be useful.

The issue of 'intervention acceptability' arose as important in this research. Future research should look at how DBT-A could be made more acceptable for this population of adolescents in an Irish context, while still attempting to maintain implementation fidelity to the DBT intervention as laid out in the protocol. Further examination on participants who dropped out of the programme would also be useful.

Another possible avenue for further investigation is to gain the perspective of the parents/caregivers who attend DBT-A with their child. This is a unique element of DBT-A and one that has the potential to offer rich information on the efficacy of the programme. Many young people in this study referenced changes in 'Family Life' and this represented an important theme in the qualitative findings. Conducting interviews or focus groups with parents would be valuable in a number of ways. Firstly, it would add another perspective to how the adolescents engaged with the programme and factors which influenced their ability to make change or not. Parents could offer an objective view of the adolescent's process of change. Furthermore, parents are active participants in the skills training group and learn skills in

tandem with their child. This is quite a unique feature of DBT-A and requires further investigation in terms of the parent/caregivers personal experience of DBT-A and in relating this to how the programme impacted on their child.

This qualitative phase of this study unlocked another layer of important information about DBT-A. This study has attempted to understand the intricacies of therapeutic change for people attending DBT-A. Further research is needed to address particular mechanisms which contribute to therapeutic change. This requires further examination of specific DBT-A ‘ingredients’ of success, client characteristics which influence therapeutic change and external factors which effect change. The examination of change in this layered way can direct therapeutic components such as content, format and delivery, enhance appropriate allocation to treatment, and help to develop and deliver optimal treatment programmes which best meet the client’s needs (Kroner & Yessine, 2013; Kazdin & Nock, 2003; Trompetter et al., 2015)

5.8 Conclusion

The current research has examined the effectiveness of DBT for adolescents using mixed methods. Research exploring DBT-A is in the early stages of development and this research contributes to the preliminary positive findings in the literature in this area. The results are set in an Irish context using a whole population of participants making the findings comparable at an international level. This study has addressed an outstanding gap in the literature through its use of mixed methods to evaluate effectiveness, whereby quantitative results have provided a broad overview of symptom reduction and qualitative findings have helped to explain the underlying components responsible for the amelioration of symptoms. The qualitative findings demonstrated that the effectiveness of DBT-A involves an interplay of factors, both therapy related and non-therapy related. It has provided important information about the impact of internal idiographic processes such as readiness and motivation on response to treatment. These results also highlighted particular therapeutic components which were deemed useful and represents a step towards isolating DBT-A’s ‘ingredients’ for success.

In essence, this study has evaluated outcomes as well as underlying processes responsible for outcomes, which has important implications for ongoing clinical practice and the future development of DBT-A. The results from this research have highlighted that both qualitative and quantitative methods provide important yet different dimensions of DBT-A’s effectiveness, and given a voice to young people engaged in DBT-A, which up to this point has

been absent from the literature. In conclusion, continued exploration of the approach is necessary and recommendations for future research have been outlined, however, the current study represents an important step in the advancement of research in DBT-A through its comprehensive and novel examination of intervention effectiveness.

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APPENDICES

Appendix A: Information sheets, consent forms for parents and young people and opt in form.



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

PARTICIPANT INFORMATION LEAFLET

(please retain for your own records)

You are being invited to participate in a research study which will explore adolescent's experiences of the DBT programme for adolescents. This information leaflet provides detailed information about the research study and what your participation in the research will involve. Please take as much time as you need to think about whether you would like to participate in this study. Once you feel that you understand what is being asked of you and have decided to participate, you will be asked to sign a consent form. As you are under 18 years of age we also need your parent/ guardian to sign a consent form to allow your participation in the study.

WHAT IS THE PURPOSE OF THE STUDY?

The aim of the study is to explore how change is experienced as a result of engaging in the DBT programme for adolescents. We would like to explore with you your personal experience of change, what this means for you and what parts of the DBT programme you feel contributed to this change.

WHY HAVE I BEEN CHOSEN?

You have been selected because you have recently completed a DBT programme and for this reason you are suitable to take part in this study.

WHAT WILL HAPPEN IF I VOLUNTEER?

If you decide to take part in this study, there will be a few things to keep in mind. Firstly you and your parent/guardian will be asked to complete a **consent form** which is attached. This consent form will have two parts. The first part will ask you to consent to the researcher accessing some questionnaires you answered as part of the National DBT project. The second part will ask you whether you consent to coming into the clinic to meet with the researcher and complete a 50-60 minute interview. This interview will involve an exploration of your experiences of the DBT programme that you have recently completed. Should you decide to participate and sign the consent form, a suitable time to meet for the interview will be arranged between you and the researcher.

WHAT ARE THE BENEFITS OF PARTICIPATING?

By participating in the study you will be providing important information about your personal experience of the parts of the DBT programme you feel have contributed to change. By participating in this study, it is hoped that this will help to increase our understanding of how change occurs for adolescents who engage in a DBT programme. You will be providing important information about the effectiveness and benefits of the DBT programme in Ireland. Participation will also give you an opportunity to provide feedback on your experiences of the programme.

ARE THERE ANY RISKS INVOLVED?

The risks involved are minimal. However, it is possible that the questions may be stressful for you. Some participants may experience increased emotional discomfort as they recall their engagement with the DBT programme. You are not under any obligation to answer all questions in the interview. Should you feel distressed by any of the questions asked you discuss this with the researcher or with a member of the DBT team.

WILL MY PARTICIPATION BE CONFIDENTIAL?

All of the information that will be collected about you in the interview will be kept strictly confidential. The information will be collected and kept anonymously so that your identity is protected. Your name or other identifiable information will not be reported in the research. However, there are some limits to confidentiality. If the researcher thinks that you may be at risk to yourself or others, they will be responsible to report this to your therapist or other relevant people (GP or parents). Should this occur, we will discuss this together.

WHAT WILL HAPPEN IF I DO NOT TAKE PART?

Participation in this study is completely voluntary and you are free to decide whether you would like to participate not. If you do decide to take part and change your mind you can opt out at any stage. If you change your mind during the interview you are also free to discontinue. Not participating will not affect your right to treatment in any way. You have a right to make this decision at any stage without giving a reason.

CONTACT DETAILS

If you have any further queries please do not hesitate to contact me at the details below:

Sarah Hardiman (Researcher)
Psychologist in Clinical Training

Chief Investigator: Dr Patrick Ryan, Director of Clinical Psychology, Department of Psychology, University of Limerick, Limerick.



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

PARENT INFORMATION LEAFLET

(please retain for your own records)

Your child is being invited to participate in a research study which will explore adolescent's experiences of the DBT programme for adolescents. This information leaflet provides detailed information about the research study and what your child's participation in the research will involve. Please take as much time as you need to think about whether you would like to participate in this study. Once you feel that you understand what is being asked of you and your child and have decided to participate, you will be asked to sign a consent form to grant consent for your child's participation.

WHAT IS THE PURPOSE OF THE STUDY?

The aim of the study is to explore how change is experienced as a result of engaging in the DBT programme for adolescents. We would like to explore with your child their personal experience of change, what this means for them and what parts of the DBT programme they feel contributed to this change.

WHY HAS MY CHILD BEEN CHOSEN?

Your child has been selected because they have recently completed a DBT programme and for this reason are suitable to take part in this study.

