Exploring Inpatient Experiences of Dialectical Behaviour Therapy

for Borderline Personality Disorder.

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Author: Danielle Desperles

<u>Declaration</u>

I declare that the present research reported is my own work and has not been submitted for any other academic award.

Exploring Inpatient Experiences of Dialectical Behaviour Therapy for Borderline Personality Disorder

Thesis Abstract

Literature Review

A systematic review of the literature on the use of Dialectical Behaviour Therapy (DBT) in both inpatient and outpatient settings was conducted. The results demonstrated that significant treatment gains were made by individuals with BPD when treated with DBT. The review supported the use of DBT in both treatment settings.

Research Report

This explored patients' experiences of DBT in a long term secure inpatient unit. Nine participants diagnosed with BPD were interviewed. The interviews were transcribed and analysed using Interpretative Phenomenological Analysis. A total of eight superordinate themes were identified and summarised separately. The first section related to the DBT programme and two superordinate themes emerged. These were the *Components of DBT* and the *Effects of DBT*. The second section examined the journey participants described when undergoing DBT in an inpatient unit. Six superordinate themes emerged, these were: A *Hopeless Beginning; the DBT Programme; Promoters of Inpatient DBT; Obstacles of inpatient DBT; A Brighter Future and Preparing for Discharge.* The present study highlighted that inpatient uses of DBT are as acceptable as outpatient uses. The journey participants described highlighted the unique promoters and obstacles of inpatient DBT therapy. The clinical implications of this research supported the use of DBT in inpatient settings and provide a rationale for the development of more DBT services. Areas for future research were also discussed.

Critical Appraisal

This paper provides an account of the researcher's reflections and experience of the research process. Issues related to the decision making processes involved in the research and reflections on personal reflexivity are discussed.

Author: Danielle Desperles

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<u>Critical Literature Review</u>

<u>Evaluating the effectiveness of in and outpatient uses of Dialectical Behaviour Therapy for the treatment of Borderline Personality Disorder.</u>

1. Abstract

Introduction. Over the last eighteen years there has been a developing evidence base for Dialectical Behaviour Therapy (DBT) as an intervention for the treatment of Borderline Personality Disorder (BPD). The aim of this review was to examine the effectiveness of DBT in both inpatient and outpatient settings.

Methods. A systematic review of the literature on the use of Dialectical Behaviour Therapy both in an inpatient and outpatient setting was carried out using electronic databases (PsychINFO, PsychArticles, Web of Science, Ovid and Open Sigle) and reference citations. Twenty articles were identified and included in the present review.

Results. The papers presented in the current review demonstrated the treatment gains made by individuals diagnosed with BPD, when treated with DBT, in both outpatient (community) and inpatient (hospital) settings. The findings from this review supported previous reviews and demonstrated that reductions in self harm, improved treatment retention rates and increases in global levels of functioning were present in both treatment environments. Little variation was found between the outcomes of outpatient and inpatient uses of DBT, which demonstrated that both are acceptable forms of treatment. However, the poor methodological robustness of the studies included in the present review and the weak evidence base for inpatient studies, must be considered when interpreting the overall effectiveness of DBT.

Conclusions. DBT is a relatively new therapy with growing and promising evidence to support its effectiveness; however more controlled, randomised studies are needed to confirm the findings of much of the research available. Although the majority of the studies in the present review were conducted in an outpatient setting, the increasing evidence base for inpatient DBT may reflect the positive changes which are occurring in healthcare systems, where the need to provide structured interventions for patients whilst they are in a hospital setting (such as DBT) has been identified.

Key Words: Dialectical Behaviour Therapy; Borderline Personality Disorder; Effectiveness; Treatment and Interventions.

2.   Introduction

Borderline Personality Disorder (BPD) is a pervasive and serious mental disorder that is characterised by a pattern of instability in affect regulation, impulse control, interpersonal relationships and self-image.   Often those diagnosed with BPD will go to frantic efforts to avoid imagined or real abandonment. In addition they are often at high risk of suicide or acts of self-harm (American Psychiatric Association (APA) [*DSM-IV*], 2000). Enduring impairments in overall levels of functioning are often present with research indicating that BPD individuals have a significantly greater impairment in work, leisure and social relationships than individuals diagnosed with depression (Skodol, Gunderson, & McGlashan, 2002).

Developing effective and acceptable interventions for those with a diagnosis of BPD has proved difficult. BPD individuals are often difficult to engage in a positive therapeutic relationship and are difficult to treat due to their pattern of affective instability, high impulsivity and unstable interpersonal relationships (APA [DSM-IV], 2000; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004; Swenson, Torrey, & Koerner, 2002). They often present to services in crisis and are at risk of self-harm or suicide and in need of hospital admission (Moran, 2002). Consequently, higher demands are placed on services to intervene both with pharmacological and psychosocial interventions (Lieb et al., 2004; National Institute for Clinical Excellence (NICE), 2007).

The need for large quantities of economic resources and funding by crisis services and inpatient hospitals to manage these individuals often means that existing budgets and

resources for this patient group are spread thinly, with a lack of specialist services (NIMHE, 2003). As a result, this puts additional pressure on a limited number of health care professionals to manage and contain such unstable individuals without adequate and necessary resources.

Due to the strong clinical need for risk management for those with BPD and their tendency to be frequently admitted into inpatient units, services are increasingly using interventions such as Dialectical Behaviour Therapy (DBT) which have been recommended by NICE (2009). With an ever increasing, but relatively small evidence base, there is promising evidence that DBT is effective in reducing rates of self harm (Binks, Fenton, McCarthy, Lee, Adams & Duggan, 2006). Consequently, with outcome benefits such as this, DBT has gained popularity with National Health Services and is being increasingly used to manage and contain BPD individuals in both outpatient (community) and long term inpatient (hospital) settings. As a result, the broad aim of the present review was to examine the effectiveness of DBT within both inpatient and outpatient clinical settings. In the next few sections issues are explored related to the prevalence and aetiology to provide a context for the current review.

2.1. Prevalence

Estimates of the prevalence of BPD vary in the general population from about 0.7% to 2% and it is estimated that 70-75% of those with BPD are female (APA, Widiger & Weissman, 1991). However, these figures are based on assessments and diagnosis in clinical settings where females are more likely to present for treatment (Bjorklund,

2006).   It is estimated that about 10% of people seen in outpatient (community) clinics and approximately 20% of inpatients in hospital settings may suffer BPD (NIMHE, 2003; Widiger & Weissman, 1991).

2.2.   Aetiology

BPD was first recognised as a condition in the 19th century (Kernberg 1975; Stone 1990) but was only first formalised in DSM-III (APA, 1980).   There are a number of theories on the aetiology of BPD and many attempt to account for both biological and experiential factors.   There are models which use only one theoretical standpoint such as biological or experiential and these are often worth examining individually to gain a better understanding of the theoretical underpinnings of more integrated approaches.

Models that take a predominantly biological view often rely on theories related to either genetics (Torgersen, Lygren, & Oien, 2000), neurophysiological impairments (Rusch, van Elst, & Ludaescher, 2003; Schmahl, Vermetten, & Elzinga, 2003) or the effects of stress and cortisol on brain development (Gerhardt, 2004) and suggest that one or more of these biological factors leave the individual with a weakness or predisposition to developing BPD.   However, such theories do not fully explain the development of BPD as they fail to consider the effects of individual social and attachment circumstances.

 Family studies have identified a number of risk factors that may be relevant in the development of personality disorders.   These include poor early attachment styles (Levy, 2005) and invalidating family environments where parental styles are likely to

be non nurturing, distant and critical (Fruzetti, Shenk & Lowry, 2003; Fruzetti, Shenk & Hoffman, 2005). Experiences of any form of abuse during childhood are also associated with the development of BPD. Studies examining the correlation between BPD and abuse have indicated that patients with BPD are significantly more likely to report previous experiences of abuse or neglect as young children (Brown & Anderson, 1991; Zanarini et al., 1989, 1997, 2000).

An integrated model has been proposed by Linehan (1993a) on the basis of clinical observation. She proposed a biopsychosocial theory of the development of BPD. This is a three factor model where there is: a genetic predisposition to poor emotional control; poor/deprived childhood experiences; and the experience of growing up in an emotionally invalidating environment (where parental responses to emotions are inconsistent). Linehan (1993a) suggested that it is the combination of these three factors which leave the individual with inappropriate emotional regulation skills which lead to the development of a diagnosis of BPD (Berger, 2004; Linehan, 1993a).

While it is appreciated that the term BPD comes from a medical model and is flawed in its construct due to its failure to take social and cultural factors into consideration and the vast range of difficulties experienced by individuals, the term shall be used for ease in this paper to represent the group of individuals diagnosed with the label. In addition, every participant in the study had been given the diagnosis of BPD, which reflects a similar set of difficulties present in the DSM-IV and is therefore used for continuity.

2.3. Approaches to treatment

Treatments for BPD in the past have largely relied on pharmacological interventions. However, such treatments are often not effective on their own and psychosocial interventions are often required (Becker, 2005 as cited in Turner, 2005; NICE, 2008). Such interventions may be based on psychodynamic models to explore and find the roots of present feelings in childhood or cognitive models to identify and develop techniques to modify disruptive behaviours (Barley, Buie, Peterson, & Hollingsworth, 1993; Freeman, 2004). It is only since the mid 1980s that specific systematic interventions were developed to work with the difficulties faced by the clients. At the time of writing, there were three main interventions which were currently favoured for the treatment of BPD: Psychodynamic therapy, Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy.

2.3.1. Psychodynamic Interventions

In much of the research on the use of psychodynamic approaches for BPD, positive outcomes are generally witnessed. Piper, Rosie, Azim and Joyce. (1993) in their Randomised Control Trial (RCT) of psychodynamically group-orientated partial hospitalisation, found significantly better outcomes than the control group for seven out of seventeen of their outcome variables. These included interpersonal functioning, illness symptoms, self-esteem, life satisfaction, and defensive functioning. Improvements were seen after four months treatment and were maintained at the eight-month follow-up.

Mentalisation Based Treatment (MBT) is a psychodynamic approach aimed at reducing the psychosocial stress linked with personality disorders, in addition to increasing an individual's ability to mentalise and regulate their own thought processes and emotions (Bateman & Fonagy, 2006). In their RCT using MBT, Bateman and Fonagy (1999) demonstrated that reductions in deliberate self harm, suicidal behaviour, anxiety and depression were visible over the course of an eighteen month treatment programme and at thirty six month follow up.

Although it has been demonstrated that psychodynamically orientated therapy may be an effective treatment for some of the symptoms of BPD, this approach is largely dependent on the capacity of an individual to integrate their experiences with their own internal mental states. For those individuals who struggle with this, they are often unable to benefit from such approaches (Gibson, 2006).

2.3.2. Cognitive Behavioural Interventions

A number of cognitive therapy approaches have been used to help those suffering with BPD. These include standard Cognitive Behaviour Therapy (CBT), Cognitive Analytical Therapy (CAT), and Schema Therapy. There are consistent indications that CBT approaches are beneficial in the treatment of BPD. For example in a RCT comparing CBT plus Treatment as Usual (TAU) versus TAU, Davidson et al. (2006) reported significant reductions in suicidal acts, in-patient psychiatric hospitalisation and contacts with Accident and Emergency for the CBT+TAU group compared with TAU over the two years of study. Improvements in dysfunctional core beliefs and state anxiety were observed at two years follow up.

Although there does appear to be benefits of CBT as a treatment for BPD it has been found that these approaches are often not considered helpful by the patients, due to the strong focus on change, which is sometimes explained as invalidating (Amstadter & Squeglia, 2007; Linehan, 1993a).

2.3.3. Dialectical Behavioural Therapy

DBT is an adapted form of cognitive behavioural therapy developed by Marsha Linehan (1993b) which incorporates mindfulness and acceptance based philosophies and practice into the therapy. One of the key strengths of DBT lies in its use of highly structured manuals and protocols and a commitment to training for DBT therapists to ensure that treatment is delivered in a standardised manner.

A consistent research finding is that standard DBT for BPD, conducted in an outpatient setting, decreases hospitalisation, reduces the risk of suicide and improves retention rates in therapy (Binks et al., 2006; Bornovalova & Daughters, 2007; Feigenbaum, 2007; Martens, 2005). Such findings have led to the use of DBT in a broader range of clinical settings.

Many services that care for those who either are diagnosed with BPD (or who have similar symptoms) are now implementing DBT. The levels of risk and suicide in such settings are often high and the structured nature of DBT and its adherence to treatment protocols means that it also lends itself well to implementation in secure settings where additional support may be given to those who are often in most need and at higher risk.

2.4. Previous DBT systematic reviews

The present review focused on DBT for BPD. To date there have been very few systematic reviews on the efficacy of DBT for the treatment of BPD. Most reviews have focused on other types of psychological intervention, or have reviewed the efficacy of psychological interventions in general (Binks et al., 2006; Clarkin, Marziali, & Munroe-Blum, 1991; Davidson et al., 2006; Duggan, Huband, Smailagic, Ferriter & Adams, 2007; Guilé, Greenfield, Breton, Cohen, & Labelle, 2005; Levin, 2007; Paris, 2005).   In a recent Cochran review, Binks et al. (2006) examined psychological therapies for people with BPD, with a particular focus on DBT. However only seven studies were examined and all were RCTs using outpatient samples.

Only two reviews have specifically addressed the efficacy of DBT for BPD (Feigenbaum, 2007; Martens, 2005).   Feigenbaum (2007) examined seven papers on DBT for the treatment of BPD; four of the studies were RCTs using outpatients. The remaining three studies used inpatient samples (one of which was a follow up study). There was no comment about the methodology or the inclusion / exclusion rationale for choosing the seven articles included in the review. In addition, there was no attempt made to comment on the differences in outcomes between these two settings.

The review by Martens (2005) incorporated both qualitative and quantitative data and included a combination of RCTs and quasi experimental studies. However no method or any rationale of inclusion / exclusion criteria was presented, to justify the articles chosen to include in the review. As with the Feigenbaum review (2007), only a small

number of quantitative studies were included and no distinctions between in and outpatient uses of DBT were made.

2.5.   Rationale and aims of the present review

As a result of service implementation guidelines (e.g. NICE guidelines for BPD, 2009) and the Department of Health Guidance (e.g. "Personality disorder: no longer a diagnosis of exclusion", 2003), healthcare services have a requirement to develop specialist services for individuals with personality disorder. Due to the growing evidence base of DBT and its use within a variety of settings across an increasingly broad range of client groups, the current review focused on the evidence base of DBT for BPD.

There are a number of important differences in the implementation of therapeutic programmes between outpatient and inpatient settings. There are also additional structures and boundaries that exist when considering DBT for BPD in more secure units. For example, power differentials often exist between patients and staff which often undermine positive therapeutic relationships (Swenson, Sanderson, Dulit & Linehan, 2001). In DBT there is a strong emphasis on the therapeutic relationship between the 'patient' and the therapist which Linehan (1993b) felt was at the core of the effectiveness of the DBT strategies. Therefore, it could be assumed that inpatient uses of DBT may not be as acceptable as outpatient DBT due to the constraints on the therapeutic relationship that may exist in more secure settings. As DBT is increasingly being used within inpatient settings, the current review attempted to

explore if treatment setting affects outcome by comparing and contrasting both inpatient (secure and non secure) and outpatient uses of DBT.

Due to the hugely differing treatment conditions which exist in the literature, such as the length of the DBT programme and the various outcome measures used, the current review did not included a meta-analysis.

3.   Method

3.1.   Procedures for identification and selection of studies

A systematic review of the literature examining the treatment of personality disorders using DBT was conducted between 21st and 29th September 2009 using the main psychological electronic databases: PsychINFO; PsychArticles; Web of Science; Medline using the Medical Subject Headings (MeSH) database; Ovid; and Open Sigle which explores the grey unpublished literature in Europe.   In addition, the NHS specialist reviews database was searched and this included the Cochrane Database of Systematic Reviews.   To ensure no articles were missed by the search terms, the reference sections of relevant studies and review papers were scanned and relevant references were searched for on the selected databases.

The keywords used for the search were developed with reference to the review question and included *Dialectical Behaviour Therapy* and *Personality Disorder* and their derivatives, identified using the truncation function of the database.   A full

summary of the search terms and limiters used and the number of articles identified can be seen in Table 1.

The titles and abstracts (where available) of the 191 potentially relevant studies were scanned using the selection criteria identified in Figure 1. All relevant selected articles were combined in a reference management database (Refworks) to remove duplicates. This resulted in 131 articles being excluded from the present review. The full text articles were retrieved for the resulting 28 studies which potentially addressed the research question of the present review. To ensure the sensitivity of the search criteria, the searches were performed once more on the 13th October 2009 using the search terms and inclusion /exclusion criteria to ensure previously identified papers were found[1].