WHAT WILL MY CHILD BE ASKED TO DO?

If you decide to consent to your child's participation in this study, there will be a few things to keep in mind. Firstly you and your child will be asked to complete a **consent form** which is attached. This consent form will have two parts. The first part will ask you to consent to the researcher accessing some questionnaires your child answered as part of the National DBT project. The second part will ask you whether you consent to your child coming into the clinic to meet with the researcher and complete a 50-60 minute interview. This interview will involve an exploration of your child's experiences of the DBT programme that they have recently completed. Should you decide to consent to this participation and sign the consent form, a suitable time to meet for the interview will be arranged between your child and the researcher.

WHAT ARE THE BENEFITS OF PARTICIPATING?

By participating in the study your child will be providing important information about their personal experience of the parts of the DBT programme they feel have contributed to change. By participating in this study, it is hoped that this will help to increase our understanding of how change occurs for adolescents who engage in a DBT programme. Your child will be providing important information about the effectiveness and benefits of the DBT programme

in Ireland. Participation will also give your child an opportunity to provide feedback on their experiences of the programme.

ARE THERE ANY RISKS INVOLVED?

The risks involved are minimal. However, it is possible that the questions may be stressful for your child. Some participants may experience increased emotional discomfort as they recall their engagement with the DBT programme. Your child is not under any obligation to answer all questions in the interviews. Should your child feel distressed by any of the questions asked they can discuss this with the researcher or with a member of the DBT team.

WILL MY CHILD'S PARTICIPATION BE CONFIDENTIAL?

All of the information that will be collected about your child in the interview will be kept strictly confidential. The information will be collected and kept anonymously so that all identities are protected. Your child's name or other identifiable information will not be reported in the research. However, there are some limits to confidentiality. If the researcher thinks that your child may be at risk to yourself or others, they will first inform you as their parent as well as your child's clinician. Your GP may also be informed should this be deemed warranted. Should this occur, it will first be discussed with your child and then with all other relevant parties (parents, clinician and GP).

WHAT WILL HAPPEN IF I DO NOT CONSENT TO PARTICIPATION?

Participation in this study is completely voluntary and you are free to decide whether you would like your child to participate not. You do not have to consent to your child's participation in the study. If you decide not to consent to your child taking part or change your mind you can opt out at any stage. If your child changes their mind during the interview you are free to discontinue. Not participating will not affect you or your child's right to treatment in any way. You have a right to make this decision at any stage without giving a reason.

CONTACT DETAILS

If you have any further queries please do not hesitate to contact me at the details below:

Sarah Hardiman (Researcher)
Psychologist in Clinical Training

Chief Investigator: Dr Patrick Ryan, Director of Clinical Psychology, Department of Psychology, University of Limerick, Limerick.



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

AGREEMENT TO CONSENT (ADOLESCENT)

Research Study: *Evaluating the mechanisms of change of Dialectical Behaviour Therapy*

- The research study and what my participation entails have been fully explained to me
- I have had the opportunity to ask questions concerning any and all aspects of the research study and any procedures involved
- I am aware that participation is voluntary and that if I decide not to participate, or if I want to withdraw from the study, I may do so at any time. I understand that this decision will not affect my right to treatment in any way
- I am aware that the information that is collected during the study will remain confidential as appropriate
- If I decide to withdraw from the study, I understand that the information collected about me for this research study will be stored confidentially unless I specifically request that it be destroyed
- I have received a copy of the information leaflet for myself
- I am aware that information collected as part of the National DBT project will be accessed as part of this study
- I understand that if I have any questions about this research, I can discuss this with my clinician who will link with the research team on my behalf as required



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

AGREEMENT TO CONSENT (PARENT/ GUARDIAN)

Research Study: *Evaluating the mechanisms of change of Dialectical Behaviour Therapy*

- The research study and what me and my child's participation entails have been fully explained to me
- I have had the opportunity to ask questions concerning any and all aspects of the research study and any procedures involved
- I am aware that participation is voluntary and that if I decide not to participate, or if I want to withdraw from the study, I may do so at any time. I understand that this decision will not affect my child's right to treatment in any way
- I am aware that the information that is collected during the research study will remain confidential as appropriate
- If I decide to withdraw from the study, I understand that the information collected about me for this research study will be stored confidentially unless I specifically request that it be destroyed
- I have received a copy of the information leaflet for myself
- I am aware that information collected from my child as part of the National DBT project will be accessed as part of this study
- I understand that if I have any questions about this research, I can discuss this with my child's clinician who will link with the research team on my behalf as required

ADOLESCENT

I consent to participate in this research study:

Participant Name: _____

Participant Signature: _____

Do you consent to your participation in the study? Yes ____ No ____

Do you consent to information collected as part of the National DBT project (more specifically the Participant Satisfaction Questionnaire, the Beck Youth Inventory, the Beck Hopelessness Scale, the State Trait Anger Expression Inventory and the DBT client record form), be accessed by co-investigator (Sarah Hardiman) as part of this study? Yes ____ No ____

Date: _____

PARENT/GUARDIAN

I consent to my child's participation in this research study:

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Do you consent to your child's participation in the study? Yes ____ No ____

Do you consent to information collected from your child as part of the National DBT project (more specifically the Participant Satisfaction Questionnaire, the Beck Youth Inventory, the Beck Hopelessness Scale, the State Trait Anger Expression Inventory and the DBT client record form), be accessed by co-investigator (Sarah Hardiman) as part of this study? Yes ____ No ____

Date: _____

Witness Signature (Clinician/ Researcher): _____

Date: _____

Appendix B: Extracts of memos from research journal.

Memo Box 1: Extract from Interview 4 memos

22/06/2015

The client made a concerning statement expressing suicidality during the interview ‘I want to kill myself and I still do that has not changed throughout the whole thing’ (p13, Interview 4). Initially, I quickly thought about my professional responsibility and limits to confidentiality and the risk this posed considering I did not work therapeutically with this individual. I was relieved that I had worked with suicidal individuals before in my clinical work and felt able to manage this during the session. However I also felt slightly anxious about stepping out of my role as researcher and did not want my ‘clinical hat’ to take over the way I managed the interview. I felt the best way to manage this was to listen and provide space for her to elaborate. I had explained the limits to confidentiality at the beginning of the session and got a sense from this young person that she had substantial experiences of the mental health services, including inpatient admission. I got a sense that this was an ongoing issue for her. She also spoke about her attitude toward professionals and how she felt they were overly concerned with risk and keeping her alive and not enough about what was really going on for her. I became conscious of my position as a researcher and a as professional and I did not want to react to her in such a way as to reinforce this experience. I did, nonetheless, need to engage in a conversation with her about my responsibility to ensure her safety and speak to her clinician about this. She consented without issue and the interview continued without difficulty. All the same, I was left wondering what this was like for her.

Memo Box 2: Extract from Interview 1 memo

17/12/2015

In analysing the interview I am remembering being in the room with this participant and feeling at the time that there was a lot unsaid for this participant. In developing the initial codes, I can see that as the interview unfolds so too does Ruth’s ability to elaborate. I am seeing my attempts to build rapport and create safety during the interview that will allow her to open up about her experiences. At one point I repeated back what Ruth had said ‘dealing with things better, ok ok’ which prompted further discussion on the topic. I wonder, however, without subtle prompts such as these, whether the interview would have continued to flow. I am struck by the need to scaffold some individuals throughout the interview process and wonder whether this is at least in part due to their developmental stage or is it that some individuals are simply more comfortable in an interview setting.

Memo Box 3: Extract from Interview 4 memos
21/01/2016

This interview seems to diverge significantly from the others on a number of levels. This participant seems quite dissatisfied with her experience of DBT and does not express gaining any benefit from the 16 week programme. She makes some valuable contributions as to why this might be the case include acknowledgement of her own readiness to engage and feeling forced into enrolling in the programme. Divergences between this participant's experience of the programme compared to others is exemplified by Ben in interview 2, who talked about the individual sessions helping him to get to the root of his difficulties. Karen, on the other hand describes feeling that DBT is symptom focussed and was not getting to the root of her difficulties. Other parts of her feedback about the programme are quite negative and not necessarily constructive- I am finding the coding difficult in these instances. I want to capture her experience in a way that truly represents her experience particularly given that she talks about feeling misunderstood, not met in her experience and not heard. I am keenly aware of this as I code and of not wanting to repeat this through my analysis.

Memo Box 4: Data Analysis
15/02/2016

I am thinking about change and am wondering how I can really capture this in a succinct yet comprehensive way. A general pattern seems to be arising in relation to how participants talk about change. Firstly, I notice participants talk about the meaning of change and how their lives are different now compared to before engaging in DBT. For example, in interview 1, Ruth talks about feeling better able to manage her distress, equally Ben, in interview 2, talks about feeling calmer '*it's this different sort of sense of calmness*' (p6, interview 2). For many of the interviewees, I am getting a sense of what life was like before DBT, the journey up to that point and while this is not answering the question about how change happened, it is providing me with a context for how their lives were before and subsequently how their lives developed in a positive way. Maybe I will call this 'The Landscape of Change' or 'Life before DBT' but this needs more consideration. Secondly, participants talk about how they brought about change in their lives and what got in the way of making change. Many participants talk about specific aspects of DBT that helped them and supported them to make desired changes. A variety of DBT-specific factors seem to be arising, including the value of individual sessions and group work. However, the development of skills seems to be coming up time and time again for the young people. I feel this will need to be a superordinate theme given the level of importance it has been given throughout the interviews. Even though it is a specific component of DBT, I feel it needs to be separate.

Memo Box 5: Data Analysis**21/02/2016**

My research question refers to the process of change. There seems to be different dimensions in the way participants are talking about this. Many participants talk about specific elements of DBT which helped them to make change. For example, Ben in Interview 2 talks about growing through the group and learning from other's experiences of adversity and Ruth and Maria talk about using skills to make behavioural changes e.g. using Mindfulness to step back and gain objectivity before making decisions, using validation to enhance communication and resolve conflict and using 'tip skills' e.g. splashing face with water, to help to manage distress. Participants also talk about change on a deeper level, a level within themselves that helped them to use the intervention to make changes. They talk about factors like feeling ready and motivated to make change, being open to change, taking an active role in their recovery and taking responsibility for their part in their difficulties. Karen talks about not gaining benefit and not experiencing any change. She also refers to not being open to the approach, feeling disenfranchised by mental health services and feeling a lack of fit between her needs and the approach. These feel like core internal aspects that are important in making change and that are perhaps important regardless of the type of intervention. I wonder whether this might tap into the idea of important pre-requisites to therapy or characteristics worth assessing for selection of participants for the programme. I am wondering how to best capture this in a theme and how can I incorporate those who felt they did not make change- maybe something about obstacles to making change. It feels like the elements which helped bring about change also had the potential to hamper change e.g. motivation- they seem related.

Appendix C: Example of a research field note used following each interview.

Interviewer: Sarah Hardiman

Participant Number/Pseudonym: #4

Date of Interview: 22/06/2015

1. Describe the environment where the interview took place in as much detail as you can (e.g. time, space, lighting, sound)

A therapy room was used for the interview. The room had comfortable seats, plenty of natural light, and was small but spacious. The interview took place in an Adult Mental Health Service which meant I needed to collect the interviewee at the Child and Adolescent Service- in a building down the road. I met the participant and walked back to AMHS with her. I wondered how the walk together would go and was a little anxious about this but in the end this provided an opportunity to build some rapport and allowed the participant to become familiar with me before the interview. It worked really well, I think this was especially helpful given I was interviewing adolescents and it allowed for a natural flow of conversation, walking down the street in a natural setting before entering the interview room. It also gave me the opportunity to debrief after the interview as I walked back with her.

2. Describe the participant in as much detail as you can (e.g. appearance, body language, tone of voice, comfort level)

Body language- she held her bag over her torso when talking, somewhat closed body language initially but eased out as the interview progressed. Voice was low in tone although she impressed as quite articulate. At times she appeared to be doubting herself and what she was saying, apologising after making a statement at one point in the interview.

3. Describe the interview process (e.g. flow, depth of participant responses, rapport between interviewer and participant, change over the course of the interview).

Interview was fairly fluid. The participant was easy to build rapport with and this was helped by the walk together before the interview. The participants responses were somewhat closed in the early stages. She tended to make negative remarks about her experience in a very matter of fact manner. However, as the interview progressed and as she seemed to become more comfortable with me, she started to add more context to her statements, as though she was trying to help me to understand what she meant. I remained in a curious position throughout the process and this seemed to help her to elaborate. At one point, she asked me for some paper so she could draw a diagram of what she meant. At times some of the content was quite abstract and required some unpacking in order to understand exactly what she meant. She relied on analogies at various points in the interview when explaining her experience. This was helpful for me in gaining insight into her experience and also caught my attention and drew me in.

- 4. Were there any unexpected interruptions that need to be explained to the transcriber?** (e.g. loud noises, someone needing to take a phone call, the recorder being shut off for a period of time).

The interview room was on the top floor of the building so there were people walking up and down the stairs which was next to the room. Doors opening and closing could be heard but this did not interrupt the interview in any major way.

- 5. Think back over the interview. Were there any keywords or phrases used by the participant that struck you in some way? If so, list them here.**

“Generic”

“Fitting into a box”

“Conforming”

“Existential”

“Elephant in the room”

“Common sense”

“Nothing is going to change”

“Coping vs. Living”

- 6. Summarize the key points from this interview in 2-3 paragraphs.**

Quickly into the interview, she established that her experience was not positive and she did not gain benefit or make change as a result of the programme. The interview centred on why change did not happen and what she felt were the main obstacles for her in making change. She talked about entering the programme due to a sense of obligation-not feeling like there was a choice in this. This impacted on her attitude towards the programme and she went in thinking this was not going to be of any benefit for her but she agreed to do it as a sort of tick box exercise so that she could say “I did it, now can I do something that actually works”.

Prior to DBT-A there had been extensive involvement with mental health services. There was a sense of disillusionment with mental health professionals and their ability to help and “fix” problems. The first few sessions of the programme were upsetting due to a lack of faith that it would be useful for her. She continued to attend as she saw others starting to gain benefit from it, she described staying as her “act of kindness”. Not wanting to spoil other people’s experience seemed to drive a sort of compliance. She also made reference to attending to placate her parents.