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[1] The search was repeated on 26th March 2010 to ensure no new articles had been published which could be included in the present review

Table 1.   Database Search Summary

Database	Date searched	Key words	Number of hits	Number of potentially relevant articles extracted	Number of relevant articles	Limiters
PsychINFO and PsychArticles	21/09/09 to 29/09/09	*" Dialectical Behav* Therapy" AND "Personality Disord*"*	293	80	24	English; Exclude dissertations; Adult; Peer reviewed journals
Web of Science	21/09/09 to 29/09/09	*" Dialectical Behav* Therapy" AND "Personality Disord*"*	184	48	15	Document type = Articles and English
Medline with MeSH Database	21/09/09 to 29/09/09	*" Dialectical Behav* Therapy" AND "Personality Disord*"*	116	49	16	Document type = Articles and English;
Ovid	21/09/09 to 29/09/09	*" Dialectical Behav* Therapy" AND "Personality Disord*"*	35	9	3	English; Adult;
Open Sigle	21/09/09 to 29/09/09	*"Dialectical Behav* Therapy" + "Personality Disord*"*	39	1	1	None Applied
Cochrane	21/09/09 to 29/09/09	*"Personality Disorder*"*	47	4	1	None Applied
Total Number Articles Retrieved			714	191	60	
Total Number Unique Relevant Articles Retrieved (duplicates removed)					**28**	

3.2.   Rationale for selection criteria

The papers selected for the present review were those whose aim was to examine the effectiveness of DBT for BPD. Consequently only those studies that used a range of outcome measures and were quantitative in design were included.   Books were excluded as were theoretical and opinion papers, case studies and articles relating to adolescents.   Papers examining the interaction of DBT with specific drug treatment

were also excluded due to potential interference from the medication on DBT outcomes.

3.3   Paper retrieval

The twenty eight full text articles retrieved were screened against the inclusion / exclusion criteria in Figure 1.   On the basis of these criteria eight articles were excluded due to their focus on DBT for a non personality disorder; specific aspects of DBT such as phone coaching; adolescents; or where DBT had been too heavily modified from the standard DBT package.   This resulted in the selection of twenty articles for inclusion in the present critical review paper which are identified in the reference list by the use of an asterix.

3.4   Data Extraction

Data from the twenty articles were extracted using the Data Extraction Proforma (see Appendix A).   The form was designed specifically with the present review in mind and the extraction categories were adapted from the NHS Critical Appraisal Skills Programme (CASP) and the categories identified by Crombie (1996).

3.5   Data Synthesis

Based on the data extracted from the articles using the Data Extraction Proforma (Appendix A), the information was synthesised into summary tables of the findings (Tables 2-4).   The studies were grouped according to whether they were outpatient or

inpatient and by study design. This resulted in three broad categories of classification

for the studies: outpatient RCTs, outpatient non-RCTs and inpatient studies.   Within

these three categories, the articles were ordered by date of publication starting with

the oldest. Each article was given a unique ID code ranging from 1-20.   A meta-

analysis was not conducted due to the variability within the data sets, i.e., sample size,

length of DBT programme, use of comparator groups and outcome assessments used.

Figure 1.   Flow Chart of Full Text Screening

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┌─────────────────────────┐          ┌──────────────────────────────────────────┐
│       N =191            │          │            N = 131 Excluded.               │
│ (Potentially relevant   │──────────▶│                                            │
│  articles extracted     │          │ Exclusion Criteria:                        │
│  from database searches)│          │ - Articles with no specific focus on DBT   │
└─────────────────────────┘          │ - Articles with focus on specific aspects  │
             │                       │   DBT i.e.  Phone coaching                 │
             │                       │ - Case studies                             │
             │                       │ - Reviews                                  │
             │                       │ -Duplicates of articles found in other     │
             │                       │   databases                                │
             │                       │ - Studies where DBT was heavily modified   │
             │                       │ - Drugs as treatment either with or as     │
             │                       │   alternative to DBT                       │
             │                       │ - Drug and cluster B improvements          │
             │                       │ - Studies on adolescents                   │
             │                       │ - Focus of DBT with non PD client's i.e.   │
             │                       │   Eating Disorders                         │
             │                       │ - Dissertations                            │
             │                       └──────────────────────────────────────────┘
             │
┌──────────────┐                     ┌──────────────────────┐
│   N = 60     │─────────────────────▶│      N= 32           │
│              │                     │ Duplicates Removed    │
└──────────────┘                     └──────────────────────┘
             │
             │                       ┌──────────────────────────────┐
             │                       │        N = 8 excluded        │
             │                       │                              │
             │                       │ Reasons:                     │
             │                       │ -Focus of article on DBT for │
             │                       │   non personality disorder   │
┌──────────────┐                     │ (N=3)                        │
│   N = 28     │─────────────────────▶│ -Focus on specifics of DBT   │
│              │                     │ (N= 2)                       │
└──────────────┘                     │ -Focus on adolescents        │
             │                       │ (N=2)                        │
             │                       │ -DBT too heavily modified.   │
             │                       │ (N=1)                        │
             │                       └──────────────────────────────┘
             │
             ▼
┌─────────────────────────┐
│     N = 20 included:    │
│                         │
│ Data Extraction and     │
│ Quality assessment      │
└─────────────────────────┘
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4.   Results

4.1.   General Description

Twenty articles were identified using the selection criteria and were included in the present review.   The studies were categorised according to whether they were examining outpatient or inpatient uses of DBT and by the study design.   Eight of these studies used RCTs in examining outpatient DBT (ID code: 1-8), six studies used either repeated measures or quasi-experimental design to examine outpatient DBT (ID code: 9-14), and six studies examined inpatient uses of DBT (ID code: 15-20).

A summary of the methodology, outcome measures, used results and study limitations can be found in Tables 2-4 respectively[2].

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[2] A complete list of abbreviations used within the table can be found in Appendix B.

Table 2.   Randomised Control Trials.   Outpatient Studies.

ID code, Author (s), Country	Aims of study	Sampling and treatment duration	Measures used and method of analysis	Results	Reliability and limitations
1. Linehan et al. (1999). **USA**	To Compare DBT with TAU amongst substance abusing women.	Ppt referred ages 18-45 who met criteria for BPD and substance abuse disorder. Excluded if psychosis, LD, Bipolar disorder. Ppt screened using DSM-III and PDE interviews. **Sample Size = 27** **Treatment Duration = 12 months.**	Independent clinical interviewers blind to treatment condition conducted assessments at 4,8,12 and 16 months. Drug abuse assessed using structured clinical interviews and urinalysis at each assessment point. Other measures included PHI, SHI GSA, GAS and STAXI. ANCOVA used to analyse drug abuse scores and ANOVA used for all other measures.	**Drug Abuse***:* Significant improvements in DBT compared to TAU, with higher proportion of drug abstinent days for DBT. DBT Ppt also produced cleaner urinalysis samples. **Treatment Retention:** a trend emerged in favour of DBT compared with TAU with dropout rates of 36% and 73% respectively. **Psychotherapy:** no between group differences existed on other outcome measures during assessment or at the 12 month post treatment follow up. At 16 months DBT demonstrated greater improvements in social and global functioning and significantly lower scores on the GSA.	Use of Randomised Control Trial provides high reliability and confidence in the results. Limitations include 1) the additions made to standard DBT, 2) Small sample size (n=27) which reduces statistical power to low 3) Study conducted where DBT was developed 4) poor generalisability to males and non substance abusers 5) DBT Ppt received more treatment than TAU which may bias final resulted from outcome measures due to additional inputs received by DBT group. Finally due to lack of follow up data, efficacy of DBT in long term cannot be determined.
2. Koons et al. (2001). **USA**	To compare DBT against TAU in women veterans	Ppt included women veterans who met DSM-IIIR criteria for BPD. Exclusion criteria included schizophrenia, bipolar disorder, substance dependence and ASPD. **Sample Size = 20** **Treatment Duration = 6 months**	At assessment Ppt interviewed using the structured interview for DSM-III Axis I and II. Measures given at baseline, and 6mths and included: PHQ, BSI, BHS, BDI, HRSD, STAXI, DES and health care utilisation data collected from the decentralised hospital computer programme. The treatment groups compared by t-tests. In order to assess if treatment conditions differed in change over time a series of 2 and one way ANOVAS were used.	Results generally supported efficacy of DBT. **1.** Of 11 outcome variables patients differed significantly from TAU on 4 (Suicidal ideation, hopelessness, BDI and Anger out). **2.** On 4 others only those in DBT changed significantly (no. parasuicides, no. hospital stays, Anger in & DES **3.** On Hamilton depression and number BPD criteria, both groups changed significantly. **4.** On the anxiety variable, neither group made significant improvements.	Randomised control trial produces high reliability in results; however, results must be interpreted with caution. Limitations include 1) the specific group targeted which does not allow for generalisability. 2) The small sample size (n=20) which causes low statistical power 3) The difference in anxiety scores between DBT and TAU groups at assessment means Ppt not matched 4) the differing treatment conditions resulted in DBT gaining more access to treatment than TAU group which may result in less favourable changes in post measure scores within TAU group.

Table 2 Continued.   Randomised Control Trials.   Outpatient Studies.

ID code, Author (s), Country	Aims of Study	Sampling and Treatment Duration	Measures used and Method of Analysis	Results	Reliability and limitations
3. Linehan et al. (2002). **USA**	To assess if DBT is more effective for heroin dependent women than Comprehensive Validation Therapy with 13 step (CVT+12)	Ppt selected on basis fulfilled criteria 1) had diagnosis BPD based on PDE and DSM-IV 2) had diagnosis opiate dependence, 3) absence Bi-polar disorder, 4) absence pregnancy, 5) absence of treatment coercion. Drug replacement medication given to all Ppt during treatment. **Sample Size = 23** **Treatment Duration = 12 months**	Urine analysis- 3 times weekly for the duration to assess proportion of positive tests. 2. Interviews and self reports, pre-treatment, 4,8,12 and 16 months. During each 4-month period, client reports of illicit drug use are measured. Data were analysed on intent to treat sample of 23. Baseline characteristics used t-tests for continuous measurements, chi-square tests for categorical measurements and urine analysis used regression tests.	**Attendance and Drop out**: Higher treatment drop out in DBT compared with CVT-12, possibly due to male therapist in DBT cohort, however there was greater attendance rates at DBT than CVT-12. **Drug use**: both groups demonstrated significant decline in drug use, with DBT eliciting greater improvements, however at 8mth point CVT-12 Ppt showed increasing drug use, while DBT Ppt maintained reduction in use levels. In addition when compared with non opiate positive results, a significant reduction still shown (t=3.75, p<0.001).	The study was conducted well, using an RCT which accounted for and controlled Ppt within each group. Intent to treat approach adopted, to allow for use of all data. Limitations include: 1) no control group was used to measure either treatment against, (i.e. drug replacement treatment alone) 2) Small sample size of 23 is too small to make any definitive conclusions due to low statistical power 3) the sample was purely female 4) Differences between therapists in each condition could also have impacted on treatment results, and the male therapist in DBT group could have resulted in the poorer treatment retention rates shown.
4. Verheul et al. (2003). **Netherlands**	To compare Treatment as Usual (TAU) with DBT for BPD.	64 Ppt assessed eligible. 31 assigned to DBT 33 assigned to TAU. Exclusion criteria, diagnosis bi-polar disorder, those not fluent in Dutch, and severe cognitive impairments. Diagnosis BPD made using PDE AND DSM –IV. **Sample Size = 58** **Treatment Duration = 12 months**	Baseline measures at 1 -16 weeks average 6 weeks before randomisation. Then therapy began 4 weeks later. Self harm behaviours measured at baseline, 11, 22, 33, 44 and 52 weeks, using sections of the BPD severity index and a semi structured interview to determine frequency of symptoms. Methods of data analysis included chi-square and general linear mixed model.	**Treatment retention** showed that more patients in DBT (63%) continued in therapy for the year compared with TAU (23%), (x2 =9.70, p=0.002). **High risk behaviours** assessed using general linear mixed model was used, at week 52 assessment, a significant difference was found for reported self harm behaviours for DBT (35%) compared with TAU (57%). **Impact of baseline severity**: DBT found to be superior over TAU for patients in high risk group, but no comparable difference found for low risk group between conditions.	Good rigorous study, good sample size, and one of a few studies to examine use DBT outside USA which demonstrates the transferability of DBT. Considered range of clinical implications and used good standardised tools for assessment. Quite transparent throughout. Limitations: 1) only compared DBT against TAU. 2) Can't assess impact medication had on overall findings, 3) potential bias with researchers finding out which treatment group they're assessing. 4) Sample all female.

Table 2 Continued.   Randomised Control Trials.   Outpatient Studies.

ID code, Author (s), Country	Aims of study	Sampling and treatment duration	Measures used and method of analysis	Results	Reliability and limitations
5. Van den Bosch et al. (2005). **Netherlands**	To assess if treatment results observed at end of treatment sustained during a 6mth follow up.	As Verheul (2003) Study above. (Id Code 4)	As Verheul study above. All available data used from the complete study as only 71% of Ppt had complete data at weeks 52 (discharge from DBT) and 78 (6 mth follow up). General Linear Mixed Modelling used to analyse data. Instruments used included BPD severity index and suicidal behaviours measured using the LPC	The results from this study indicate that the benefits originally observed in the Verheul study of improvements in impulsivity and self-harming behaviours in the DBT group over the TAU group are maintained. Also, it was shown that there was also a greater reduction in alcohol consumption in the DBT Gp at discharge and follow up. No additional gains made post follow up by DBT group.	As this study used the same Ppt it maintained the original rigor with which the original study was completed. Due to some missing data, all available data has been incorporated into this study to create more valid estimates of effects, compared to if they had only used data from weeks 52 and 78. The limitations of this study remain as those within the original.
6. Linehan et al. (2006). **USA**	To evaluate if unique aspects of DBT are more effective than treatments offered by community Treatment by Experts (CTBE).	All female and diagnosed with BPD using DSM-IV & PDE. Inclusion at least 2 suicide/self harm attempts in last 5 yrs, min one in last 8 weeks. Exclusion Criteria: 1) Lifetime diagnosis Bi-polar disorder or psychosis 2) seizure disorders needing medication 3) need for continuous treatment for another condition 4) requirement to be treated. **Sample Size = 101** **Treatment Duration = 12 months**	Initial assessments taken prior to treatment allocation and at 4 Mth intervals during treatment and follow up. Measures used: Suicide attempt self-injury interview, SBQ, RFLI, THI, HRSD. Analysis conducted using random regression modelling and mixed models ANOVA. T-tests used for normally distributed variables and Mann-Whitney for non-normally distributed variables.	**1) Medication use:** During treatment use medication significantly reduced in DBT group compared with CTBE **2) Treatment retention:** compared with DBT, CTBE Gp members significantly more likely to drop out of the study **3) Suicidal behaviours**: the DBT group was recorded as having half rate suicide attempts than CTBE GP, (23.1% versus 46%) **4) Crisis service:** Results show CBTE Gp used crisis services significantly more than the DBT group, and less hospital admissions **5) HRSD:** Both groups had reductions in scores on HRSD however difference between the groups was not significant.	Use of Randomised Control Trial provides high reliability and confidence in the results. The limitations of this study lie in the relatively small sample size and the fact that CTBE subjects dropped out of the study completely more than DBT subjects despite efforts to retain.

Table 2 Continued.   Randomised Control Trials.   Outpatient Studies.

ID code, Author (s), Country	Aims of Study	Sampling and Participants	Measures used and Method of Analysis	Results	Reliability and limitations
7. Harned et al. (2008). **USA**	To evaluate the efficacy DBT against treatment by non-behavioural psychotherapy experts in reducing Axis 1 disorders among suicidal individuals with BPD.	As Linehan (2006) above. 101 Ppt selected based on the same criteria as Linehan (2006) **Sample Size = As Linehan (2006) study above (Id code 6)** **Treatment Duration 12 months.**	SCID-I assessed Axis I at pre treatment. Other measures included: The THI, LIFE Using timeline follow back procedure weekly psychological status ratings assigned for each disorder identified at pre-treatment. For substance dependence disorders criteria used from DSM-IV. Group comparisons conducted on intent to treat sample using t-tests for continuous variables. Chi-squares and Fishers exact tests used for categorical variables.	Treatment groups did not significantly differ on any demographic variables or in Axis I diagnoses at assessment. For specific Axis I disorders DBT Ppt were more likely to achieve full remission from Substance dependence disorders (SDD) than CBTE Ppt. Additionally DBT Ppt spent significantly more time in partial remission and less time in no remission than CBTE Ppt.	As Linehan (2006) study above (Id code 6)
8. Soler et al. (2009). **Spain**	To evaluate whether skills training within DBT is sufficient to induce observable improvement in people with BPD compared with standard group therapy (SGT).	Inclusion criteria: 1) DSM-IV diagnosis BPD based on Axis I and II interviews, 2) age 18-45, 3) no schizophrenia, LD psychosis, organic brain syndrome, or substance misuse 4) Clinical global impression severity score >4, 5) no current psychotherapy. **Sample Size = 60** **Treatment Duration = 3 months**	Measures included: CGI-BPD, HRSD, HRSA, BPRS, SCL 90-R, The Buss-Durkee Inventory for hostility/irritability, Barrat Inventory to assess impulsivity. In addition self-injury, suicide attempts and visits to psychiatric emergency were also monitored. Demographic and clinical variables compared with chi-square for categorical data and t-test for continuous data. A paired t-test used for before and after analyses. Kaplan-Meier survival analysis was used for time to dropout.	**Treatment Retention:** at end of study 19 Ppt in DBT and 11 in SGT. Reasons for dropouts in both conditions were patient dropout (7 DBT; 13 SGT) and inpatient hospitalisations (3 DBT; 6 SGT). **Psychiatric symptoms:** In HLM analysis DBT group showed greater decrease in depression and general psychiatric symptoms when compared with SGT group. **Functioning:** HRSA and BPRS also showed significant differences between DBT and SGT groups A greater decrease in scores for the SCL-90 and Buss-Durkee inventory also observed within DBT group. No significant differences were observed in the other behavioural scales.	Use of a RCT improved reliability in findings, however, limitations include the short duration of DBT group and the use of a single blind design, where the extent to which Psychiatrists were unaware of Ppt treatment condition cannot be determined

4.2 Outpatient Randomised Control Trials.

Eight studies used a RCT to examine the effectiveness of outpatient DBT (studies 1-8, Table 2). Sample sizes ranged from 23-101 and the total number of participants was 465 (which includes the use of the same sample in studies 4 and 5 and 6 and 7).   All the participants were female and the mean ages of participants ranged from 29.6-36.1 years.   Ethnicity was only reported in five of the studies (ID Code 1,2,3,6&7) and the majority of participants were described as either Caucasian or European descent (78.6%).   All the participants were diagnosed with BPD using standardised measures, which included the structured clinical interview for the DSM-III or DSM-IV or the Personality Disorders Exam (PDE). Studies 1,3,4,5,6,7 used both measures.