The next phase of the interview looked at her perception and understanding of the process of change. She explained that she did not believe change was possible. She talked about the programme not fitting with her personality and views on life feeling that DBT focussed too much on “common sense”, the practicalities of recovery and symptoms of anxiety rather than exploring the “why” of her issues. For her, the use of DBT language to frame her experience was not useful, she talked about wanting psychotherapy, an open explorative space rather than a focus on problem solving. The impact of not fitting arose and she described feeling like an outsider. Examples of negative elements of the programme included not directly discussing suicidality in the group and how this led to a feeling of the issue being minimised. Suggestions included providing examples which had greater context to the issue of self-harm.

7. Consider your main interview question. In what ways does this interview help you respond to that question?

The research question looks at the process of change and what elements of the therapy contributed to making change. This interview explored and discussed the personal meaning of change and beliefs about change. Seeing as change did not occur, aspects which contributed to change could not be addressed. Instead, a conversation unfolded about the obstacles to change which answers the research question in a different way. This interview highlighted various obstacles that got in the way of making change, namely a lack of belief in change, self as obstacle, disillusionment with services and the model not fitting with individual.

8. Now turn your attention to your own experience of the interview itself. How did you respond throughout the session? Did you hear pretty much what you expected to hear? If so, explain. Did anything about the participant's experience surprise you or make you feel uncomfortable? If so, explain.

I was intrigued from the outset of the interview. The participant appeared at first a little dubious in speaking honestly and sharing her experiences. She seemed to think that I wanted to hear only positive things about the programme. This was exemplified by her apologising at the beginning for not having positive things to say. I reiterated that my only agenda was to hear her experience as it was; whether positive, negative or indifferent. My interest in making sense of her experience seemed to open up her exploration and self-reflection in the interview.

I was also a little taken aback at the beginning of the interview when early on she mentioned not making any change. This provoked a little anxiety for me as the interview centred on the process of change and contributing factors. However, I comforted myself by telling myself that regardless of my interview schedule, the aim is to simply hear her experiences. This provided enough comfort for me to gain confidence in taking a slightly different direction with the interview. The interview became about her beliefs about change and the obstacles she faced in this process. Based on other participant's expression of making change and their exploration of the factors they felt contributed to that, I expected that I would hear something similar in this interview and was taken a little by surprise with the differences in her experiences.


There were elements of this participant's experience that made me feel sad. I felt sad at her disenfranchised attitude to mental health services and helping professionals. I felt sad that she held a hopeless attitude toward change and that this seemed to hamper her ability to make change. At the same time, I felt privileged that she felt okay to share the negative side of her experiences and in a way I found myself feeling glad that she was using her voice in this research. I was taken a little by surprise at her ease in expressing her level of suicidality and her current thoughts about killing herself. I quickly became aware of my professional responsibility and discussed this with her. I was surprised that my need and intention to speak to her clinician did not seem to affect any rapport we had built. I was glad about this.

Appendix D Reflection on the research process

My initial curiosity in DBT-A came from my work in a CAMHS service who were the first team to deliver DBT-A in Ireland. I was on placement at the time and had the opportunity to witness it being rolled out in the service. It was at this point two years ago that I started to think about DBT-A and how it works to treat suicidal behaviour. As a psychologist in clinical training, I have developed an interest in how all interventions produce change. This research, was therefore, to a degree filtered through a lens of clinical psychology. My beliefs about therapeutic change have been influenced by a number of things, including my experience with clients, knowledge I have acquired through more experienced clinicians/supervisory input, reading I have engaged in throughout my training to aid my understanding of therapy, and my own experiences of personal therapy. My curiosity about DBT-A was also ignited by its popularity and its growth as the treatment of choice for BPD in Ireland. My research questions arose from the reading I had engaged in on DBT-A as well as my own questions about its success. I wanted to investigate whether the research already in existence could be supported as well as add new insights to the literature base.

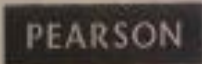
I chose mixed methods as this fit with my research questions, which aimed to examine different dimensions of DBT-A, from an overview of symptomatology of the whole group of participants to the individual experiences of a subgroup of participants. My choice to use mixed methods was both challenging and rewarding. There were periods of time when I struggled with the use of both methods in a way that stayed true to the underlying philosophy and procedures of each. I found trying to switch between the stringency of quantitative methods to a more open and reflective position of qualitative methods a challenge at times. Feelings of apprehension arose for me at the stage of merging my findings and trying to do so in a way that upheld the reliability of each approach. The more in-depth the interviews got, the further away from the quantitative findings they appeared to go. I wondered how I was going to represent this disparity. As I got to grips with the two sets of data and how they related, my nervousness about this dissipated and I realised that this finding within itself held importance. During the interview stage, I experienced both feelings of nervousness and excitement. While I felt exhilarated at having an opportunity to hear from the young people and make sense of their experiences, I also felt keenly aware of my responsibility to safeguard this vulnerable population in my research endeavours.

Appendix E: Questionnaire pack of instruments used in the research



Here is a list of things that happen to people and that people think or feel. Read each sentence carefully, and circle the **one** word (Never, Sometimes, Often, or Always) that tells about you best, especially in the last two weeks. **THERE ARE NO RIGHT OR WRONG ANSWERS.**

	0	1	2	3
1. I think that my life is bad.	Never	Sometimes	Often	Always
2. I have trouble doing things.	Never	Sometimes	Often	Always
3. I feel that I am a bad person.	Never	Sometimes	Often	Always
4. I wish I were dead.	Never	Sometimes	Often	Always
5. I have trouble sleeping.	Never	Sometimes	Often	Always
6. I feel no one loves me.	Never	Sometimes	Often	Always
7. I think bad things happen because of me.	Never	Sometimes	Often	Always
8. I feel lonely.	Never	Sometimes	Often	Always
9. My stomach hurts.	Never	Sometimes	Often	Always
10. I feel like bad things happen to me.	Never	Sometimes	Often	Always
11. I feel like I am stupid.	Never	Sometimes	Often	Always
12. I feel sorry for myself.	Never	Sometimes	Often	Always
13. I think I do things badly.	Never	Sometimes	Often	Always
14. I feel bad about what I do.	Never	Sometimes	Often	Always
15. I hate myself.	Never	Sometimes	Often	Always
16. I want to be alone.	Never	Sometimes	Often	Always
17. I feel like crying.	Never	Sometimes	Often	Always
18. I feel sad.	Never	Sometimes	Often	Always
19. I feel empty inside.	Never	Sometimes	Often	Always
20. I think my life will be bad.	Never	Sometimes	Often	Always



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This questionnaire consists of 20 statements. Please read the statements carefully one by one. If the statement describes your attitude for the **past week including today**, darken the circle with a 'T' indicating TRUE in the column next to the statement. If the statement does not describe your attitude, darken the circle with an 'F' indicating FALSE in the column next to this statement. **Please be sure to read each statement carefully.**

- | | | |
|--|-----------------------|-----------------------|
| 1. I look forward to the future with hope and enthusiasm. | <input type="radio"/> | <input type="radio"/> |
| 2. I might as well give up because there is nothing I can do about making things better for myself. | <input type="radio"/> | <input type="radio"/> |
| 3. When things are going badly, I am helped by knowing that they cannot stay that way forever. | <input type="radio"/> | <input type="radio"/> |
| 4. I can't imagine what my life would be like in ten years. | <input type="radio"/> | <input type="radio"/> |
| 5. I have enough time to accomplish the things I want to do. | <input type="radio"/> | <input type="radio"/> |
| 6. In the future, I expect to succeed in what concerns me most. | <input type="radio"/> | <input type="radio"/> |
| 7. My future seems dark to me. | <input type="radio"/> | <input type="radio"/> |
| 8. I happen to be particularly lucky, and I expect to get more of the good things in life than the average person. | <input type="radio"/> | <input type="radio"/> |
| 9. I just can't get the breaks, and there's no reason I will in the future. | <input type="radio"/> | <input type="radio"/> |
| 10. My past experiences have prepared me well for the future. | <input type="radio"/> | <input type="radio"/> |
| 11. All I can see ahead of me is unpleasantness rather than pleasantness. | <input type="radio"/> | <input type="radio"/> |
| 12. I don't expect to get what I really want. | <input type="radio"/> | <input type="radio"/> |
| 13. When I look ahead to the future, I expect that I will be happier than I am now. | <input type="radio"/> | <input type="radio"/> |
| 14. Things just won't work out the way I want them to. | <input type="radio"/> | <input type="radio"/> |
| 15. I have great faith in the future. | <input type="radio"/> | <input type="radio"/> |
| 16. I never get what I want, so it's foolish to want anything. | <input type="radio"/> | <input type="radio"/> |
| 17. It's very unlikely that I will get any real satisfaction in the future. | <input type="radio"/> | <input type="radio"/> |
| 18. The future seems vague and uncertain to me. | <input type="radio"/> | <input type="radio"/> |
| 19. I can look forward to more good times than bad times. | <input type="radio"/> | <input type="radio"/> |
| 20. There's no use in really trying to get anything I want because I probably won't get it. | <input type="radio"/> | <input type="radio"/> |

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QSI

Listed below are statements about *thoughts that people sometimes have*.

Please indicate how often you may have had these thoughts in the **PAST WEEK** by ticking the appropriate response below each statement.
Please keep in mind that there are no right or wrong answers.

1. I thought it would be better if I was not alive

Not at all	Once	2-3 times	4-6 times	Daily or more

2. I thought about ending my life

Not at all	Once	2-3 times	4-6 times	Daily or more

3. I thought about how I would end my life

Not at all	Once	2-3 times	4-6 times	Daily or more

4. I thought that ending my life would solve my problems

Not at all	Once	2-3 times	4-6 times	Daily or more

5. I thought that no-one cared if I lived or died

Not at all	Once	2-3 times	4-6 times	Daily or more

6. I thought that others would be happier if I was not alive

Not at all	Once	2-3 times	4-6 times	Daily or more

STAXI-2 C/A

Thomas M. Brunner, PhD
Charles D. Spielberger, PhD

Rating Booklet

Instructions

This booklet has three parts. Each part has different instructions for responding to sentences that people use to describe their feelings and behavior. Read the directions for each part carefully before circling your responses.

For each sentence, please circle the number under the answer that describes you best. There are no right or wrong answers. Circle only one number for each sentence.

The sentences in Part 1 ask about how you feel right now. For the sentences in Part 1, use the following guide:

- Circle 1 if you feel this way **Not at all** right now
- Circle 2 if you feel this way **Somewhat** right now
- Circle 3 if you feel this way **Very much** right now

The sentences in Part 2 ask about how often you usually feel a certain way. For the sentences in Part 2, use the following guide:

- Circle 1 if you **Hardly ever** feel this way
- Circle 2 if you **Sometimes** feel this way
- Circle 3 if you **Often** feel this way

The sentences in Part 3 ask about how often you feel or act a certain way when you are angry. For the sentences in Part 3, use the following guide:

- Circle 1 if you **Hardly ever** feel or act this way when you are angry
- Circle 2 if you **Sometimes** feel or act this way when you are angry
- Circle 3 if you **Often** feel or act this way when you are angry

If you make a mistake, **DO NOT ERASE**. Draw an X through the answer you want to change and then circle the correct answer.

1. I feel upset.

1



3

Before you start, please print your name, mark the correct box to tell us if you are a boy or a girl, today's date, how old you are, your grade in school, and the name of your school at the top of the next page.

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STAXI.2 C/A Answer Sheet

Name _____ Gender: Boy Girl Today's date: / /
 Age _____ Grade _____ School _____ Examiner _____

Part 1 Directions: The sentences below talk about feelings people sometimes have. Read each sentence below and then circle the response that indicates how you feel **right now**. There are no right or wrong answers. Be honest. Do not spend too much time on any sentence.

	Not at all	Somewhat	Very much
1. I feel annoyed	1	2	3
2. I feel angry	1	2	3
3. I feel irritated	1	2	3
4. I feel like shouting out loud	1	2	3
5. I feel like hitting someone	1	2	3
6. I feel like yelling	1	2	3
7. I feel like kicking somebody	1	2	3
8. I feel grumpy	1	2	3
9. I feel like throwing something	1	2	3
10. I am mad	1	2	3

Part 2 Directions: The sentences below talk about feelings people sometimes have. Read each sentence below and then circle the response that indicates **how often you usually feel that way**. There are no right or wrong answers. Be honest. Do not spend too much time on any sentence.

	Hardly ever	Sometimes	Often
11. I feel angry	1	2	3
12. I get mad	1	2	3
13. I get angry quickly	1	2	3
14. I feel annoyed when I do a good job and no one notices me	1	2	3
15. I get mad when I am punished unfairly	1	2	3
16. I feel grouchy	1	2	3
17. I get angry when I do well and am told I did something wrong	1	2	3
18. I feel angry when I am blamed for something I did not do	1	2	3
19. I am hotheaded	1	2	3
20. I feel like yelling when I do something good and someone says I did bad	1	2	3

Directions: Everyone feels angry from time to time, but people differ in what they do when they are angry. The sentences talk about how you may feel or act when you are angry. Read each sentence and then circle the response that best describes how often you feel or act that way when you are angry. There are no right or wrong answers. Be honest. Do not spend too much time on any sentence.

	Hardly ever	Sometimes	Often
1. I show my anger	1	2	3
2. If I do not like someone, I keep it a secret	1	2	3
3. I keep my cool	1	2	3
4. I say mean things	1	2	3
5. I hide my anger	1	2	3
6. I try to relax	1	2	3
7. I lose my temper	1	2	3
8. I keep my anger in	1	2	3
9. I try to calm down	1	2	3
10. I try to calm my angry feelings	1	2	3
11. I get into arguments	1	2	3
12. I do something to relax and calm down	1	2	3
13. I am afraid to show my anger	1	2	3
14. I do things like slam doors	1	2	3
15. I get mad inside, but do not show it	1	2	3

DO NOT WRITE IN THIS AREA.