With respect to treatment conditions, six of the studies used the standard twelve-month DBT programme (studies 1,3,4,5,6,7).   One study used a six-month DBT programme where all modules and modes of treatment were delivered (study 2) and the final study (study 8) used a three-month DBT programme which was adapted to only include the 4 skills training modules over 13 weekly sessions.   Four of the RCTs compared standard DBT against the local version of Treatment As Usual (TAU; studies 1,2,4,5).   The remaining studies compared DBT against a different treatment intervention: Comprehensive Validation Therapy with 12 step (CVT+12) in study 3; Community Treatment by Experts (CBTE) in study 6; Non Behavioural Psychotherapy in study 7 and finally Standard Group Therapy (SGT) in study 8.

4.2.1   Results from outpatient RCTs

All eight of the outpatient RCTs demonstrated that statistically significant improvements were made by participants enrolled in DBT compared with the alternative interventions.   Of these improvements, four main findings emerged across the majority of the studies as most important.

I.   Reduction in self harm

Koons et al. (2001; study 2) assessed the use of DBT against TAU and found the proportion of patients reporting any acts of self harm at pre treatment and post treatment reduced from 50% to 10% in DBT and 30% to 20% in TAU.   In examining the results from the outcome measures used, DBT patients reported significantly less Suicidal Ideation (SI) and hopelessness post treatment than those in TAU.   TAU patients did not significantly change on either of these scores.   These findings were further supported in studies 4, 5 and 6 where DBT demonstrated greater improvements in suicidal / self harm behaviour when considered against the comparator intervention.   In a follow up study of Verheul et al. (2003; study 4), Van den Bosch, Koeter, Stijnen, Verheul and van den Brink (2005; study 5) found that the original improvements observed in self harm behaviours at immediate completion of DBT were maintained up to 6-months post discharge from the group.

II.   *Improved treatment retention*

Studies 1,3,4,6 and 8 all examined either treatment retention or attendance rates of participants and found significant improvements in the DBT group compared with their control groups (TAU: study 1,4; CVT+12: study 3; CTBE: study 6 and SGT: study 8).   Studies 1,3,4 and 8 all had comparable rates of retention in DBT around 64%. The DBT rates of dropout in study 3 were greater than CVT+12. The authors attributed this to the presence of the only male therapist in the DBT group who it was felt possibly experienced difficulty in understanding, accepting and validating the clients' perspectives.   Despite this the DBT group in study 3 had significantly higher attendance rates than CVT+12 (M=26.6 $\pm$ 15.9 for DBT and M=10.8 $\pm$ 12.8 for CVT+12).

III.   *Reduction in substance /medication use*

Linehan et al. (1999, 2002; studies 1&3) specifically examined the effectiveness of DBT in reducing illicit drug misuse when compared against either TAU (study 1) or CVT+12 (study 3) and found within both studies that DBT was superior to the comparator programme.   In study 1, it was found that DBT resulted in a higher proportion of drug abstinent days than TAU at 4, 8, and 16 months; with observable mean rates of 0.83 and 0.56 days respectively in the treated year total.   In study 3 both groups demonstrated a significant decline in drug use of 27% DBT and 33% CVT+12.   At the 8-month point however, CVT+12 participants demonstrated an increase in drug use while DBT participants maintained reductions.

In contrast, Linehan et al. (2006) examined the use of prescribed medications by participants during DBT. Using random regression modelling, it was found that whilst there were no observable differences in the use or types of psychotropic medication at pre-treatment, during treatment medication use significantly reduced in the DBT group compared with CTBE.

IV. *Improvements in functioning*

Several additional benefits of DBT compared to the control condition were observed across the RCTs. These included improvements in social and global functioning (studies 1&8), reductions in scores of depression (studies 2&8) and remission from co-morbid Axis I conditions (study 7). In addition to the benefits of DBT as previously discussed, studies 2 and 6 found that DBT resulted in a decreased use of crisis services and hospital admissions. At year one (study 6), 43.1% of DBT versus 57.8% of CTBE subjects visited the emergency department at least once and in addition 19.6% of DBT subjects and 48.9% of CTBE subjects had at least one hospital admission during this period.

4.3 Non randomised control trials (outpatient)

Six studies used a non-RCT design to examine the effectiveness of outpatient DBT (Studies 9-14; Table 3). Study 9 used a quasi-experimental design and compared DBT against Community Treatment by Experts (CCT) and the remainder used a repeated measure design. The total number of participants that completed DBT across these six studies was 200 and the majority was female (89.9%).

Table 3.   Non Randomised Control Trials.   Outpatient.

ID code, Author (s), Country	Aims of study	Sampling and treatment duration	Measures and method of analysis	Results	Reliability and limitations
9. Turner (2000). **USA**	To assess effectiveness of DBT for BPD by comparison with a Client Centred Therapy (CCT) control condition.	19 females and 5 males were selected on basis of 2 assessments 1) interview based on DIB and DSM III 2) PDE. All met criteria for BPD. **Sample Size = 24** **Treatment Duration = 12 months**	Assessments conducted pre treatment at 6 mths and 12 mths Measures for self-harm, measures for affective disturbance and measures of global mental health functioning (GMHF). Means and standard deviations provided for dependent measures from both assessor and self report. To compare interventions, repeated measures multivariate ANOVA used.	**1. Self harm behaviour** showed significant improvements for both treatments, however DBT gains were greater $F(6, 84) = 5.1$, $p = 0.001$, $R^2 = 0.268$. **2. Emotional Domain** showed improvements for both treatments, however there was a significant treatment Vs time effect. DBT gave lower rates of impulsivity at 12 months than CCT but not 6 mths and same was shown for anger scales. **3. GMHF**, DBT again gave more significant results at 12 mths than CCT.	Of the 24 Ppt, 9 DBT and 6 CCT were still in treatment at 12 mths, however all 24 completed all measures. This study provided excellent descriptive data on Ppt selected. Ethnicity and sex, education levels stated. Quality of therapist shown to have effect on outcome. No control condition was used to assess either treatment against.
10. Ben-Porath et al. (2004). **USA**	To evaluate the effectiveness of DBT in Community Mental Health Team (CMHT) setting with Ppt with BPD and co morbid Axis 1 conditions.	36 clients recruited from CMHT diagnosed with BPD and axis 1 problems. 10 Ppt excluded due to : 1) gaining additional psychological help outside DBT 2) not receiving complete DBT procedures 3) not completing minimum of 6 mths 4) Abuse alcohol or drugs. **Sample Size = 26** **Treatment Duration = 6 Months**	Measures taken 6-mth prior to and end of treatment. Baseline measures recorded for 3 treatment targets 1) Life Threatening Behaviours, tracked using daily Diary Cards 2) Therapy Interfering Behaviours and, tracking number of missed sessions per Ppt 3) Quality of life interfering behaviours using BHS, SCL-90, DRPS and employment rates. Staff also completed measures on Ppt, using DPRS. Method of analysis predominantly used paired t-tests and Chi square to compare scores at start and end of in treatment	**Target 1**: paired t- tests used to compare suicidal thoughts pre and during treatment show that Ppt recorded far less thoughts during treatment than 6 mths prior. **Target 2:** assessed through examination of attendance rates. Attrition at 11.5%, found to be significantly lower than other outpatient treatments e.g. Linehan (1991). **Target 3**: Employment status showed significant reduction in unemployment rates 78.3% prior to DBT and 60.9% during. Paired t- test on BHS revealed no changes. On SCL-90 Ppt recorded improvements in several sub-scales post treatment.	1) Only 30% of group had history suicidal behaviour, therefore data not representative for the whole group. 2) Assessments and diagnosis based on 1 psychiatrist, therefore risk of misdiagnosis as no standardised measured used to assess for presence BPD or Axis 1 problems. 3) DBT only completed for 6 mths, not representative of many other studies where Ppt enrolled for 12 mths therefore may not reflect as accurate a picture. 4) Repeated measures design was used, therefore no control group to assess changes against. However strength in non- homogenised sample, therefore could prove more reflective of real world settings.

Table 3 Continued.   Non Randomised Control Trials.   Outpatient.

ID code, Author (s), Country	Aims of study	Sampling and treatment duration	Measures and method of analysis	Results	Reliability and limitations
11. McQuilan et al. (2005). **Switzerland**	To examine the effectiveness of an intensive version DBT for patients in crisis, in an outpatient setting	During study period 127 patients referred Patients assessed using PDE. After assessment 87 Ppt admitted to the programme. Of 87 referred, 71 completed the programme. **Sample Size = 71** **Treatment Duration = 3 weeks**	Baseline measures taken pre and post using BDI, BHS, SASS. Analysis used was paired t-test. Effect sizes also measured. Independent t-tests used for continuous samples	Treatment completion high, with only 16 dropouts. No significant differences found in pre-treatment scores on measures for patients completing programme, those dropped out and those referred elsewhere. Following completion of DBT Significant changes noted for BDI (t= 6.76, p=0.001, medium effect size 0.60) and BHS (t=2.58, p=0.012, low effect size 0.26). No significant changes noted for SASS.	The strength of this study lies in its larger sample size which has proved intensive DBT is a good intervention for those in crisis. Limitations: 1) no control group was used 2) No statement of Ppt characteristics of those finally completing DBT was provided 3) The study period of one month was short and may not represent total gains, particularly over the longer term. 4) Measures of changes in Parasuicidal and Self-harm behaviours were not measured, only scores on BDI and BHS which are open to flaws of over/under reporting.
12. Brassington and Krawitz (2006). **New Zealand**	A pilot study to examine the "clinical utility and feasibility of implementing DBT into standard New Zealand public mental health services.	11 Ppt recruited from existing service, undergoing TAU. Ppt Screened IPDE. 11 found suitable, 1 dropped out. Data analysed on 10 Ppt. All Female 21-53 yrs old. **Sample size = 10** **Treatment Duration = 6 months.**	Outcome measures collected pre and post treatment using MCMI (3rd Ed) and SCL-90-revised. Only 5 Ppt completed SCL-90 between both groups. Qualitative interviews conducted at discharge for all Ppt. Analysis used Independent t-tests for pre /post measures.	**Improvements in functioning:** were made on 10 of the 24 scales of the MCMI-III, including borderline, paranoid, anxiety and dysthymia. **SCL-90**: Data from the 5 to complete the SCL-90 demonstrated that statistically significant reductions were evident on the Global Severity Index and 10 of the 12 sub scales **Hospitalisation:** There were less acute inpatient stays and all 10 patients reported being satisfied with their experience of DBT. 4 of the 7 also reported less incidents of self-harm.	The study was conducted well for a pilot study and appeared to research all aspects needed to assess the feasibility of incorporating DBT into standard Mental Health Care. The study had high retention rates and the use of standardised questionnaires allowed for objective assessment of the individuals. The small sample size and small number of data collection for the SCL-90 is not representative. In addition no control group was used, so it is therefore difficult to predict real impact of the DBT on the groups.

Table 3 Continued. Non Randomised Control Trials. Outpatient.

ID code, Author (s), Country	Aims of study	Sampling and treatment duration	Measures and method of analysis	Results	Reliability and limitations
13. Harley et al. (2007) **USA**	To examine the effectiveness of a modified DBT Programme for BPD in a naturalistic setting	Ppt with BPD referred by primary care physicians. Ppt screened using DSM-IV interview. Exclusion criteria included: medical or cognitive impairments, a resistance to commit to completing full course and those with no individual therapy sessions outside group. **Sample Size = 49** **Treatment Duration = 7 Months**	Baseline measures included PAI & SOS-10. Pre and post Changes measured on Borderline BOR, Depression DEP, Anxiety ANX, Suicide SUI and Negative Impression Management NIM, sub scales of PAI. Descriptive statistics obtained for outcome data and comparisons made between completers and drop outs using MANOVA	**Treatment Retention** 49% completion rates for those entering full cycle DBT. 51% dropout rate. 70% of those with out-system therapists dropped out compared with 35% of this with in-system therapists Chi Square for this was significant p=0.05. **PAI Scores**, mean pre treatment t-scores on mentioned sub-scales elevated (>70) demonstrating significant difficulties. Post treatment mean t-scores were significantly improved on mentioned sub-scales, except ANX.	Naturalistic setting of this study allows for real world hypotheses to be made with results showing significant improvements on BPD symptoms. Limitations: 1) No control group was used. 2) All Ppt included not undertaken full treatment under the same conditions i.e. In-system and out-system therapists, therefore hard to ascertain how much of an impact this had on results. 3) This study had no follow up data, so conclusions about the overall efficacy would be hard. 4) Individual therapist characteristics were not controlled, therefore we can not assess the impact of one to on therapy on overall treatment gains.
14. Stanley et al. (2007). **USA**	To evaluate the effectiveness of a shorter course of DBT in reducing urges for non-suicidal self-injury (NSSI).	Ppt with diagnosis BPD enrolled. All were outpatients and had active suicidal ideation at baseline. Exclusion criteria: psychotic disorders and LD or other cognitive impairment. Diagnosis determined by interview for DSM-IIIR Axis I and II. **Sample Size = 20** **Treatment Duration = 6 Months**	NSSI measured using a count of episodes in previous week. Other outcome scores included BHS, BDI and HAMD. Paired t-tests used to assess changes from pre and post scores	All variables except HAMD decreased significantly following 6 months DBT. HAMD did not show a significant decline. Drop out rate at 5% (1/20) who declined due to group element of programme.	Brief study with high rates of retention, however due to lack of follow up it cannot be determined if changes were maintained long term. In addition lack of comparison / control group and small sample size leave results non-generalisable.

The mean age of participants completing the studies was 32.44 and the majority described themselves as Caucasian (88%). The majority of the participants were diagnosed using standardised measures: these included the structured clinical interview for the DSM (either DSM III or IV); the PDE or the Diagnostic Interview for Borderlines (DIB); study 9 used all three. Study 10 used no standardised measures and diagnosis was purely based on a semi-structured interview with a psychiatrist.

The duration of the DBT programmes in the non-RCT studies varied considerably. Treatment lengths ranged from 3 weeks to 12 months. In the majority of the studies the structure and content of the DBT programme was largely unaffected, with the only change being how often group sessions were delivered In the majority of the studies, participants still received the group skills training sessions weekly in addition to their individual sessions and phone coaching. In study 11, however, where DBT was delivered over 3 weeks, group members had skills training sessions 4/5 days per week and each module was taught only once.

4.3.1 Results from outpatient non-RCTs

All six of the outpatient non-RCTs demonstrated that participants enrolled in DBT made statistically significant improvements. The two main findings were improvements in functioning and reduced rates of self harm. These are discussed below. The majority of these studies used a repeated measures design with no reported control conditions. Good rates of retention for treatment were observed in the majority of these studies with an average rate of retention of 77.9%.

I.   Improvements in functioning

 Significant improvements in psychological functioning were reported in studies 9 and 11-14.   This included improvements in global mental health functioning (studies 9&12); hopelessness as assessed by Beck Hopelessness Scale (studies 11&14) and depression as assessed by Beck Depression Inventory (studies11&14).

Turner (2000) in study 9 assessed the efficacy of DBT against Client Centred Therapy and found improvements in scores on impulsivity and anger for both treatments over time. However, DBT gains were significantly greater at 12 months.   Brassington and Krawitz (2006; study 12) found improvements on 10/24 sub-scales of the Millon Clinical Multixial Inventory (MCMI III).   This included the Borderline, Paranoid, Anxiety and Dysthymia scales.   In the study by Harley, Baity, Blais and Jacobo (study 13), post treatment scores on the Personality Assessment Inventory (PAI), suggested improvements in Borderline, Depression and Suicide scales with no change from pre treatment scores on Anxiety sub-scales.

II.   Reduced rates of self harm / hospital admissions

Reductions in rates of self-harm / suicidal ideation and acute hospital stays were observed in 4 of the non-RCT outpatient studies (9,10,12,13).   Turner (2000; study 9) compared DBT with CCT and demonstrated significant improvements for both treatment conditions, however DBT gains were greater.

4.4 Inpatient studies

Six studies examined the use of DBT in an inpatient setting (Table 4, ID codes 15-20). Of these studies three used a quasi-experimental design to assess the effectiveness of DBT against a comparator group. Comparator groups were TAU in study 17 and waiting list controls in studies 18 and 20 (study 20 was a follow up from study 18). The sample sizes of participants ranged from 10 to 50 with a total sample size of 200 across all studies (although in studies 18 and 20 the same sample was used). The mean age of the participants was 30.3 and the majority were female (89%). In general very little demographic data was presented on the participants, however, in studies 15-17 data on either the average number of hospital admissions (studies 15&17) or average duration of hospital stay was reported (study 16&17). Ethnicity was not reported in any of the studies.

The majority of the participants were diagnosed using standardised measures such as the DIB (study 15&17), the structured clinical interview for the DSM-III or IV (studies16, 18&19), or the PAI (study 17). The length of the DBT programme ran in each study ranged from 3 to 18 months. In all the studies DBT was delivered as standard but with modifications to the duration of the programme.