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

National DBT Project-Client Record Form

(To be completed by the client's therapist at baseline)

*Please note that baseline is the date of the first DBT group skills session
(week that your client commenced all modes of the DBT intervention)*

Participant ID Code:
(to be assigned by research team)

Date Completed:	<input type="text"/>
Therapist Name:	<input type="text"/>

Client Information

Name:	<input type="text"/>
Date of Birth:	<input type="text"/>
Gender:	<input type="text"/>
Address:	<input type="text"/>
Educational Level (Year):	<input type="text"/>
Parent/ Guardian Name	<input type="text"/>
Parent/ Guardian Contact Number:	<input type="text"/>

Are files from the following accessible/ available for review:

- inpatient Yes No
- outpatient Yes No
- A&E (E.D) Yes No

Section 1: Inclusion Criteria

Please tick this box if the inclusion criteria for the DBT intervention (which can be found on the following page) have been met:

Additional Comments:

National DBT Project Referral Criteria for CAMHS DBT Intervention

Inclusion Criteria

1. Between/ including the ages of 14 and 18 years
 2. Demonstrating emotional behavioural disturbance/ emotional dysregulation
 3. There needs to be a persistent pattern of *deliberate self harm*¹ ~~with~~ deliberate self-harm behaviour or a *suicidal act*² having occurred within the last 16 weeks
- or
- There needs to be *chronic suicidal ideation*³ reported
- (Priority will be given to those who are currently *actively self-harming and/or reporting chronic suicidal ideation*³)
4. The client and their guardian will have discussed their emotional behavioural disturbance/ emotional dysregulation with you or a member of your team and will have expressed an interest in, and commitment to the 16 week programme.

Exclusion Criteria

If a client is experiencing the following, it is recommended that they do not undertake the DBT programme:

1. An active psychosis
2. If the client has severe developmental delays, cognitive impairment or learning disabilities (exceeding mild range)
3. If a clients' substance/drug dependence, eating disorder or any other mental health issues/ behaviour is at such a level that it would impede their engaging with any of the modalities of DBT.

¹ **Deliberate Self-Harm:** The definition that is deemed most comprehensive, used in the WHO/EURO Multicentre Study on Suicidal Behaviour and the NSRF in Ireland is that self-harm is:

"an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes, that the person desired via the actual or expected physical consequences"

² **Suicidal Act:** Self injury that is intended to result in death.

³ **Chronic Suicidal Ideation:** Thoughts about being dead, killing oneself, or being killed

Section 2: Client Presentation

a. Does the client present with emotional behavioural disturbance/ emotional dysregulation?

Yes No

b. Which of the following manuals was used to examine emotional behavioural disturbance/ emotional dysregulation?

DSM IV/V ICD-10 None

If none were used, please specify how the individual was assessed (for referral to the DBT programme):

c. Is there evidence of the following:

1. Emotion dysregulation (e.g. affective lability, problems with anger)

Yes No

2. Interpersonal dysregulation (e.g. chaotic relationships, fears of abandonment)

Yes No

3. Self dysregulation (e.g. identity difficulties, unstable sense of self, feelings of emptiness)

Yes No

4. Behavioural dysregulation (e.g. suicidal behaviour, deliberate self injury, impulsive behaviour)

Yes No

5. Cognitive dysregulation (e.g. dissociative responses, paranoid ideation)

Yes No

d. Does the client currently present with other mental health difficulties or comorbid diagnoses?

Yes

No

If yes, please give brief detail:

e. Is there evidence of deliberate self-harm behaviour within the last 4 months?

Yes

No

- If yes, please indicate which behaviours have been present in the last 4 months:

- Cutting
- Burning
- Overdose
- Threatening harm
- Ligatures
- Dysregulated eating habits

Other (please specify) _____

- If yes, please indicate how often the client has deliberately self-harmed in the last 4 months by circling one of the following:

Rarely (less than once a month)	Occasionally (monthly)	Often (weekly)	Most of the Time (daily)
------------------------------------	---------------------------	-------------------	-----------------------------

<i>Was the information in this section (Section 2 pgs. 4-5) obtained from:</i>	Yes	No
Clinical Files		
Client Self-Report		
Other (please specify):		

Section 3: Services Used in the Last 4 Months

a. In the last 4 months has the client:

- Attended A&E (E.D) for a *mental health related incident*? Yes No

If yes, please indicate the **number of visits** in the past 4 months:

If yes, how many times was the client taken to A&E (E.D) by ambulance:

- Had a mental health related inpatient admission: Yes No

If yes, please indicate the **number of admissions** in the past 4 months:

If yes, please complete the box below to provide more information about each admission in the last 4 months:

Admission	Was the admission in a public or private mental health facility?		Please indicate the duration of each admission (no. days)
	Public	Private	
No. 1			
No. 2			
No. 3			
No. 4			
No. 5			

Appendix F: Interview Protocol

1. How did you find the programme (DBT-A) overall?
2. How did the problems you faced before entering DBT affect your life?
3. How were you able to overcome these problems?
4. What do you think happened, that enabled you to resolve this problem?
Probe: What parts of the programme helped you to do this?
5. What do you think it was that stopped you from resolving it before this time?
Probe: What elements of the programme created obstacles for you in making change?
6. When I mention change what comes up for you?
Probe: What does change mean for you?
7. What changes have you noticed about yourself since engaging in the programme?
Probe: What was it about the programme that helped you to make those changes?
What do you think accounted for those changes?
8. Have other people noticed changes in you?
Probe: if yes, what kind of changes have other people noticed?
9. What parts of the programme do you feel contributed to the changes you/others have noticed?

Appendix G: Participant Satisfaction Questionnaire.

Participant Satisfaction Questionnaire

Please help us evaluate the DBT Programme by answering some questions about the service that you have received. We are interested in your **honest opinions**, whether they are positive or negative.

Please answer all of the questions by ticking the answer that best matches your opinion.

1. How would you rate the quality of the DBT programme that you have taken part in?

Poor	Fair	Good	Excellent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. To what extent did the DBT programme meet your needs?

Not at all	A little	Somewhat	Very much
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Having completed the DBT programme, do you think the material covered in the programme will be of use to you?

Not at all	A little	Somewhat	Very much
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Has the DBT programme helped you to deal more effectively with the difficulties you have been experiencing?

Not at all	A little	Somewhat	Very much
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Having completed the DBT programme, how helpful did you find the following aspects:

<i>Individual Therapy</i>	Not at all	A little	Somewhat	Very much
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Group Skills Sessions</i>	Not at all	A little	Somewhat	Very much
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Phone Coaching</i>	Not at all	A little	Somewhat	Very much
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Can you identify one thing about the DBT programme that you **found helpful** to overcome the difficulties you have been experiencing? Please elaborate

7. Can you identify one thing about the DBT programme that you **did not find helpful** to overcome the difficulties you have been experiencing? Please elaborate