Table 4. Non Randomised Control Trials. Inpatient Studies

ID Code, Author (s), Country	Aims of study	Sampling and treatment duration	Measures used and method of analysis	Results	Reliability and limitations
15. Bohus et al. (2000). **Germany**	To examine reduction in number of parasuicidal acts and improvement in emotional regulation.	24 females, who met criteria of BPD as diagnosed by DSM-IV and Diagnostic Interview for Borderlines- Revised (DIB-R) and at least 2 parasuicidal acts within past 2 years. **Sample Size = 24** **Treatment Duration = 3 months**	LPC; SCL-90; BDI, HAMD, STAI, HAMA; DES; STAXI. Test of normal distribution to check frequency of self-harming. Comparisons of means for variables at interval levels and Wilcoxon Matched Pairs Signed Ranks Test for ordinal variables	**SCL-90:** From 19 tests of differences in central tendencies (based on SCL-90 subscales) 16 highlighted significant differences. **DES, HAMA and HAMD:** Self-ratings for Dissociation, Anxiety and Depression also demonstrated significant difference. Overall effect size calculated at 1.04 (0.69-1.40)	Only improvements in 24 patients demonstrated, greater sample size is needed. No Control group used and Sample is purely female. DBT is normally ran for 12 months outpatient. This study only gave patients 3 months DBT, a full course is needed.
16. Low et al. (2001). **UK**	To assess the effectiveness of DBT in a group of self-harming women in a high security hospital.	17 females referred to the study. Inclusion criteria: 5 criteria for diagnosis BPD from DSM-III, current self-harming and motivation. 3 did not meet criteria. 1 was unwilling and 3 dropped out in first 4 mths. **Sample size = 10** **Treatment Duration = 12 months**	Data collected from 3 mths preceding therapy and the 6 months after, and 12 months during. Psychological variables assessed at baseline, 4 mths, 8 mths, at end and 6mths follow up. Rates of self-harm collected monthly from ward records. Additional measures included IDAS; DES; RFL; BHS; BSI; BDI and Impulsiveness scale. Analysis included repeated measures ANOVA's to examine treatment effects and paired t-tests for change within variables.	**Self-Harm:** 8/10 patients showed a reduction between pre and post scores. Post treatment-rebound effect indicated after first follow up. The repeated measures ANOVA showed significant effects for IDAS; DES; survival and coping beliefs sub-scale for RFL; suicide ideation and BDI.	The study appeared to be conducted rigorously and was quite transparent; however it has several major limitations. The Sample size of 10 is very small; there is no control group with which to compare treatment effects.

Table 4 continued.   Non Randomised Control Trials.   Inpatient Studies

ID Code, Author (s), Country	Aims of study	Sampling and treatment duration	Measures used and method of analysis	Results	Reliability and limitations
17.Evershed et al (2003). **UK**	To examine the effectiveness of DBT, targeting anger and violence, against TAU on a group of male forensic patients.	8 male forensic patients who met criteria for BPD as assessed by PAI completed 18months slightly modified DBT. A Comparison group of 9 who also met the criteria for BPD as assessed by the PAI completed TAU. This study used a cut off point of 65 for BPD symptoms. **Sample Size = 8** **Treatment Duration = 18 months**	Behaviour changes measured at six month intervals, prior to treatment, 7 and 12 months into treatment and after treatment using nursing records. Both groups completed psychometric tests, 1 mth prior to treatment, 9 and 18mths. The DBT group also completed the tests at 6-mth follow up. Overt and Covert hostility measured by BDHI; STAXI and NAS. Methods of data analysis included MANOVA for comparing group means and ANOVA for comparing means.	**Violence:** on seriousness of violence DBT engaged in less serious offences (f=8.05, p=<0.00) than TAU group (f=6.45, p=0.024). When comparing the means and standard deviations for psychometric tests using ANOVA, overall outcomes reflected DBT group either remained stable or improved on all measures, over the TAU group who appeared to be steadily worsening on several measures.	The study appeared to be conducted rigorously and was quite transparent, however it has several major limitations: 1) Small sample size (all male and forensic). 2) They used cut off of 65 to assess BPD, PAI manual suggests using cut off of >70 to be clinically significant. 3) Nursing records to assess behaviour change rife with internal biases. 4) The 2 groups were not matched at intake, and TAU group not offered extra input as DBT GP, which could account for DBT strength over TAU. However from this study we could suggest that DBT is transferable across environments, however more research needed.
18. Bohus et al. (2004). **Germany**	To evaluate the efficacy of a 3 month inpatient DBT programme against a waiting list group	Ppt all female and met criteria for DSM-IV on basis of clinical interview for DSM and Diagnostic interview for BPD. Ppt required to have 1 suicide attempt, or 2 non suicidal self harms. Exclusion criteria of diagnosis of Psychosis, bipolar disorder, substance abuse and cognitive impairments. **Sample Size = 60** **Treatment Duration = 3 months**	Baseline measures recorded at assessment, start of group and 4 weeks after discharge from group. Assessments included LPC; SCL-90R, HAMA; BDI; GAF, IIP. Only completers included in analysis. Independent t-tests used for pre treatment between groups, dependent t-tests used for within groups. Chi square used to compare Ppt with self-harm acts after 4 mths.	**1) Within groups** showed significant gains on all outcomes except anger (t=3.790, p=0.001) **2) Between groups** more ppt in DBT than TAU restrained from self harm acts (62% in DBT and 31% in TAU)	This study suffered from a purely female sample and small numbers. Also the number of Ppt in each condition was not equal. More Ppt present in DBT group than the waiting list group. The study did also not include randomisation into each condition, selecting Ppt in order from a waiting list, therefore there could be selection bias in Ppt selected for DBT. In addition, although this study highlights DBT's effectiveness, DBT is usually a 12 month program and therefore this study cannot stand up to those studies incorporating 12 mths DBT.

Table 4 continued.   Non Randomised Control Trials.   Inpatient Studies

ID Code, Author (s), Country	Aims of Study	Sampling and treatment duration	Measures used and method of analysis	Results	Reliability and limitations
19. Kroger et al (2006). **Germany**	To evaluate the effectiveness of DBT in more severe and broader disturbed sample of BPD Ppt in a clinical setting	All Ppt recruited from inpatient wards between 2000 and 2001. Each screened to ensure 1)>18 2) normal IQ 3) no organic symptoms 4) definite diagnosis BPD, based on clinical interview for DSM-IV. Ppt also assessed using SCID for presence of co-morbid Axis I conditions. **Sample Size = 50** **Treatment Duration = 3 months**	Baseline measures collected pre and post treatment and at 15 month discharge to assess general psychopathology, using SCL-90, BDI and GAF. Results based on data for 37 Ppt. Wilcoxon test used pre and post treatment to assess frequency Axis I and II problems. No significant differences found between Ppt and dropouts. Therefore intention to treat sample used for analysis.	**Co-morbidity**: All Ppt had high co-morbidity pre treatment Axis I & II, mean 6.2 axis I and 5.5 Axis II, during follow up this had decreased to 4.2 (SD= 2.2) Axis I. **SCl-90:** For the SCL-90R Global Severity Index this decreased over time ($F[1,47]=10.66$, $p=0.002$), **BDI:** scores Decreased ($F[1,47] =20.77$, $p<0.001$) **GAF:** significantly increased ($F[1,47]=162.58$, $p<0.001$)	The strengths lie in the larger sample size. In addition this sample included a mixture of sex, although significantly more females. In addition these Ppt were impaired by Axis I and II disorders, which is more representative of real world situations. However the limits lie in the fact no control group was used to assess impact of change, medication was not monitored or accounted for. Interviewer bias may have been apparent at initial assessment and Ppt received additional psychotherapy during the follow up, so it would be hard to determine from this the true impact of the DBT alone.
20. Kleindienst et al. (2008). **Germany**	To clarify the long-term effects of inpatient DBT.	As Bohus et al. (2004; ID code 18). Participants matched with respect to age, severity of illness, previous hospitalisations, and number co-morbid disorders.	Prospective ratings taken at admittance and at 4, 12 and 24 months. Follow up data for this study taken from 31 DBT completers from Bohus study. Primary measures as Bohus (2004) study. Analysis of psychometric measures based on intent to treat analyses.	On average Ppt met 6.6 criteria for BPD according to DSM-IV criteria. ANOVA's showed significant improvements in GSI scores at the 4 assessment points. The results also indicated that positive changes made as a result of DBT are maintained over a 20mth follow up period, with all initial treatment effects in Bohus et al (2004) remaining statistically significant.	As Bohus et al (2004)

4.4.1 Results from inpatient studies

Statistically significant improvements were found in all six of the inpatient studies. This included improvements in anxiety, overall mood, depression and physical symptoms. There were reductions in self-harm (studies 16,18), improvements in co-occurring Axis I conditions (study 19), improvements in violence and anger (studies 17&18), and improved global assessments of functioning (studies 16,19) which were maintained at 20 month follow up (study 20). Treatment completion was high with an average retention rate of 84.7% across the studies.

Evershed, Tennant Boomer and Rees et al. (2003; study 17) compared DBT against TAU in a forensic setting to assess the impact of DBT in targeting anger/violence (study 17) compared to TAU. They found that the seriousness of violent acts by DBT group members was significantly reduced. In addition those who had undergone DBT remained stable or improved on all psychometric measures. In comparison, the TAU group appeared to steadily worsen.

When comparing DBT against TAU, Bohus, Haaf and Simms et al. (2004; study 18) found that those in DBT made significant improvements on 7 of the 9 variables analysed and on abstention from self harm acts. These improvements were maintained at 20-month follow up (Kleindienst, 2008; study 20).

4.5 Critical appraisal of the review papers

The twenty articles included in the present review were chosen for inclusion based on the quality of the research design using the CASP criteria and the categories identified by Crombie (1996). However, a number of methodological limitations need to be addressed when evaluating the results of this review. The specific limitations identified for each individual study are summarised in Tables 2-4.

4.5.1 Samples

The sample sizes for the studies included in the present review were relatively small. Power calculations were not reported and it was also unclear whether these had been conducted. In the majority of the studies participants were Caucasian (83.3%) and females (93%), therefore the results of this review are not necessarily transferable to different populations (for example males or ethnic minorities). Although retention rates within the studies remained relatively high (mean average 78.3%), the attrition rates of participants may have reduced overall effect sizes, increasing the probability of Type II errors. However, in an attempt to address this bias, several studies used an intent-to-treat analysis in their results (including studies 3,5,7 and 8), which found that DBT results still demonstrated significant improvements over the control condition.

Although in most studies, demographics were reported (e.g. level of education, marital status, number of hospital admissions, employment status, ethnicity, and income) the impact of these factors on the repeated measure and quasi-experimental

designs of many studies included in the present review remained uncontrolled. As such, the extent to which such potentially confounding variables affected outcome is not clear. Furthermore many of the studies included in the present review were conducted primarily in the USA, where a different healthcare system operates than in the UK, which leaves one to further question the generalisability of the outcome data.

4.5.2   Study Designs

Three main sources of bias were evident in the study designs of the papers included in the present review. First, of the 20 studies included in the present review, only 8 studies (studies 1-8) used a RCT and most of these had very small samples negating many of the statistical principals of the RCT so cannot be considered to be that robust. As studies 9-20 did not use a RCT, the methodological biases that will have been present in these studies must therefore be considered. Only one study (18) attempted to control for treatment allocation bias by enrolling participants in consecutive order and conducting an intent-to-treat analysis.

Second, within many studies, participants were only matched on their diagnosis of BPD. In the majority of the studies, standardised assessment tools for diagnosing BPD were used, however, how they were used and the cut-off scores for caseness were rarely reported. In study 17, where the PAI was used to diagnose BPD, a cut off score of 65 was used as a means of diagnosing BPD. However, the clinical significance cut off score recommended in the PAI manual is >70.

Third, several of the studies included within the present review derived their data from a comparison of DBT against TAU (Evershed et al., 2003; Koons et al., 2001; Linehan et al., 1999; Van den Bosch et al., 2004; Verheul et al., 2003). Although the use of TAU provides a helpful comparison of the effects of DBT against standard treatment that is offered in place of DBT, the variability of TAU across different services and the generally reduced amount of clinical time provided to patients undergoing TAU than DBT renders this a poor comparator condition (Scheel, 2000; Soler, Pascual, Tiana et al., 2009). There needs to be a consistency between treatment conditions, in terms of clinical and therapeutic time provided, to rule out biases associated with this.

Finally, as no control group was used in many studies, it is much harder to assess how many of the findings were due to DBT and how much was due to other factors. Such factors include: the effects of time; medication; therapists' styles; therapists genders and the effects of participants' expectations that positive changes should be made.

4.5.3   DBT programme variations

The majority of studies included in the present review used a repeated measure design and modified DBT slightly from the twelve-month outpatient programme Linehan (1993b) developed. Due to these differences in the DBT programmes and the study design employed, reliable comparisons cannot be made across the studies. However, the evidence tentatively suggests that even in modified forms and within different environments, DBT leads to positive treatment outcomes, although these must be

considered in light of the limitations identified within this section such as poor statistical power and large number of uncontrolled confounding variables.

4.5.4   Measures

The majority of the data reported was based on standardised measures that have known validity and reliability (a full list of the measures used within the studies can be seen in Appendix B under the abbreviation table). In most cases the data was based on self-report and is therefore subject to some of the standard biases associated with such data collection models. This includes participants' insight into their difficulties, social desirability and over / under reporting of difficulties in line with perceived treatment availability and gains (Lezak, 1995).

The timing of the assessments also varied across the studies with some reported baseline measurements being taken as early as 6 months prior to the start of treatment (study 10). For these studies it was difficult to differentiate which improvements were attributable to DBT and which occurred before treatment started (as all improvements would be demonstrated in end of treatment outcome assessments).

In the majority of studies, particularly those conducted in an inpatient setting, reports from significant others and members of staff may have offered a fuller account of the improvements made by those undergoing DBT and as such increased the reliability of the findings.   A few studies did include such data (studies1,3,8,10&16) and it was generally found that reports from additional sources, such as ward records (study 16), supported the findings from the self-report questionnaires.

4.5.5 Control of additional confounding variables

Several additional confounding variables may have impacted on DBT scores. Some of these were not necessarily reported or acknowledged within the studies such as the use of medications for BPD and their effects on treatment outcomes. The effects of support outside the programme from both professionals not involved in the programme, from other group members outside of sessions and by friends and family was also not considered. As a result, the large number of unreported variables across the studies may have increased the probability of Type I errors.

5. Discussion

5.1 Effectiveness of interventions

The current review demonstrated the significant treatment gains made by individuals with BPD when treated with DBT. This included reductions in rates of self harm / suicide attempts (Turner, 2000; Van den Bosch et al., 2005; Verheul et al., 2003), improved treatment retention rates (Linehan et al., 1999, 2002; Soler et al., 2009; Verheul et al., 2003) and increases in global levels of functioning (Bohus et al., 2000; Kröger et al., 2006). These findings were consistent with previous reviews (Binks et al., 2006; Clarkin et al., 1991; Davidson et al., 2006; Duggan et al., 2007; Guilé et al., 2005; Levin, 2007; Paris, 2005).

5.1.1 Comparing inpatient and outpatient uses of DBT

Based on a physical examination and comparison of the outcome data between studies by the present researcher, no difference in outcome data for DBT between in and outpatient settings was observed; both demonstrated positive findings. However, as a caveat to this statement, the poor methodological robustness of the studies included in the present review (due to the factors previously outlined, such as poor statistical power, variability of comparator conditions such as TAU and the large number of uncontrolled confounding variables) and the weak evidence base for inpatient studies, must be considered when interpreting the findings from this review.

The main findings from the present review suggest that DBT improves treatment retention, reduces rates of self harm and improves overall global levels of functioning across both in and outpatient treatment environments. When considering the application of DBT to both inpatient and outpatient settings, we must consider the differences between patients in these treatment environments. There may be a number of differences between those who are treated in an inpatient setting from those treated in an outpatient setting. For example, inpatients may experience more severe impairments than outpatients due to their need for long term care. As a result, this demonstrates that DBT in an inpatient setting is performing well, considering the greater complexity of the client group. Therefore the findings of the current review support the use of DBT in both inpatient and outpatient environments.

Whilst examining the studies included in the present review, it was noted that inpatient studies more frequently reported greater improvements in anxiety and

depression than outpatient studies. One reason for this one difference may relate to the increased structure, boundaries and containment offered within an inpatient unit. In addition, the lack of significant difference between DBT and the comparator treatment programme for Axis I conditions such as anxiety and depression, suggest that general factors related to professional therapy may account for this. However, the data presented in the current review only considered published data and did not consider the potential evidence base of unpublished data held by services which could shed further light on these findings.

The majority of the studies in the present review were conducted in an outpatient setting, leaving studies examining DBT in an inpatient setting under represented (Duggan, et al., 2007). This may simply reflect the fact that many patients with BPD reside and are managed in the community. However, the more recent use of DBT in inpatient settings may reflect a more positive change in inpatient units to use more psychological approaches, where patients may be better supported and contained.

5.2   Clinical implications

Mental health services have previously struggled to provide adequate services for people with personality disorders, with many clients often inappropriately admitted to inpatient units or treated by unspecialised services though community mental health teams (NIMHE, 2003). As a result, the National Institute for Health and Clinical Excellence (NICE) have developed new guidelines for the treatment of borderline personality disorder, suggesting that pharmacological interventions be combined with psychological interventions (NICE, 2009).