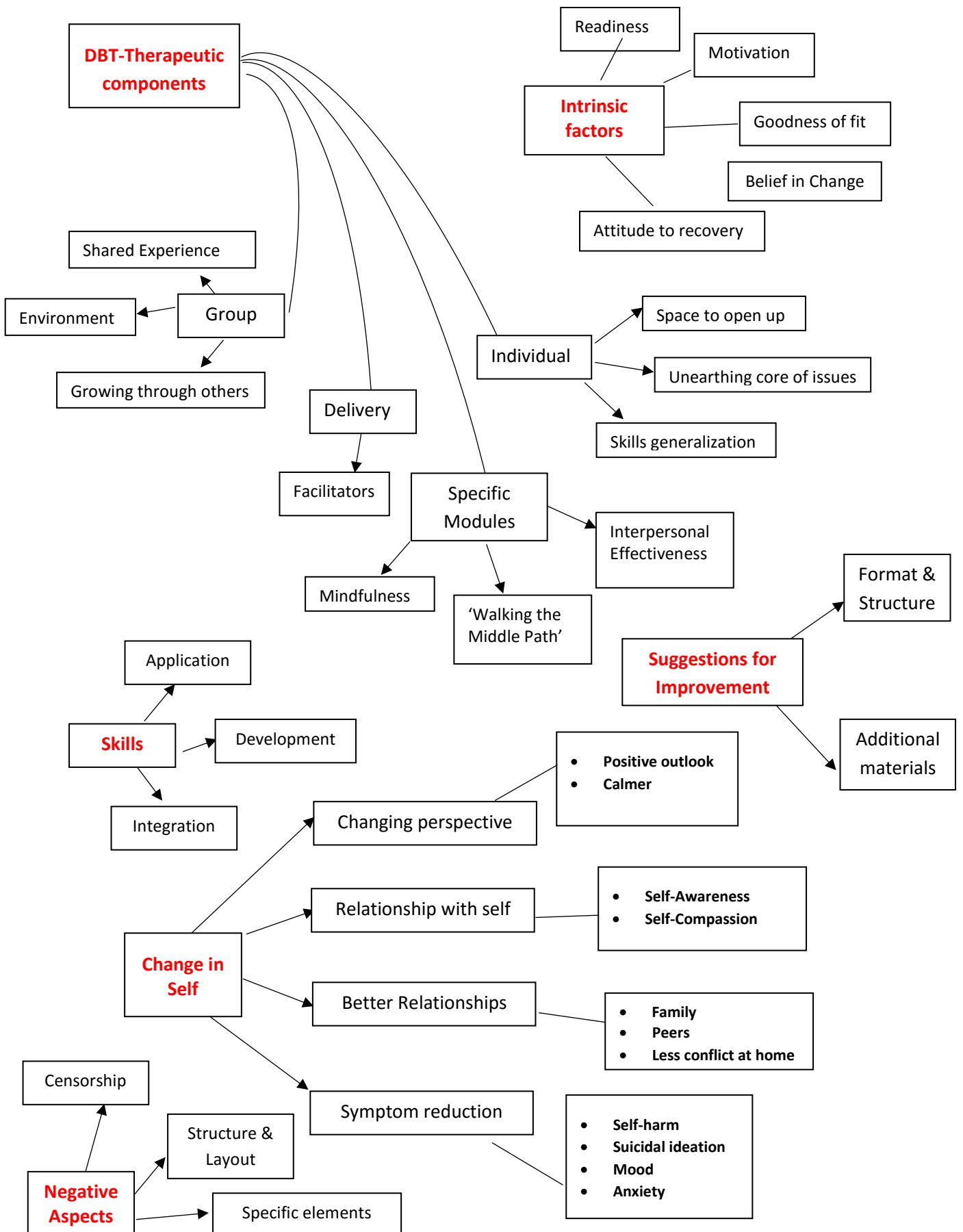
8. Please include any additional comments about your experience of the DBT programme in the box below:

Appendix H: Extract from excel spreadsheet and physical arrangement of themes before refinement based on initial notes.

	A	B	C	D	E
1	Interview 1 initial notes	Possible theme	Possible Superordinate theme	Page no.	Comments
2	Time commitment-travel difficult	Unhelpful aspect	Toward a Better DBT	p1	
3	Using skills to ↓ anxiety	Skills utilization	The Process of Change	p2	
4	Unrealistic skills = not useful	Unhelpful aspect	Toward a Better DBT	p2	skills 'handy'
5	Practical skills = useful	Skills Generalization	Skills Acquisition	p2/17	tips and tricks'
6	Using skills to get needs met	Application of skills	Skills Acquisition	p2	
7	Using skills to enhance communication w parents	Application of skills	Skills Acquisition	p2	
8	Selecting skills that fit own circumstance	Skills Generalization	Skills Acquisition	p2	
9	Using skills to control emotion	Application of skills	Skills Acquisition	p2	
10	Treatment goal ↑ contentment ↓ distress	Readiness	The Process of Change	p3	
11	Mindfulness-useful for overactive thoughts	Integration of skills	Skills Acquisition	p3	
12	↑ self- compassion, non judgemental	Change in self-positive	Then vs Now	p3	
13	↓ NATS ↑ self-awareness ↑ self-reflection	Change in self-from negative to positive	Then vs Now	p3	
14	Becoming present focussed	Change in perspective	Then vs Now	p3	
15	Developing open mind through new learning	Change in perspective	Then vs Now	p3	
16	Acquiring new skills	Skills Acquisition	Skills Acquisition	p3	
17	Individual sessions-space for disclosure	Mode of Therapy	Therapeutic Components	p4	
18	Individual sessions- generalising skills from group	Mode of Therapy	Therapeutic Components	p4	
19	Having DBT model consistently run through Indiv and Group	Consistency of Approach	Therapeutic Components	p5	
20	Openness and motivation to change	Attitude to change	The Process of Change	p5	
21	↓ catastrophising ↓ ruminating	Change in symptoms	Then vs Now	p5	
22	change in outlook- more positive	Change in perspective	Then vs Now	p5	
23	Generalising skills through home work	Skills Generalization	Skills Acquisition	p5	
24	Practising skills through home work	Skills Generalization	Skills Acquisition	p6	



Appendix I: Mind-map of possible themes prior to refinement



Appendix J: Extract from Interview 2- an example of IPA coding process

Emergent Theme	Interview Transcript	Initial Notes*
Open to intervention	I said I'd give it a shot, whatever and coming up to DBT well I'd had a really intense period before that, I was in the hospital with like a, just lots of kind of [use of profanity] hit the fan, like that summer, those few months em but I really came out of it then coming towards Christmas and January, like I had done a lot of work and stuff and I was em just I think I was a lot better than I had ever been in my life like coming into DBT at that point was like the best point in my life for me em and I was worried about giving up time because it was a massive time commitment and I don't have a lot of time as it is, I'm committed to a lot of different things em but I said I would give it a shot because it is kind of the last piece that I have with CAMHS before I turn 18 and it was probably the last, I'm probably not going to get referred to adult services because like because of my personal choice, I I don't think I will em but it was important for me to have something I think to kind of equip me to go out in the world myself because it has been like 4 years I've been in counselling, em even like there's been gaps but it's always been there you know to go back to so em it's quite worrying but em yeah I said I'd give it a shot and yeah no, it was it was incredible, like I got so much out of it, I was so happy and I think when you look at the group dynamic there were some people who	'Give it a shot' suggestive of openness, readiness to try something new.
Life Before DBT		Life before DBT difficult
Pathway into DBT		<i>Use of profanity to highlight intensity?</i> Paints a picture of crisis and intense distress in the lead up to DBT.
Readiness		Engagement in therapy and personal development before DBT. <u>Acclimatised to the therapeutic process- sounds like Ben has a lot of experience of being a client.</u> In a good place prior to starting DBT <u>Is being in a good place suggestive of readiness to engage and gain benefit?</u>
Time Commitment difficult		Apprehensive about the time commitment due to busy schedule.
Personal Meaning of DBT		DBT representative of final therapeutic piece in Child and Adolescent Services. <u>There is a sense of the client leaving the nest of mental health services. This seems meaningful, like a transitional stage in a process of individuation.</u>
Readiness-prepared, clear purpose.		Clear purpose to engagement in DBT- to develop life skills <i>'equip' a verb connected with having resources, like having appropriate tools for a job.</i> DBT- a preparation for life without counselling. <u>This seems like an exciting and perhaps scary time of independence.</u> <i>'always been there'- therapy as a consistent and steady support up to this point.</i>
Positive Experience		Very positive experience of DBT- gained significant benefit from the intervention. <u>Was the positivity of this experience influenced by DBT having a clear purpose and meaning?</u>
Attitude to Intervention- open vs closed		