The main clinical implications of the current review lie in the cost effectiveness of DBT and the development of service provision, highlighted by the scope paper for NICE guideline development (NICE, 2007). Borderline Personality Disorder is a pervasive lifelong condition, and service users often place heavy demands on local services, which are often ill equipped to deal with them (NIMHE, 2003). Most often people with BPD will present to services in high levels of crisis and at high risk of suicide or self harm (Moran, 2002). As a result this places huge costs on mental health services across the country and current service provision is not generally adequate for individuals within this client group. Rendu, Moran and Patel et al. (2002) estimated that the annual cost for service provision was £3094 (per person per annum) for people with personality disorders in comparison to £1633 (per person per annum) for people without. As a result, if DBT is proving to be an effective intervention with treatment gains that are maintained, then better services could be put in place for these service users, such as DBT in inpatient settings where patients most often present at their highest level of crisis and risk.

The findings of the current review supported the use of DBT in both in and outpatient settings, as both treatment environments elicited positive outcomes. In addition the support and containment found within inpatient units and its effect on reducing co-morbid Axis I conditions provides a further rationale for the use of DBT when patients are at highest risk and in need of the most containment .

5.3   Further investigation and clinical utility

There is a need for consistency in outcome measures used for assessing DBT. Over

twenty separate measures were used across the twenty studies examined in the present review, which made a meta-analysis of the benefits of DBT very difficult to complete.

The findings of the current report demonstrated that both inpatient and outpatient uses of DBT are effective. Of course, DBT is a standardised intervention, therefore, it is no surprise that it is similar across different settings. The lack of qualitative research in the area, suggests that a significant portion of our understanding about how DBT is an effective intervention is missing (as outcome measures are not provided in the context of patients' experiences).

5.4 Review Critique

This review aimed to identify and evaluate empirical literature from 1999 that assessed the effectiveness of DBT for the treatment of BPD. The results from this were consistent with previous reviews (Binks et al., 2006; Feigenbaum, 2007; Martens, 2005). However, it remains possible that there are sources of bias. For example one the exclusion / inclusion criteria may have excluded papers from the review that demonstrated important findings. Such exclusions included those papers that were not written in English, case studies, studies using adolescents and papers that were unpublished or were dissertations. In addition, as there was a lack of a second researcher to examine the material and corroborate the findings this could also potentially call into question the internal validity of this review.

In conclusion, although DBT is relatively a new therapy, there is growing evidence to support its effectiveness. With its grounding in cognitive behavioural therapy and use

of well-developed treatment protocols, such as mindfulness, it is no surprise that DBT is continuing to find support and a place amongst professionals as a solid, effective intervention for the treatment of BPD. However, more rigorous research in the field is still needed, using larger sample sizes and exploring patient experiences using qualitative methodologies to truly assess the impact DBT has on BPD and its transferability to larger real world settings.

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Paper Two: Research Report

Exploring Inpatient Experiences of Dialectical Behaviour Therapy

for Borderline Personality Disorder.

7.   Abstract

Introduction: The current study explored patients' experiences of Dialectical Behaviour Therapy (DBT) in an inpatient unit. As inpatient DBT poses very different challenges to patients compared with outpatient DBT, the aim of the project was to explore these experiences.

Method: Nine participants, who were all diagnosed with Borderline Personality Disorder and on section in a private inpatient hospital, were interviewed to understand their experiences of undergoing inpatient DBT. The interviews were transcribed and analysed using Interpretative Phenomenological Analysis.

Results: A total of eight superordinate themes were identified. These were split into two different sections. The first related to the DBT programme and two superordinate themes emerged. These were the *Components of DBT* and the *Effects of DBT*. The second examined the journey participants described as having experienced when undergoing DBT in an inpatient unit. Six superordinate themes emerged, these were: A *Hopeless Beginning; the DBT Programme; Promoters of Inpatient DBT; Obstacles of inpatient DBT; A Brighter Future; and Preparing for Discharge.* The three main promoters of inpatient DBT which were identified related to: *support and containment; improved working relationships; and feeling validated and normalised* and the three main obstacles identified related to: *managing the dual system of care; living together; and being an inpatient.* The positive changes which occurred for individuals as a result of DBT were discussed as were the challenges of preparing for discharge.

Conclusion: Inpatient use of DBT appears to be as acceptable to patients as outpatient use, based on a comparison of previous qualitative literature. The clinical implication of this research supported the use of DBT in inpatient settings and as a result several recommendations, such as the need for suitable risk management and support after discharge, were made for both the service where the present research was conducted and more generally for other inpatient services.

8.   Introduction

Traditionally, Dialectical Behaviour Therapy (DBT) was designed for people diagnosed with Borderline Personality Disorder (BPD) in outpatient services. However, more recently, DBT has been adapted to different settings such as inpatient units, where services often struggle to manage such individuals[3]. There is a range of literature on the efficacy of DBT for BPD (Binks, Fenton, McCarthy & Lee et al., 2006; Clarkin, Marziali, & Munroe-Blum, 1991; Davidson, Norrie, Tyrer and Gumley et al., 2006; Duggan, Huband, Smailagic, Ferriter &Adams, 2007; Guilé, Greenfield, Breton, Cohen, & Labelle, 2005; Levin, 2007; Paris, 2005). However, there are not many papers that explore clients' experiences of DBT and those that do have focussed on outpatient settings.

Hodgetts and Wright (2007) stated that clients' experiences are valuable in research to providing an understanding of what works and evidence for the debate about the specific and non specific factors that effect change. Inpatient DBT programmes may involve quite different challenges and benefits compared to outpatient programmes, due to the systemic structures which surround the DBT programme such as the nursing regimes and the patient management procedures. As there were no papers currently examining inpatient experiences of DBT, the current paper explored the experiences of inpatients diagnosed with BPD undergoing DBT and the impact of the inpatient system on their experiences of therapy. Some background information on

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[3] While it is appreciated that the term BPD comes from a medical model and is flawed in its construct due to its failure to take social and cultural factors into consideration and the vast range of difficulties experienced by individuals, the term shall be used for ease in this paper to represent the group of individuals diagnosed with the label. In addition every participant in the study had been given the diagnosis of BPD, which reflects a similar set of difficulties present in the DSM-IV and is therefore used for continuity.

BPD and DBT relevant to the research is provided below.

8.1   Borderline Personality Disorder

Individuals diagnosed with BPD often pose difficulties to mental health services due to their pervasive pattern of affective instability, high impulsivity and unstable interpersonal relationships (American Psychiatric Association (APA) [*DSM-IV*], 2000; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004; Swenson, Torrey, & Koerner, 2002). Consequently, these individuals often present to services in crisis and at risk of self-harm or suicide, frequently needing hospital admission (Moran, 2002). Often the main challenge faced by services is managing suicidality and self harm (Paris, 2005). It is estimated that at least three-quarters of people with BPD attempt suicide and 3-9.5% are eventually successful (Zinkler, Gaglia, Arokiadass & Farhy, 2007; NIMHE, 2007). Paris (2005) noted that suicide attempts often peak when patients are in their early 20s, but are most often completed in a patient's 30s after there have been many failed attempts at recovery through psychosocial interventions. Consequently, higher demands are placed on services to intervene both with pharmacological and psychosocial interventions to manage such risks (Lieb et al., 2004; NICE 2007).

In their current guidelines, NICE (2009) recognise that individuals with BPD have often been excluded from services because of their diagnosis. Others are treated 'at the margins' either by Accident and Emergency or admissions to acute inpatient units who often lack specialist knowledge (NIMHE, 2003). Consequently, the new guidelines laid out the need for services to provide appropriate interventions for those

with BPD. Furthermore, as many patients with BPD are frequently admitted to acute inpatient units, there are increasing requirements on inpatient services to provide effective interventions to better prepare patients for release in the community. NICE (2009) also stated that when providing psychological interventions, treatment must be based on an 'explicit, integrated theoretical approach' which is structured. One treatment recommended by NICE (2009) that adheres to these principles, and is gaining favour amongst mental health services is DBT.

8.2   Dialectical Behaviour Therapy (DBT)

DBT is an adapted form of Cognitive Behavioural Therapy developed by Linehan (1993a), which includes mindfulness and acceptance based philosophies and practice in to the therapy. It was originally developed to target and reduce rates of suicidality and self harm and one of the key strengths of DBT lies in its strong internal structure with core manuals and protocols for treatment. DBT has been shown to decrease hospitalisation, reduce the risk of suicide and improve retention rates in therapy (Binks et al., 2006; Bornovalova & Daughters, 2007; Feigenbaum, 2007; Martens, 2005). DBT has four modules and these focus on developing core mindfulness, emotional regulation, interpersonal effectiveness and distress tolerance. In addition, a very structured training programme exists for therapists to ensure treatment is delivered in a standardised manner.

The DBT model holds two major principles at its core. First, it assumes that those with BPD lack the necessary interpersonal and self regulation skills and second that personal and environmental factors inhibit the use of positive behavioural skills and /

or reinforces the use of less helpful ones. Using these principles, patients are encouraged to acknowledge and accept painful emotional experiences, using skills such as mindfulness and radical acceptance. Using their other skills, they are encouraged to prevent or push away their negative emotions. At the beginning of treatment the therapist and the individual will set a prioritised list of targets for change which guides one to one therapy. At the same time, patients attend regular group skills training sessions that focus on core DBT skills to help them implement change. In addition, support telephone coaching is available to patients should they feel the need to discuss their use of DBT skills between sessions.

8.3   Efficacy of DBT

Randomised Control Trials (RCTs) have demonstrated statistically significant improvements by participants enrolled in DBT programmes compared with alternative interventions and treatment as usual (Harned, Chapman, Dexter, Comtois, Linehan et al., 2008; Linehan et al., 1999, 2002, 2006; Soler, Pascual, Tiana, Cebria, Barrachina et al., 2009; van den Bosch, Stijnen, Verheul et al., 2004; Verheul, van den Bosch, Koeter, Ridder, Stijnen et al., 2003). Important and significant improvements have been found in levels of self harm, treatment retention, and substance misuse. Additional benefits of DBT have included improvements in social and global functioning (Linehan et al., 1999; Soler et al., 2009), depression (Koons et al., 2001; Soler et al., 2009), and remission from various other co-morbid Axis I conditions (Harned et al., 2008). In addition, Koons et al. (2001) and Linehan, Comtois, Murray, and Brown et al. (2006) found that DBT resulted in a decreased use

of crisis services and hospital admissions. These RCTs were all conducted with outpatient services and none have been conducted with inpatient services.

8.4   Clinical Application

Traditionally DBT was designed for use by outpatient services. However, it has more recently been adapted into different treatment environments, such as inpatient wards and forensic settings. Inpatient and forensic setting uses of DBT have been discussed by a number of authors (Bohus et al., 2000, 2004; Evershed, Boomer, Rees, Barkham, et al., 2003; Kleindienst, Limberger, Schmahl, Steil et al., 2008; Kroger, Schweiger, Sipos, Arnold et al., 2006; Low, Duggan, Jones, Power, et al., 2001). Reductions in self-harm, improvements in co-occurring Axis I conditions, improvements in violence and anger and improved global assessments of functioning have all been observed in addition to high rates of treatment retention. Nevertheless, the empirical evidence is limited (Scheel, 2000) and fails to incorporate the important contribution of clients' experiences of DBT (Hodgetts, Wright and Gough, 2007).

8.4.1   The use of DBT in inpatient units

Managing BPD in inpatient services is often difficult as clients are high risk and demanding and services and staff are often stretched thinly. As a result, patients may be left in invalidating environments where their needs are unmet and which increases their need for containment and support. Psychoanalytic models of managing BPD have been used in inpatient settings and have focussed on developing a therapeutic milieu to contain the experiences of the patient. As DBT highlights the need for

validation, structure and containment of those with BPD, applying this model to DBT, and implementing DBT in inpatient units seems logical (Swenson, Sanderson, Dulit and Linehan, 2001).

Some minor changes are needed to the standard DBT programme to ensure successful implementation in an inpatient setting, for example, by trying to ensure that power differentials do not impede the collaborative therapeutic relationship. However, changes and adaptations are generally accepted as being in the spirit of the philosophy of DBT (Palmer, 2002). In fact, given the high intensity of treatment required in a DBT programme, then it may be that long term inpatient environments can provide more benefit to patients where there are goals that centre on stabilising clients' levels of functioning (Scheel, 2000). Although there is some evidence for the effectiveness of DBT for long term more secure inpatients, there are no papers exploring patients' experiences.

8.5   Qualitative Research on DBT

There are relatively few published qualitative studies on DBT programmes, all of which have been conducted with outpatients. A recent qualitative study by Perseius, Ojehagen, Ekdahl, Asberg and Samuelsson (2003) who used individual focused interviews and grounded theory to examine the patients' and therapists' perceptions of the use of DBT in treating suicidal and self harming behaviours. For the patients group, the following themes emerged as important: *therapy is life saving; therapy provides skills to conquer self harm urges;* and *therapy helps acceptance of own feelings.* Additional themes to emerge around the effective components of therapy

included, *respect as a foundation and recognising the importance of ones' own responsibility*. In the majority of cases the therapists' views were concordant with those of the patients. However, the location of the interviews at the premises of the DBT team may have resulted in overly favourable responding due to patients' expectations of how negative responses would be received and the potential impacts on further treatment.

Another qualitative study with outpatients was conducted by Cunningham, Wolbert and Lillie (2003). They undertook their research with the aim of understanding, from the perspective of the patient, what is effective about DBT and why. Three major themes emerged. The women who were positive about DBT placed great emphasis on the solid working relationship that was "non-judgmental" and "validating". However, most patients also realised the difficulties in applying skills taught to everyday life. When examining the impact DBT had had on the patients' interpersonal relationships and their level of suffering, reports were often very positive and many identified that DBT had allowed them to gain more control of their emotions and had reduced impulsive behaviours. Despite the rigorousness of this study, several participants had not completed at least one full cycle of the DBT which leaves one to question if they were experienced enough in DBT to comment fully on the positive and negative impacts.

A third qualitative study was conducted by Hodgetts, Wright and Gough (2007). They examined client experiences of DBT and its impact on their lives. Five participants were selected from a DBT programme in the UK and the data was analysed using Interpretative Phenomenological Analysis (IPA). In total, three main themes

emerged. The first theme was around *joining a DBT programme*. The second theme focussed on *experiences of DBT* (for example the structured nature of DBT and relationship with the therapist). The third theme focussed on their *evaluation of DBT* where participants made reference to the positive impact of DBT but recognised that this was only because of their additional work outside sessions. This study also highlighted the need for choice in service provision as many participants had believed they had been given an implicit message from the service that DBT was the only treatment that would work for them. This study provided a good insight into clients' experiences of DBT, from joining the programme through to completion, but many of the interviews took place up to 12 months post completion. As a result, participants' memory of treatment may have been subject to change in the intervening period.

8.6   The focus of the current research

The NICE (2009) guidelines for BPD expect that services will provide a person centred care approach for individuals with BPD. As many individuals with a diagnosis of BPD have previously been excluded from services because of their diagnosis and risk, health authorities are being actively encouraged to develop and implement specialist services for their treatment. Structured psychological interventions with an explicit and integrated theoretical background have been recommended as first line approaches for treatment (NICE, 2009). Although many health authorities have developed and implemented specialist services for the treatment of BPD, many are not necessarily using DBT as their main psychological intervention and fewer are using DBT in an inpatient setting. As the NICE (2009) guidelines for BPD are recommending DBT as one of the major (if not the main)

intervention for services wishing to address suicidality and self harm, then research is needed to add to the increasing evidence base to support the development and implementation of DBT in different settings.

So far DBT has developed a reasonable evidence base, is growing steadily in popularity, and is increasingly being used for client groups in different settings for problems other than BPD (Palmer et al., 2003; Telch et al., 2001). Given the difficulties experienced by individuals with BPD, such as self-harm, emotional lability (Swenson et al., 2001; Paris 2005) and the difficulties of patient retention in outpatient settings (Verheul et al., 2003; Davidson, Norrie, Tyrer, Gumley, et al., 2006), then it may be that DBT will become more common in inpatient settings (Swenson et al., 2001).

As DBT is being adopted within different services and NICE (2009) recommends that patients are given autonomy and choice over interventions, there becomes a need for services to reflect on patients' experiences when developing and offering services to patients. Elliot and James (1989) noted, it is only though understanding the types of experiences clients have in therapy that practitioners and researchers can understand the process and action of therapy. At present there are very few qualitative studies that examine clients' experiences of DBT and none that examine inpatient experiences in secure settings. Therefore the main aim of the present study was to explore patients' experiences of inpatient DBT treatment.

In addition, inpatient treatment of individuals with BPD is often fraught with difficulty, both for the staff who are often "stretched to their limits, dealing with life

threatening impulsive behaviours and for patients who are already in crisis, having to negotiate an often invalidating environment" (Swenson et al., 2001). Also inpatient uses of DBT pose very different benefits and challenges for inpatients compared with outpatients. Therefore, the main clinical aim of the present research was to explore what these may be so they can be taken into account by services running DBT programmes in longer term secure settings.

8.7   Aims

In summary, the present study had two main aims. First to examine clients' experiences of DBT in an inpatient setting in order to assess if inpatient experiences of DBT raise similar themes to those of outpatients thus adding to the limited evidence base. Second it examined the impact of the inpatient system on clients' experiences of DBT to explore the obstacles and benefits of completing DBT in such a structured inpatient environment.

9.   Method

9.1   Design

The present study used qualitative methodology to address the research question which focussed on patients' subjective experiences. As qualitative approaches use an exploratory, inductive style it was felt that this would provide valuable insight into clients' experiences of therapy that have not previously been acknowledged. Although a range of sources to obtain qualitative information exist, a semi structured interview was chosen over alternative methods as they allow the researcher flexibility to tailor their interviews to clients' personal accounts, drawing out their most meaningful experiences.