<p>Belief in Therapy</p> <p>Readiness</p> <p>Attitude to Intervention</p> <p>Negative element</p> <p>Family Life-conflictual</p> <p>Family Life-communication difficulties</p> <p>Family Life-personal impact of conflict</p>	<p>were quite closed off to it maybe like they kind of broke down over the weeks and embraced it more but a lot of people came in very closed em whatever but like I've always been like a very open person and I did like a summer course in behavioural psychology and stuff, all that kind of stuff really fascinates me and I think it's it's a really important and incredible thing and like you know I believe all of it, and I believe that like it's not a waste of time like they're doing stuff to help me so I think I really, I think why I got so much out of it was I was kind of in the headspace to kind of jump into it anyway at the start, from the get go and kind of embrace it as much as I could em I hated the diary cards, they used to bug me so much, oh it was just the...it was just the effort em yeah em.</p> <p><i>I: Tell me about that process of change for you because it sounds like going in there, tell me what you mean when you say going in there in the right headspace.</i></p> <p>Em well I suppose it was it was August and my parents had a big thing, I'm a smoker whatever and we had big arguments over that and it sounds like quite a childish silly thing but it was just the fact that neither of us could really, we didn't really know how to handle the problem as opposed to the problem in itself that everything just kept blowing up and getting incredibly intense em and yeah we had like loads of massive</p>	<p>Others not as open to the process. <i>'broke down' suggestive of defences dropping</i></p> <p>Familiarization with DBT over time impacted attitude and engagement.</p> <p>Self as open and curious about self and the world. <i>'fascinates', 'incredible' give impression of participant being mesmerised and excited by it</i></p> <p>Belief in utility of therapy, others as supportive, self as helpable.</p> <p>Gained benefit as a result of attitude and mindset entering the programme. <i>'jump into it' - ready for action from the start.</i> <u>Buy in from the beginning an important factor in gaining benefit from intervention.</u></p> <p>Negative aspect- diary cards, felt arduous.</p> <p>Trying to get a sense of hoe description of 'headspace' relates to a process of change.</p> <p>Disharmony in parent-child relationship</p> <p>Conflict at home <i>'childish silly thing'- judgemental language-fearing judgement by the interviewer that this issue would sound silly?</i></p> <p>Lack of skills in managing conflict problematic rather than the problem itself. <i>'blowing up' like an explosion, points to the intensity of the arguments at home.</i> <u>There is a sense that difficulties in communication is at the root of the ongoing arguments.</u></p>
---	--	---

<p>Process of Change- deciding to stop</p>	<p>fights and I ended up in, I took a like a fatal overdose of paracetamol and stuff and em ended up in the hospital em it was just, it was all kind of a silly messy thing em I yeah but when I woke up from that we kind of we just moved on like we figured like this has to stop, eh we worked our own way there, then eventually it all blew up in October again because I pretended I quit again after that and then they caught me out again in October and I tried to run away em which failed as well and we agreed that I would have to work to get the money to buy my own cigarettes cos they weren't going to give me money for it but they weren't going to ground me anymore cos it wasn't getting any of us anywhere so I got a job em and that was like the last major conflict that we had had, like we had had other things, I've had a lot of very poor friends who weren't really there for me em and I just kind of rude, manipulative, negative people, I think they really brought me down a lot and em I just kind of lost contact with them and I found new people who were incredibly good to me em and got very close to them and I just kind of matured I think, I just began to grow up and realise like you know that for a long time it was very easy for me to be upset all the time and just stay in that kind of like sad space, it was comfortable whatever em and I think just kind of just before DBT happened I had kind of finally reached that place where it was like you know being happy is</p>	<p>Conflict in the family having devastating impact Family disharmony as a major factor in suicidality.</p>
<p>Family Life- relational problems</p>		<p><u>Overdose- a turning point?</u> Making a decision to change.</p>
<p>Skills Acquisition- the end of conflict</p>		<p>Reduction in conflict short lived. <u>A pattern of relational issues causing distress</u></p>
<p>Then vs Now- change in relationships</p>		<p>Young person's behaviour forcing a resolution of the issue. <u>Communicating distress through behaviour-representative of developmental processes or personality style?</u></p>
<p>The Process of Change- Maturity</p>		<p>Developing compromise as a form of resolution. Developing relational skills marked the end of conflict.</p>
<p>Attitude to Change- stepping outside comfort zone.</p>		<p>Poor peer relationships a contributing factor for low mood <u>There is a sense of this participant being dragged down by others. Relationships seem to be a core element of this participant's wellbeing.</u></p>
<p>Process of Change- Active role in recovery</p>		<p>Developing better, more supportive peer relationships Growing up, maturing, developmental growth <u>Something about the payoffs of staying in the sick role?</u></p>
<p>Process of Change- Active role in recovery</p>		<p>Passive versus active stance in life. <i>'finally' suggests it took some time to get to that point.</i> Changing outlook on mental health.</p>

<p>DBT Structure- parent attending.</p>	<p>great and I want that and I'm going to look out and I'm gonna search for things in life that are gonna bring me there and make me feel that way.</p> <p><i>So you entered into DBT in that space, what did you want to get out of the programme?</i></p>	<p>Taking an active role in recovery.</p> <p>Taking charge of life, being happy.</p>
<p>Family Life- relationship strengthening.</p>	<p>Em I mean one of the things that I always was kind of looking forward to was I had to go with my Mum em to every session like em I'm not, like I get on with both my parents quite well, whatever em my Dad is a much more reasonable person, em my Mum and I have always had her</p>	<p>Positive element- attending session with Mum</p> <p>Relationship difficulties with Mum <i>Corrects self from 'her' to 'our' difficulties- a type of Freudian slip?</i></p>
<p>Therapeutic Component- Goals for therapy.</p>	<p>difficulties, eh our difficulties em and I thought it would be good for us to just have time to spend together.</p>	<p>Goal to strengthen parent-child relationship</p>

* Please note, linguistic codes are displayed in italics, conceptual codes are underlined and descriptive codes are in normal text.

Appendix K: Summary table of the frequency of superordinate and subordinate themes across participants.

Superordinate Theme	Subordinate Themes	Ruth	Ben	Maria	Karen	Rachel	Greg
Then Vs Now	New Self	Yes	Yes	Yes	No	Yes	Yes
	<i>'Family Life'</i>	Yes	Yes	Yes	No	No	Yes
Internal Process of Change	Readiness & Belief	Yes	Yes	No	Yes	No	Yes
	Motivation	Yes	No	Yes	Yes	Yes	Yes
Skills Acquisition	<i>'Knowing what to do'</i>	Yes	Yes	Yes	Yes	No	No
	Application & Integration	Yes	Yes	Yes	Yes	Yes	Yes
Therapeutic Components	Attitude to Intervention	No	Yes	Yes	Yes	No	Yes
	Mode of Therapy	Yes	Yes	Yes	Yes	Yes	Yes
Toward a Better DBT	<i>'The Elephant in the Room'</i>	Yes	No	Yes	Yes	No	No
	Room for Improvement	Yes	No	Yes	Yes	No	No