9.1.1   Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2008) was selected as the most suitable method of data analysis for this research. As the focus of the present research was to understand patients' experiences of undergoing intensive psychological therapy in a long term inpatient unit, IPA was felt to be the most suitable form of analysis to understand the phenomena of inpatient therapy. Other methods of qualitative enquiry were considered, such as grounded theory, content analysis and thematic analysis, however, they were felt to be too limiting due to their focus on only the content of the speech for coding purposes. As IPA moves slightly away from such models and assumes that interpretation by the researcher is needed to understand the deeper meanings of people's narratives, it was felt that this approach

would allow the deeper meanings of peoples' experiences to emerge, resulting in a deeper understanding of the phenomena of inpatient therapy.

Using a phenomenological standpoint, the aim of IPA is to explore how participants make sense of their personal and social world, in particular, focussing on the meanings that people individually attribute to particular experiences. As the main feature of IPA is to gain thorough and detailed accounts of individual experiences, it is recognised that this can only be achieved on a small scale (Smith & Eatough, 2006, cited in Breakwell, Fife-Shaw, Hammond and Smith, 2006). Through purposive sampling, IPA aims to find a more defined group for whom the research question will be significant. In the current research, this related to the individuals who were diagnosed with BPD and had been in DBT treatment for over one year.

9.1.2   Epistemological position

The epistemological stance chosen for this research was largely dictated by the choice of IPA for data analysis. IPA is concerned with the meanings of experiences, perceptions and accounts of events rather than objective records. The use of an epistemological position therefore, which assumes that reality exists and the perception of knowledge is shaped in part by subjectivity and social forces (Guba and Lincoln, 1994), seemed most appropriate. As a result the Critical Realist (CR) perspective was adopted because of the shared meaning of the nature of reality by the group of individuals who were interviewed (whom had all been diagnosed with BPD and understood the nature of the difficulties such a diagnosis assumes).

9.1.3 Researcher's declaration of interest and experience

As IPA requires that a researcher uses their own interpretations of the meanings behind the data to generate deeper and more meaningful understandings of individual narratives, the researcher was aware of the need to draw on their own experiences and understanding of DBT throughout the transcription and coding process. Having had experience of running a DBT programme for one year as an assistant psychologist and conducting literature reviews in this area, the researcher felt such experiences would allow such deeper interpretations to be made. To assist this process and to monitor the researchers' own individual thoughts, ideas and experiences throughout the research, a reflective diary was maintained which allowed the researcher to consider how their previous experiences influenced data analysis.

9.1.4 Clinical setting for research

The service where the present research was conducted was an independent charitable trust providing care for men, women and adolescents[4]. A comprehensive DBT programme ran within the women's section of the service, with all therapists having completed either the intensive or foundation training in DBT. Patients with a diagnosis of BPD meeting the inclusion criterion for the unit committed to join the DBT programme for a minimum of one-year.

DBT has four Skills Training modules: Core Mindfulness, Emotional Regulation,

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[4] For ease, for the remainder of this report this shall be referred to as 'the service'.

Distress Tolerance and Interpersonal Effectiveness Skills (Linehan, 1993b). In this local model, in first year of treatment, patients were taken through the whole DBT programme twice to fully learn and practice the skills. When patients appeared to have a solid understanding of the material and were applying the skills taught, they were moved into the Skills Application group to build on their knowledge. The Skills Application module (developed by the service) has been developed using a problem solving approach to draw on all the DBT skills. As part of this, four further modules have been developed by the service (Eating Awareness, Sleep Awareness, Mindfulness Pain Management and Contingency Management) to encourage the application of these skills to specific areas. It is for these reasons (i.e. the availability of a comprehensive DBT programme and the consistency offered within the DBT programme, through the use of fully trained DBT therapists) that the service was chosen as the site for the present research.

9.1.4. Participants

Participants were selected for inclusion in the research if they had been in DBT for over one year to ensure they had completed the whole programme at least twice, thereby allowing them to make informed comments about the DBT programme as a whole. As the individuals in the Graduate Skills Application group met this criterion, because of their developed knowledge and experience of DBT and of applying the skills taught to their own lives, it was felt to be the most suitable group to target for interview. Every participant within the graduate Skills Application group was approached to take part in the research, which was a total of ten participants. Nine participants agreed to take part in the study. A table of participants' demographic

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information can be found in Table 5 below[5].

Table 5. Demographic information of participants.

Participant Name and Id Number	Age	Ethnicity	Length of time in the service	Length of time on DBT	Length of time in Skills Application
1	34	White British	7 yrs 4 months	7 yrs 4 months	3 yrs 9 months
2	27	White British	2 yrs 6 months	2 yrs 6 months	11 months
3	30	White British	1 yr 11 months	1 yr 11 months	11 months
4	36	White British	3 yrs	3 yrs	1 yr
5	35	White British	4 yrs 3 months	4 yrs 3 months	3 yrs
6	26	White British	3 yrs 7 months	3 yrs 7 months	2 yrs
7	26	White British	2 yrs 9 months	2 yrs 9 months	4 months
8	37	White British	5 yrs	5 yrs	2 yrs
9	37	White British	3 yrs 6 months	3 yrs 6 months	1 yr 6 months

9.1.5. Development of the interview schedule

The interview schedule was designed to address the main research questions for the

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[5] Names have been removed to protect participant's identities. All participants were female.

present research and was designed in conjunction with both the academic and field supervisor (a consultant clinical psychologist and clinical lead for DBT) for the research. It aimed to discuss with participants three main areas: their experience of DBT as a therapeutic intervention for BPD; their experience of the therapeutic relationship, and their experiences of being an inpatient.

The initial interview schedule was piloted with one of the participants and subsequently changes were made to the interview schedule to address difficulties and gaps in the schedule which were identified. All questions were open ended to ensure that participants were provided with space to explore their experiences fully. Each interview was conducted with the expectation that additional questions and prompts would be asked, which were unique to the person's experiences, to generate richer and more personal accounts (see Appendix F for a final copy the Interview Schedule).

9.2 Procedure

9.2.1 Ethical and research and development approval

As all the patients within the targeted DBT group were funded by the National Health Service (NHS) and seconded for treatment in the service, the current research had to comply with the ethical and governance arrangements for both the service and the NHS. The initial proposal was first submitted for peer review within the University of Leicester. Following minor amendments, the proposal was submitted for ethical review at Nottingham Research Ethics Committee (REC) in March 2009. On

completion of minor amendments, the proposal was granted a favourable opinion in July 2009. Copies of the Nottingham REC approval letter along with additional supporting documentation were sent to Leicester Partnership Trust and the service to gain Research and Development approval (see Appendix C, D and E for copies of approval letters). Final approval of the project and CRB clearance for the service was granted in September 2009.

9.2.2   Recruitment and interview process

The field supervisor initially approached potential participants from the DBT Skills Application group who they judged had the capacity to consent. An information sheet outlining the details of the research was provided and explained (Appendix G). Participants were allowed up to one week to consider their involvement before being approached for their decision. Once a favorable decision was made, the field supervisor contacted individuals to arrange an appointment for interview based on the lead researcher's availability. A staff information sheet outlining the details of the study was made available to all staff within the women's service to brief them of the study (Appendix H).

Nine participants were interviewed in total, which included the first pilot interview. The interviews all took place in a quiet room within the ward. At the start of each interview, the participants were talked through the purpose of the research and confidentiality and anonymity were outlined. The researcher then took each participant through the Consent Form (Appendix I) and time was allowed for

questions. Each interview lasted approximately 60 – 90 minutes and was digitally recorded. At the end of each interview, participants were asked if they were happy for anonymous quotes to be used and were provided with the contact details of the lead researcher and field supervisor for any further questions and debriefing needs.

9.2.3   Transcription and data handling

Four of the interviews were transcribed by the researcher to aid the researcher to become extremely familiar with the data. Due to time constraints of the project, the remaining five interviews were transcribed by an external professional transcriber who was not affiliated to any organisation related to the present research. Prior to the starting the transcription process, she was provided with a set of confidentiality guidelines and asked to sign a confidentiality agreement provided by the University of Leicester. All interviews were transcribed verbatim and several of the notations from Jefferson's Transcription Notation model (Jefferson, 2004 cited in Lerner, 2004) were used. This included the use of brackets with times inside to annotate pauses, ( ) brackets for where the recording was unclear and (h) to denote humour. Data Storage and Handling processes were adhered to as approved by the Nottingham REC. Unfortunately, due to time constraints, participants were not able to read their transcripts to validity check them, therefore, to ensure validity and accuracy in the transcripts, each of the interviews was listened to again by the lead researcher whilst the transcripts were simultaneously read.

9.3 Data Analysis

9.3.1 Generating initial codes

The data were analysed and coded using principles outlined by Braun and Clarke (2006) and Smith, Flowers and Larkin (2009). The first stage in IPA analysis involves the researcher immersing themselves in the data to ensure the participant becomes the focus of the analysis (Smith, Flowers & Larkin, 2009). As a result, the researcher re-listened to each recording whilst reading the transcript simultaneously which aided in the process of allowing the researcher to become immersed in the data. In addition, this also had a secondary gain of allowing the researcher to check the accuracy of the transcripts against the original recordings. This was particularly important for those transcripts not transcribed by the researcher.

To ensure the process of active engagement with the data, the researcher read each transcript twice and made initial notes and areas of interest in the left hand margin on a line by line basis. The principles and definitions of what counted for a theme for the present research were based on the definition outlined by Braun and Clarke (2006, pg 82) "a theme captures something important about the data in relation to the research question, and represents some level of *patterned* response or meaning within the data set". To expand on this further and provide additional guidance on initial data coding, the three categories as outlined by Smith, Flowers and Larkin (2009) were used. These included the exploration of the descriptive comments (italics) made by the participant, linguistic styles (normal font) and conceptual concepts (underlined). An example of this initial coding and the comments made can be seen below in Table 6

Table 6. Example of the initial coding stages

	Original Transcript	Initial Coding
	TRAINEE: Do you think they had much understanding of what borderline personality disorder was? **DBT6:** I don't think they had any personally because I had it thrown in my face quite a few times was that you're just an attention seeker you just want people to molly coddle you, be around you all the time and that, when it wasn't that at all, it wasn't that I wanted people round me I was quite busy at the time because I didn't want people round me. I was actually quite busy trying to get people away from me and it just sort of, I was just attention seeking. I found it quite difficult 'cos I wanted to change my life and get my life back on track for my family I wanted them to always be around me because I done something quite dangerous.	*Sense that previous services had little understanding BPD.* *Feeling judged by services.* Staff making false assumptions of need. *Pushing others away.* Fear getting hurt? *Need for others help and to be heard. Wants to improve life.* Acknowledges own difficulties and behaviours

During this stage in data analysis, a reflective journal was kept to ensure that reflexivity was maintained. This enabled the researcher to keep track of her thoughts and observations during this initial coding stage and to note specific themes and concepts that emerged. During this process, the researcher also attempted to reflect on her own feelings and experiences to understand how this may be impacting on both the interview process and the data analysis.

9.3.2   Generating themes

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Once the initial stage of coding was complete, each transcript was re-read once more to draw out the main emergent themes within the data. This stage not only relies on exploring chunks of data to interpret the meaning within the statements, but also relies on recall from the researcher of what they learnt during initial coding stages (Smith, Flowers & Larkin, 2009). Using these principles, the researcher moved away from a pure analysis of the individual, towards more discrete interpretations of the data, based on their own experiences and understanding. An example of this can be seen in Table 7 below. The example presented relates to the previous initial coding example (Table 6) and illustrates how initial codes translated to larger themes.

Table 7. Translation of initial coding to themes

Themes	Original Transcript	Initial Coding
Little understanding BPD in community. Feeling invalidated, judged. Identity as "bad" by services. Relationships with others as problematic – source of fear and uncertainty. Lack of support in community.	**TRAINEE:** Do you think they had much understanding of what borderline personality disorder was? **DBT6:** I don't think they had any personally because I had it thrown in my face quite a few times, that you're just an attention seeker you just want people to molly coddle you, be around you all the time and that, when it wasn't that at all. It wasn't that I wanted people round me at the time because I didn't want people round me. I was actually quite busy trying to get people away from me and it just sort of, I was just attention seeking. I found it quite difficult 'cos I wanted to change my life and get my life back on track for my family I wanted them to always be around me because I done something quite dangerous.	*Sense that previous services had little understanding BPD.* *Feeling judged by services.* Staff making false assumptions of need. *Pushing others away.* Fear getting hurt? *Need for others help and to be heard. Little support given.* Acknowledges own difficulties and behaviours

As the third stage in data analysis, the researcher searched for connections across emergent themes. Using the 'Searching for Themes' stage noted by Braun and Clarke (2006), a long list of themes that had emerged from the data were drawn up. Using this list and the experiences of the initial coding stage and immersion in the data, the researcher attempted to understand and explore relationships between themes. Through this process, smaller sub-themes were categorised and grouped together to form larger superordinate themes that were more reflective and meaningful. As a result, a model of understanding of patients' experiences of inpatient DBT was developed. Using notes from the reflective diary helped as the researcher was able to recall their thoughts from the initial coding stages about how themes interconnected.

To validate the analysis, the researcher and the field supervisor met to discuss the themes and the relationships that had emerged. Amendments were made accordingly as a result of the feedback comments and alternative interpretations offered by the field supervisor.

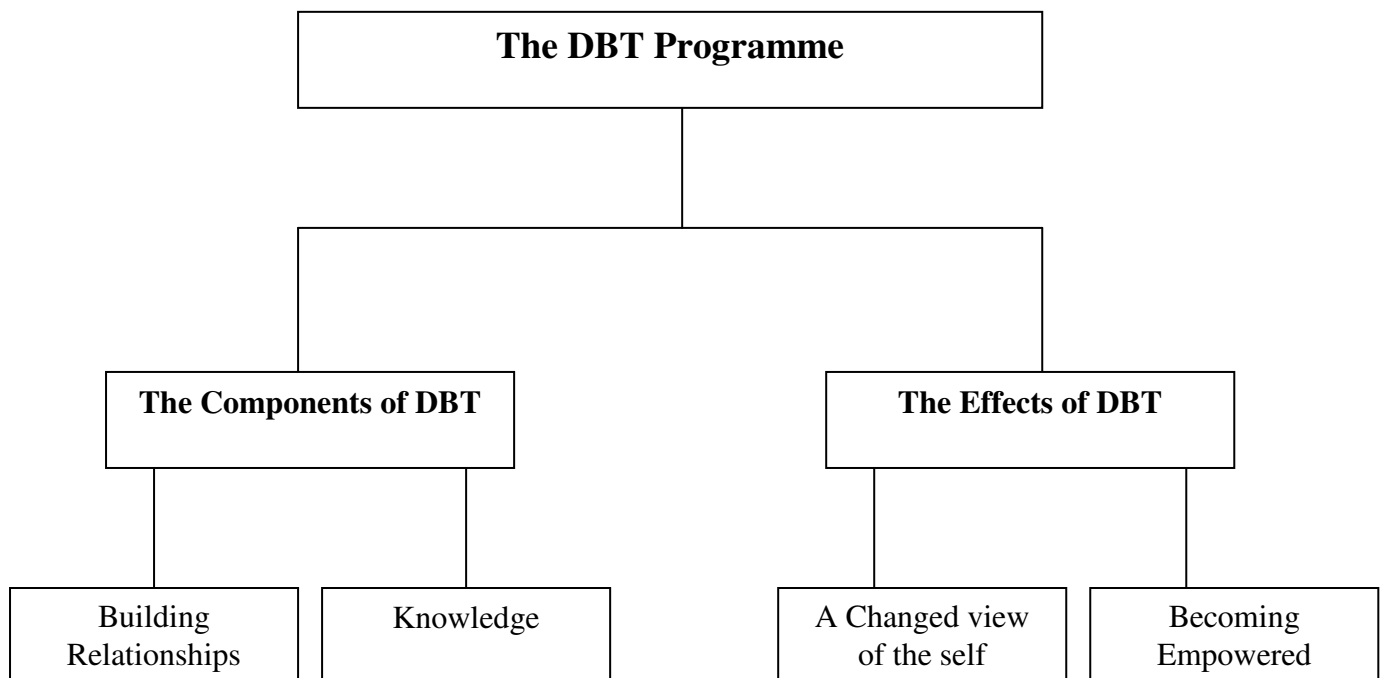## 10. Results

10.1 Overview

A total of eight superordinate themes were identified across the majority of the interviews which have been split into two different sections within the results section. The separation of the results in to two distinct parts (part a and part b) resulted from the two different data sets which emerged. The first section (part a in the Results, Figure 2) examined the DBT programme itself; which aspects of DBT participants liked, the aspects they struggled with and the interplay between group and individual therapy and two superordinate themes emerged. The first superordinate theme related to the *Components of DBT*, the second related to the E*ffects of DBT*. As research examining these experiences already existed (Cunningham et al., 2004; Hodgetts et al., 2007b; Perseius et al., 2003), this was not discussed in much detail within the current report.

As the aim of the present study was to examine the experiences of clients undergoing DBT within an inpatient setting, the second section of the Results (part b) focuses more on the remaining six themes that emerged. These themes related to the journey participants described as having experienced when undergoing DBT in an inpatient unit and a diagrammatic representation of this journey is presented later on (see Figure 3).

10.2   Part A - The DBT Programme

Two superordinate themes were identified which related specifically to the DBT programme, as discussed above. A diagrammatic representation of the themes related to this is presented below in Figure 2.

<u>Figure 2. The DBT Programme</u>

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                    ┌──────────────────────────────┐
                    │      The DBT Programme        │
                    └──────────────────────────────┘
                                   │
          ┌────────────────────────┴────────────────────────┐
┌──────────────────────┐                      ┌──────────────────────┐
│ The Components of DBT │                      │   The Effects of DBT  │
└──────────────────────┘                      └──────────────────────┘
       │        │                                     │         │
┌──────────┐ ┌──────────┐                    ┌──────────────┐ ┌──────────┐
│ Building │ │Knowledge │                    │A Changed view│ │ Becoming │
│Relationships│ │        │                    │  of the self │ │Empowered │
└──────────┘ └──────────┘                    └──────────────┘ └──────────┘
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10.2.1 The Components of DBT

Two subordinate themes emerged, which participants felt impacted on their experiences of the DBT programme: *building relationships and knowledge.*

Theme: Building Relationships

Participants described three main factors associated with DBT that enhanced working relationships with staff and patients; the first related to boundaries. Many participants described the clear and consistent boundaries in DBT, which positively affected their experiences and helped develop trust.

> *"you know what your working with, yes, you know where you are and erm, you know you can get to count on people and you get to know people then you tell them how you are really feeling and you can work on that in a safe place and it doesn't set you off"* (Ppt 3. 236)

As many participants described having previous difficulties in both giving trust and maintaining trust, this theme appeared central to their experiences.

The second factor that participants identified was feeling validated and normalised. Feeling listened to and cared about by staff often provided a sense of security and containment for patients, particularly when this had been lacking previously.

> *"Yes and I think they just listen to it you know ( ) they take on board what your telling them and they really care here whereas a lot of people they don't care, they just see you as another psychiatric patient"*
> *(Ppt 2. 236)*

When speaking about the consistency of staff, one participant noted the support and consistency she had gained, helped her to feel validated. Accounts such as these pervaded many people's narratives.

> *"I pushed people away a lot and this lot wouldn't be pushed away and that taught me a lot when I tried to leave before like in the first 2 to 6 months, and I pushed to leave and everything…..but they stuck by it anyway". (Ppt 5. 1154)*

Participants identified that transparency in communication was the third factor which developed good relationships. Accounts such as 'my therapist tells me straight' and 'I always know where I am with staff' were present in each participant's account. In many instances, although participants sometimes found this challenging, many noted how this demonstrated honest caring and support.

> *"My therapist was very good because they told me straight and they've got quite a good sense of humour and he'll tell me as it is. I don't know, I think they're brilliant and they've been very good" (Ppt 4. 668)*

Theme: Knowledge

Participants described three main factors related to knowledge as an important component of DBT. These were 1) developed emotional awareness 2) the acquisition of skills and 3) specialist knowledge of staff.

In relation to the first factor, one participant said it was this aspect of DBT which she had most enjoyed. An understanding of the self and the ability to manage one's emotions based on this understanding pervaded many accounts.

> *"In the past like (0.2), if I was angry I wouldn't be able to express it 'cos I didn't know how I was feeling, I would just lose my temper all the time and I couldn't really explain how I was feeling, but now I feel like I can actually say I'm angry instead of losing my temper and doing stuff to express how I feel"*
>
> *(Ppt 2. 225)*

For the second factor, participants had a great appreciation for the skills they had learnt which they felt enhanced their ability to cope. The structure and repetition of the modules and the use of mnemonics reinforced the learning and use of the skills for many of the participants.

> *"It helps you remember it and then when you're feeling bad or whatever, you can think right what are the distress tolerance skills, what does improve the moment stand for and then you can kind of think I'll try that first but if it doesn't work then you try something next on the list" (Ppt 7. 1484)*

Many patients found the DBT skills themselves normalising and found that they applied to others equally, not just themselves. Consequently many participants described feeling very validated by this.

> *"…..I think you realise DBT is about, erm, we've all got skills we just need to learn extra things.   You know when we start the learning the skills we joke you know, we joke with the girls, we need a DBT diary for people who haven't done DBT because you can be in a shop and you can hear people ranting and you just think ok I could introduce some personal skills there" (Ppt 3. 259)*

Also, many participants commented on the barriers of learning the skills, such as the quantity of the material and language and terminology used.

> *"I thought it was very airy fairy like mindfulness, I was thinking that its like praying to god or whatever erm, interpersonal effectiveness I can see that as to be assertive it's, most of the time it's good as long as you can realise what the words are about" (Ppt 4. 204)*

When reflecting on interventions before DBT, most participants recalled that they had not been taught skills for managing their behaviour. When describing previous interventions one participant noted:

> *"It was kind of keep me quiet sort of thing more than actually work on it.   I think I just struggled because I didn't know what was wrong with me, I didn't understand why I did things I did nobody really knew that and they came up with all various things, all kinds of treatment but nobody actually helped with the problem, and that was rather frustrating and a lot of the time I think I just gave up" (Ppt 8. 135)*

However, within DBT many participants noted that it was the specialist knowledge of the staff about BPD that helped them most, in both understanding their difficulties and learning the skills to manage their difficult behaviours.

> *"Well it was the psychiatrist as well, like (X) he really understands personality disorder where as when I was out in the community I don't really think a lot of them understood about it very much and whereas (X) got a lot of knowledge"*
>
> *(Ppt 2. 1160)*

10.2.2 The Effects of DBT

When discussing the DBT programme, a strong narrative within the transcripts related to the improved quality of life gained through DBT. The two major themes to emerge within this related to *a changed view of the self* and *becoming empowered*.

Theme: A Changed View of the Self

When examining the benefits that participants had gained from DBT, many noted that at the start of the programme they often saw themselves as either 'bad' or untreatable and consequently it appeared that many felt hopeless as a result of this.

> *"You get to a point where you're really fed up with being in and out of all the health institutions and losing everything that you love" (Ppt 2. 874)*

However, many patients reported that through DBT they had become re-humanised by the staff and learnt to start liking themselves and have started seeing themselves as someone who had difficulties that could be managed.

> *"I like myself now I sometimes have moments when I think well…. But I expected that. I found using the skills and that made it easier to accept people, yes sometimes you get pissed off, sometimes I don't like myself but being able to accept that there's a light at the end of the tunnel, everything's not always going to be how it was I'm a lot older I'm a lot more stronger to deal with things" (Ppt 6. 485)*

Feeling safe in one's self was another factor that was identified as an effect of DBT. Although many participants acknowledged that they still can engage in unhelpful behaviours, many realised that as they progressed though DBT they learnt to take control of themselves and keep themselves safe.

> *"Yes I can go out now, I can go out for 12 hours if I want to self harm without them knowing I can, I can go to the hospital and get myself patched up or do whatever I want to do, to me it's like... I don't know whether that's necessarily a good thing or not but I know that it's me that's keeping myself safe"*
> *(Ppt 4. 1278)*

Theme: Becoming Empowered

The second subordinate theme to emerge regarding the effects of DBT related to clients' experiences of becoming empowered. As a result of DBT and the skills

participants had acquired, they felt more hopeful about their future and confident in their ability to cope.

> *"it's helping me knowing that using these skills my life is going to get better and I can hopefully maintain some sort normality you know" (Ppt 1. 460)*
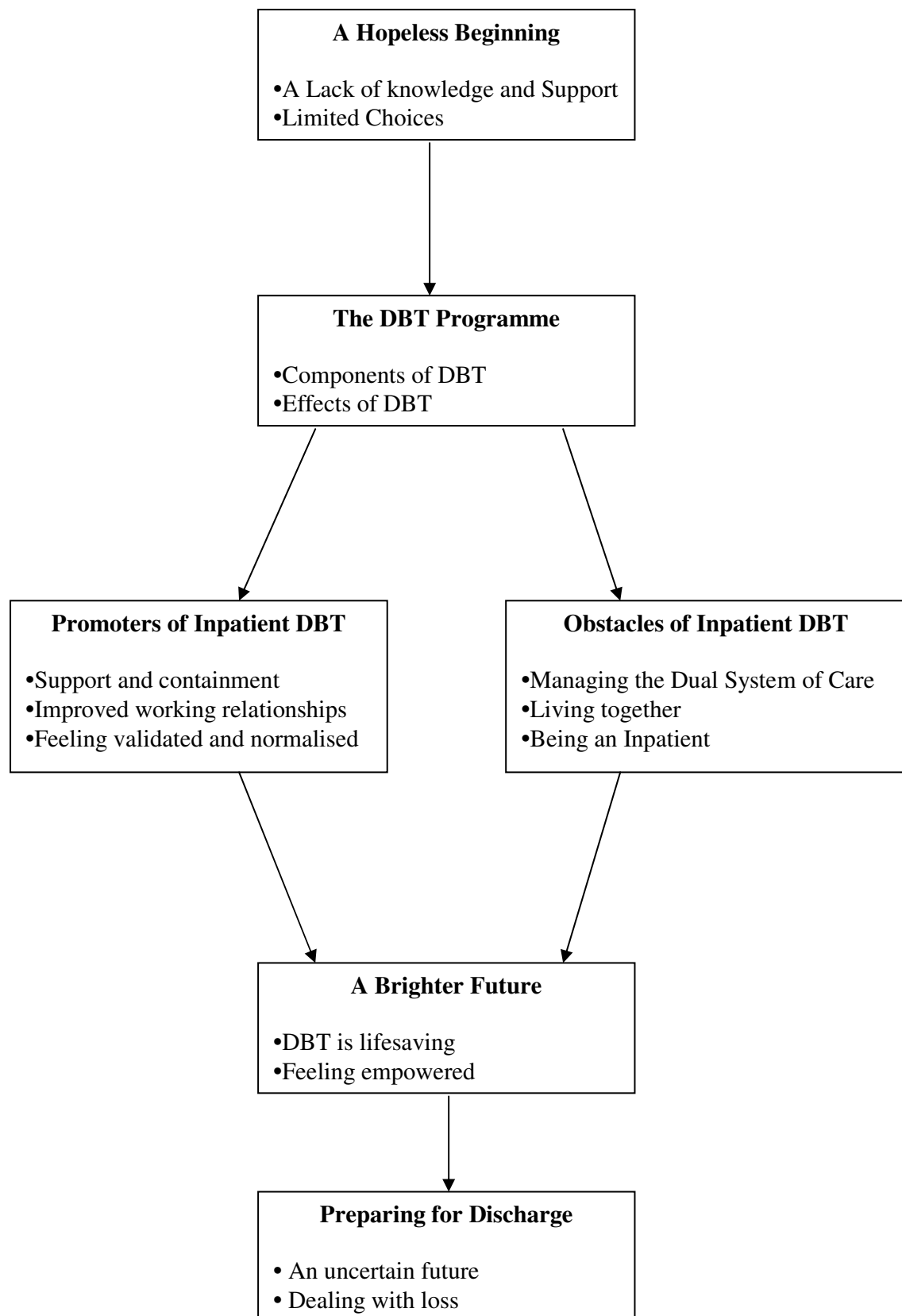
Many participants also reported how DBT had given them their control back over their life and behaviour, which had felt very out of control previously.

> *"I actually realised how much it helped knowing, even just having the security of knowing if I'd identified a skill then I was that little bit more in control, a little bit safer" (Ppt 5. 985)*

10.3   Part B - The Journey of Inpatient DBT

Six superordinate themes emerged that related to the journey participants described as having experienced when undergoing DBT in an inpatient unit. These were: A *Hopeless Beginning; the DBT Programme; Promoters of Inpatient DBT; Obstacles of inpatient DBT; A Brighter Future; and Preparing for Discharge*. At the start of each interview, each participant was asked to recount their previous experience with both services and interventions they had received. In all interviews, this account was bleak and portrayed a sense of hopelessness from the participant. During the data analysis stage, a journey of participants' experiences through inpatient DBT appeared to emerge from their hopeless beginning to their brighter future. A diagrammatic representation of this journey is presented in Figure 3 below.

Figure 3. The Journey of Inpatient Therapy

A Hopeless Beginning

•A Lack of knowledge and Support
•Limited Choices

The DBT Programme

•Components of DBT
•Effects of DBT

Promoters of Inpatient DBT

•Support and containment
•Improved working relationships
•Feeling validated and normalised

Obstacles of Inpatient DBT

•Managing the Dual System of Care
•Living together
•Being an Inpatient

A Brighter Future

•DBT is lifesaving
•Feeling empowered

Preparing for Discharge

• An uncertain future
• Dealing with loss

10.3.1 A Hopeless Beginning

When describing previous experiences of services, two subordinate themes emerged: *a lack of knowledge and support; and limited choices.*

Theme: A Lack of Knowledge and Support

There were several distinctions within this theme as participants recalled accounts of both a lack of knowledge within themselves and within services of BPD. This often resulted in participants feeling unsupported by mental health teams.

> *"Probably not because I didn't even know I was borderline erm, I've had (X)………… Nobody actually I think knew what to do with me" (Ppt 8. 86)*

A sense that help came later than it should have pervaded nearly all accounts. For many participants, previous experiences of being let down by services were a common narrative. In some cases, participants felt that it was only when they became at too high a risk and life had become unbearable had help been offered. Consequently many stories were filled with frustration at the amount of loss they had suffered before help was offered.

> *"I had to get to my lowest point possible, do you know what I mean, so that they'd say, right we can't manage you any more out in the community we're sending you somewhere else, but it just frustrates me you know that they could have done that before" (Ppt 2. 900)*

Due to the lack of knowledge of BPD in outpatient services, many patients recalled feeling judged and invalidated.

> *"Yes because they see us as, you know we get told we're attention seekers or we're not feeling what we're feeling" (Ppt 3. 107)*

Theme: Limited Choices

Participants recalled how their choices of previous interventions had been limited and often ineffective. As many patients had several different experiences of various ineffective interventions, hope for change was scarce.

> *"I didn't know there was anything to change really; I thought that was my life. That those behaviours I would continue with, I didn't hope for anything different…" (Ppt 5. 223)*

Participants also recalled how they were given limited choice over becoming an inpatient by their service providers as the choice of possible interventions was limited through the lack of appropriate services. Many recalled how they felt resistant to starting DBT during the initial few months.

> *"I came under section erm; I fought against coming here… I had an ultimatum, which was if I don't come here, I could be at any secure hospital in the country and it seemed because I'd heard of this place, it was the best option available at that time so I came unwillingly really" (Ppt 4. 175)*

For many participants, the lack of choice they were given within their home county of appropriate interventions / services meant that many participants had to move far from home to undertake DBT. For most participants this was a difficult process to adjust to.

> *"…you're thrown into a whole new world, a whole new system, and it's not a real world, it's not a real system you know…" (Ppt 3. 185) "…you've moved out of your county as well, it's not your home is it. It's a long way from home…" (Ppt 3. 195)*

Consequently, nearly all participants said that they wished that services would provide more inpatient DBT programmes for BPD, closer to people's homes.

> *"…it would just be nice though if they did more places, nearer peoples homes because that is a big drawback…" (Ppt 9. 1469)*

10.3.2 The DBT Programme

Participants' experiences of DBT as a psychological intervention for BPD ran though each account. As the themes from these accounts have been discussed previously in section 10.2.1; they shall not be further discussed in here.

As part of understanding the effects of DBT, participants were asked how effective DBT had been in meeting its aim of managing BPD and developing a life worth

living. In all accounts responses were very favourable as participants recalled how DBT had given them the skills to cope in the future.

> *"Yes I think it's very effective I mean with everything else that I've tried, and I haven't tried a lot, that's always made me more chaotic, it'd made me feel a lot more chaotic, whereas this ones given me skills to be able to cope with most of it so …. I don't think there would be anything else really".*
>
> *(Ppt 4. 1056)*

10.3.3 Promoters of Inpatient DBT

Participants identified three subordinate themes which they felt promoted the use of DBT within an inpatient unit. These were: *support and containment; improved working relationships; and feeling validated and normalised.*

Theme: Support and Containment

The support and containment participants had received through DBT in an inpatient setting came out as one of the strongest themes. As many participants had previously been in and out of inpatient services, the extended duration of stay in the service coupled with staff's understanding of BPD and effective treatment regime provided much needed protection.

> *"I feel I'm protected in here, but once I leave here I'll have to cope with things all over again but I'll hopefully know the skills better than when I came here"*
>
> *(Ppt 2.825)*

Interestingly, in the early stages of inpatient DBT, participants acknowledged the need to pass the responsibility and control for their safety and containment to the staff team to gain a sense of security which would allow them to make positive changes.

> *"Sometimes you don't feel like you can keep yourself very safe, you don't feel very safe in your head and having people to keep you, you just don't know, you know you fight against them, they piss you off something chronic sometimes but it helps to keep you like level. It's kind of having that sense of security"*
>
> *(Ppt 4. 868)*

For many patients it was only when they described feeling confident in the skills they had gained from DBT that they chose to undertake this responsibility once more.

The containment and structure offered by the consistent regimes of inpatient settings and risk management procedures gave participants the stable environment they needed to address and control unhelpful behaviours.

> *"That's the first time I've had actual consequences to, you know consequences that I didn't want to suffer, I didn't want my property taken away from me, I didn't want to be supervised….yes that was very much that, it suppressed my behaviours" (Ppt 5. 250)*

As participant five describes, previously there has been little consequence for her behaviour and the boundaries and rules in place within inpatient settings allowed her to consider her behaviour and suppress it. She later recalled in her interview that this

allowed her space to think about the skills she had and how to use them to avoid unwanted consequences.

Participant three noted that having the containing inpatient environment stopped her giving up the programme on impulse when things became difficult. She reflected on how this was important as it allowed her time to see the programme work.

> *"the thing is if you are sectioned you work in a secure building, when you come here you can get a bit pissed off with people, staff or something and you could just walk out the door but how does that work? Because sometimes you do need to, not stopped physically, but helped to stop and think to help it work, to give it time" (Ppt 3. 989)*

In addition to the containment provided by undertaking DBT in inpatient settings, many patients also spoke of the support available. Three main sources of support were identified: support from nursing staff; support from DBT therapist; and support from patients. From staff teams, it was felt the 24-hour availability of support was what allowed them to make positive changes.

> *"if you struggle in the community it can take 2 or 3 days before somebody will come out and speak to you but being in here you just turn round and say oh I need to speak to someone and someone will come and speak to you straight away" (Ppt 6. 1140)*

In gaining support from other patients, participants noted that as they were living with others with similar difficulties, as a group they keep each other motivated.

> *"Yes I think being in an in-patient setting as well it helps because if you think oh no I don't want to do it sort of thing there's others here who feel that way too so they will help jog you along" (Ppt 9. 970)*

For other participants, being supported and supporting other patients helped them to consolidate and enhance their learning by discussing outside of DBT sessions.

> *"…we get to discuss skills a lot more because we can discuss it outside groups and if you've got a problem, like my friends quite erm, she knows a lot of skills, so if I've got a problem and I go to her she'll be able to give me you know what skills to use you know and we can discuss things and it consolidates what you're learning a lot" (Ppt 7. 1618)*

Theme: Improved Working Relationships

There were three main factors associated with inpatient DBT, which participants described as improving working relationships. The first was the 24 hour availability of staff. Although many participants described being constantly observed as an obstacle which they had to manage, many found that having staff around caring for them gave them confidence in the system and enhanced their commitment to DBT.

> *"Seeing that sort of commitment (from her individual therapist) and the team's consistency sort of thing does make me feel more committed... (Ppt 5. 498)*

As participant four describes, being constantly observed by staff and having DBT therapists on the ward, undertaking nursing roles, they are able to see the whole person. Although this felt awkward at times for patients, it was also seen as a benefit.

> *"Sometimes I think you know (X) is going to know what's been said in conversation as she's a nurse in therapy plus she's a main nurse on the ward, plus she knows what I'm saying to her, and I'm just thinking well you're getting the whole picture rather than just what a nurse would" (Ppt 4. 1194)*

However, it is also important to note, that this factor only improved relationships if it was seen by patients that staff were genuine. The transparency in communication from staff and the ability to see staff both in the ward and within therapeutic roles made this apparent for patients.

A dual system of care operates in the service between the nursing system and the DBT system. Participants felt that the containment offered by staff through their monitoring and management of risk was the one of the main factors which allowed them to focus on skills acquisition. The lack of this containment as an outpatient was believed by some participants to be the reason why previous interventions failed.

> *"I think that has actually really helped (the dual systems) because I suppose for me, not being very content or able to participate in you know DBT (as an outpatient), my safety wasn't being maintained and that's good in a way and that's given me the opportunity to learn DBT which I probably wouldn't have been able to do out there"* (Ppt 5. 1535)

Theme: Feeling Validated and Normalised

Participants described how being an inpatient, and living with others with BPD felt validating. Living with others with similar life experiences, allowed many patients not to feel isolated in their difficulties, creating a sense of unity between patients.

> *"Every night when I go to get a cup if coffee I get advice from people who are in-patients themselves and actually they understand what I'm going through"* (Ppt 6. 311)

The bonds created between patients, by living with each other strengthened relationships over and above those found in outpatient services. This appeared particularly important in inpatient services where often, family relationships were limited.

> *"You feel that you're valued and you're not on your own because sometimes you can feel quite on your own but then with the patient in-put cos everyone's got that rapport and everyone's so focused on DBT I find that very, very beneficial"* (Ppt 6. 434)

Participants described how the ward can become unsettled at times due to individuals behaving very chaotically. They described this as normalising, as they were able to reflect on their own experiences of being chaotic on the ward.

> *"Yes it is hard sometimes because obviously we've all got personality disorders and it kicks off quite a lot here and sometimes, you don't want to preach to people about skills but you think about times you've felt like that"*
>
> *(Ppt 2. 585)*

Related to the support given to each other, the ability to share experiences within the group and build relationships outside of the group in a contained environment gave many patients good experience of building and managing interpersonal relationships.

> *"…here is a practise ground and the thing is your living with 23 other borderline patients you won't get better experience. You know if you could live in this environment you could live in any environment. (Ppt 3. 1129)*

10.3.4 Obstacles of Inpatient DBT

Two subordinate themes emerged which related to the obstacles participants had to either manage or overcome when undertaking DBT in an inpatient setting. These were: *managing the dual system of care; living together; and being an inpatient*.

Theme: Managing the Dual System of Care

Participants identified several obstacles that they had to manage as a result of the dual system of care, the first of which related to boundaries with staff. As consistent and stable environments were identified as crucial for participants to feel contained, accounts of the need to maintain boundaries, and the obstacles faced in doing so were present in all narratives.

Participants identified how boundaries can some times get blurred between staff's roles, as many participants have therapists who also occupy nursing roles. The need for clear and explicit boundaries between the roles of staff was highlighted.

> *"There are some therapists which are staff nurses and that can get tricky at times because you might go to one for skills coaching and they end up putting you at risk; and you go oh no this is DBT this is nursing" (Ppt 3. 686)*

As participant three described, the dual roles of some staff can leave patients feeling inhibited to share their issues in therapy for fear they will be taken into nursing role and treated as a risk issue. However, participants noted that by telling staff which role they needed, staff would ensure role expectations were maintained. If staff were unclear, they too would request clarification.

> *"The staff can be quite tricky as well because they can say well that's DBT and we're not doing DBT we're doing nursing. (0.2) so basically you have to be clear in your mind about what you're doing" (Ppt 3. 703)*

The second factor participants raised addressed issues of confidentiality. Participants realised that as an inpatient, limits of confidentiality could be blurred between nursing roles and the therapeutic roles. Participants who had DBT therapists as nurses noted that often, nurses would gain information from both roles. As a result they described feeling exposed and intimidated by this due to their lack of choice in the information shared.

> *"My therapist doesn't work on this ward, and if she's read something in my notes or heard something through the grapevine, she'll bring it up with me (1394. 5) … it's uncomfortable" (Ppt 5. 1394)*

However, as participant five continued to explain, conscious effort is needed on behalf of the patient to understand that this is beneficial for their own progress.

> *"but then again if it's something that is hindering your progress erm, then I try, I try and just kind of like be open-minded but if she feels there's something I need to work on, then maybe I do" (Ppt 5. 1403)*

In managing the dual system of care, nearly all participants described how they could often feel invalided or unsupported by ward staff when asking for help. Many participants felt that as they were undertaking DBT, the support which they might have gained from ward staff in a traditional inpatient setting was not offered as staff expected patients to use their skills and resolve issues alone.

> *"I must admit it gets frustrating sometimes when erm, you go up and ask them if they've got a solution to something and they just turn round and say just use your skills, erm, you do find that frustrating because you think well you don't know them" (Ppt 9. 1198)*

Theme: Living Together

As part of undertaking DBT within an inpatient setting, there is an expectation for those undergoing DBT to live together, which raises many obstacles for patients. Managing the chaotic living environment of a large group of borderline patients was one. Related to this, participants noted that how you cope with this and still progress in treatment was another.

> *"Yes because it's the place you're living with and if it's so unpredictable you don't know what's going to happen you don't…" (Ppt 7. 969)*

As a result, participants noted that in order to live together effectively, solid and consistent boundaries were needed. Through the interviews many participants recognised that maintaining boundaries between each other in terms of what material could be discussed both within and outside of sessions was necessary to develop trust.

> *"…there are very strict guidelines in terms of what we're allowed to discuss with each other and that's very very different from before you come here you know it's like in the community and that you'll discuss anything with anyone, I mean you learn very very quickly that you don't do that here". (Ppt 5. 676)*

With respect to maintaining relationships, participants noted that if some group member irritates you, it becomes much harder to express your feelings towards them because you live with them.

> *"Yes because if you aren't here and you're out in the community I think you'd probably tell somebody if somebody's doing your head in you'd say to them, stop whingeing, you're constantly whingeing, because you can walk away from it" (Ppt 2. 772)*

In addition, the need to share thoughts, feelings with those you live with who are in your DBT group was described as a little uncomfortable by patients, who felt there was little space for them to have personal space or privacy. While participants on low risk status could easily achieve personal space from each other through outside activities, those on higher risk, under greater supervision, struggled much more.

> *"When you're downstairs you don't get so much because you're with everybody all the time and it all depends where you are with status, you know risk status erm, so yes you do get space but not a huge amount and yeah, sometimes its hard and it gets too much, yeah, it's too much" (Ppt 4. 1160)*

The difficulty in living together was raised by each participant and the need for space to allow coping with this challenging environment was highlighted. Throughout the interview transcripts it became clear that it was the strong and consistent boundaries created by patients which enabled this to occur.

> *"… it's quite difficult because you're on the ward all day, I mean occasionally you get to come to groups and stuff but it's hard I think you're living in each others pockets all the time" (Ppt 7. 1658)*

Theme: Being an Inpatient

This theme captures the obstacles patients experienced which related to being an inpatient. The implications of standard inpatient regimes and protocols on DBT are addressed. The first factor patients identified related to the risk management system. Although many participants recognised the need for staff to maintain their risk status, the effects of this system on participants was often seen as a major obstacle. The removal of privileges and the increased levels of observation were often seen by participants as very punitive. For participants who had reached the highest levels of the risk system, the fear of losing everything they had worked for was intolerable. As a result, participants described often feeling fearful.

> *"I'm terrified…,I can basically come and go as I want. I can go outside I can do everything myself. Can you imagine losing all of that to go back to having no leave, no privacy" (Ppt 8. 765)*

Consequently many patients described how this fear drove them to a state of secrecy, hiding problems and potential risks from staff and causing difficulties in therapeutic relationships to maintain their position.

> *"I have lied quite a lot as well which is totally anti kind of commitment therapeutic relationship sort of thing and that is why I think she (individual therapist) has said to me she can't tolerate that, because if I'm not being honest they can't work with me sort of thing… I'm quite ambitious, and driven to get I want to get whatever I want and at those times it doesn't matter about relationships" (Ppt 5. 508)*

Although many appreciated that the removal of privileges and placing people under more constant supervision was for their benefit, to keep them safe, becoming psychologically comfortable with this position was challenging.

> *"I did think what's the point in saying something if they're going to take it away because it looks at the time, it feels as if it's punishment, but it's not, until you take a step back a bit that you realise that it's not punishment they're just doing their job they have to be on guard, they're here to keep us safe".*
> *(Ppt 9. 449)*

The second theme that patients identified related to the difficulties in maintaining family relationships as a result of moving far from home to complete DBT. For many patients, visits from family were rare which led to increased feelings of isolation and loneliness during times when perhaps family contact is most needed.

> *"Being away from everybody that you care about erm, I think that's the hardest because I live in…and I've had no visitors apart from one since I've been here, and that can be quite hard"* (Ppt 2. 1476)

In addition, many participants have also had to adjust to being a long term inpatient. Where as previous inpatient experiences had been brief, the long stay in the service has been a huge adjustment for many.

> *"I thought it's only a year how wrong was I? Within the first 4 months I knew it would be longer. It screwed my head up the first time here being told I could be here for 3 years"* (Ppt 8. 413)

10.3.5 A Brighter Future

When discussing the effects of DBT, two subordinate themes emerged which related to the brighter future participants felt was now possible. These were: *DBT is life saving;* and *DBT is empowering.* Many additional factors which led to DBT creating a brighter future are discussed under the E*ffects of DBT* theme above.

Theme: DBT is Life Saving

There was an overwhelming sense from participants that DBT had saved their lives. For many participants, their experience of feeling hopeless at the start of their journey led many to feel that had they not enrolled in DBT they would be dead by now.

> *"I became more emotional, in what I was doing and yes, I could have ended*
>
> *up dead yes, so we just had to stop and nobody knew what to do with me"*
>
> *(Ppt 3. 126)*

As a consequence, a strong narrative developed within the interviews which related to the improved quality of life gained through DBT.

> *"Since I've been here I've found something I never thought I'd find some sort*
>
> *of happiness and peace for once…….. Here it's showed me that I can have a*
>
> *life that I can enjoy" (Ppt 4. 900)*

Theme: DBT is empowering

For many participants, although it was felt that DBT was empowering, it was considered by many that DBT was only effective because it had the containing nature of the inpatient service to support it. Every participant felt that had they been asked to complete DBT in the community, they do not feel they would not have 'stuck' with it.

> *"I don't think I would have kept up DBT if it had been in the community*
>
> *because I don't think that I could have coped well. I don't think I could have*
>
> *coped with keeping my behaviours under control and doing DBT"*
>
> *(Ppt 4. 1240)*

Interestingly, participants also noted that the containment and structure offered by inpatient DBT allowed them to push themselves further than previously.

> *"I'm probably pushed more being an in-patient as in going out to work and having the motivation to do this that and the other but if I was at home and I was having a bad day I wouldn't bother going you know…… in-patients has probably given me more opportunities than actually I would have" (Ppt 4. 1418)*

10.3.6 Preparing for Discharge

When thinking about leaving inpatient DBT and preparing to rejoin their life at home two subordinate themes emerged. These were: *an uncertain future; and dealing with loss.*

Theme: An Uncertain Future

Although many participants felt hopeful for their future because of the skills acquired, many still felt their future was a little uncertain. Nearly all participants worried about the future and coping at home when there was no inpatient DBT to return to.

> *"I'm scared of things going back to how it was before erm, but in actual fact I have the skills and the ability to do it but it's just you know, it's not allowing that fear to paralyse me" (Ppt 5. 286)*

For many participants the process of reintegration into their families and communities posed a real challenge. Many were concerned that, as they had to leave their communities for long periods of time and family relationships had been difficult to maintain, the process of reintegrating themselves and coping with changed relationships and environments would be difficult. Consequently many participants wished that services were available closer to their home to ease this transition.

> *"Not sending some people so far away from home, you know you need to think about that more and how you bring a person back, that's a tricky one"*
>
> *(Ppt 3. 1213)*

However, some of these concerns were alleviated by the extended Occupational Therapy discharge pathway. Many participants felt this provided them with an opportunity to practise skills and iron out any difficulties that may arise.

> *"the discharge plan, it's been kind of drawn out which is a good thing because it gives me a chance to practise the skills and to see how you manage them because it gives you confidence…It's shown you that you can manage because you managed then you can manage that as well, it shows you don't have to do any behaviours" (Ppt 3. 386)*

Theme: Loss

The final theme that was discussed was the theme of loss. Participants spoke about several aspects of loss; the first of which was the loss of the structure and containment that inpatient services had provided them with.

> *"here like has been a big part of my life it's been the only place that I have sorted, I have made progress, all the other hospitals that I've been in yes I might have made a slight progress I've been ok for a while but not for this long" (Ppt 9. 1345)*

Participants also spoke about the loss of support they had from both staff and patients who were around constantly. Many participants described how they found a sense of comfort and company with each other, despite occasional difficulties. The loss of such relationships and fear that this will not be achieved as an outpatient were present in many narratives.

> *"there's been times when we've all argued but there have been times when we've all supported each other and it proved that ( ) I do miss the company, going to miss the company here" (Ppt 9. 1316)*

Tied up within this sense of loss was the loss of the 1-1 therapeutic relationship. Participants reported that the time taken to build the trust and the relationship made it

very strong and close and the loss of such a relationship left participants in a state of turmoil and mourning.

> *"I'm trying not to look at it that she's abandoning me, because that's not what she's doing, she's got me ready for me to do it on my own now (Ppt 9. 1277) …*
> *"They are the one person that I've found that no matter what I've done, shouted at her or tried to push her away she's sort of always been there"*
> *(Ppt 9. 1289)*

As a final aspect of loss, participants spoke about the inevitable loss of the life they had built in the local area around the service. Participants described how they had built up a life outside through involvement in voluntary work and college etc. On discharge, participants described how they would be faced with leaving this life behind to return to the life they had before DBT; albeit in a 'better place'. One participant described this process like taking medication, where leaving the life you had built up was the adverse side effect.

> *"its tough, I do think they need to make it more available because you can't keep sending people away all the time, because that's like if you take a pill and it has an adverse reaction or a side effect, one of the side effects can be you set up too much of a life here and it becomes too scary to leave" (Ppt 3. 1197)*

11.   Discussion

The current study had two main aims, these were: to examine clients' experiences of Dialectical Behaviour Therapy (DBT) in an inpatient setting in order to assess if inpatient experiences of DBT raise similar themes to those of outpatients; and to examine the impact of the inpatient system on clients' experiences of DBT to explore the obstacles and benefits of completing DBT in such a structured inpatient environment. The findings from the current study indicate that there are a number of similarities in the experiences of the participants, which is represented by the shared themes. The separation of the results in to two distinct parts (a & b) resulted from the two different data sets that emerged. The first area (part a in the results) examined the DBT programme itself such as which aspects of DBT participants liked, the aspects they struggled with and the interplay between group and individual therapy.   As research examining these experiences already exists (Cunningham et al., 2004; Hodgetts et al., 2007b; Perseius et al., 2003) this shall not be discussed in great detail within this report.   As the aim of the present study was to examine the experiences of clients undergoing DBT within an inpatient setting, the second section of the results (part b) which relates to the journey patients described as having experienced when undertaking DBT in an inpatient unit is discussed in more depth.

11.1 Interpretation of findings

11.1.1 The DBT programme

The main goal of DBT is to develop 'a life worth living' (Linehan, 1993b) by enhancing an individual's ability to regulate their emotions. All of the women interviewed believed that DBT had had this effect on their lives and were grateful to the service for supporting them through this process. Following an in-depth analysis of the interview transcripts using IPA, two superordinate themes emerged which related specifically to DBT as an intervention for Borderline Personality Disorder (BPD). These related to the *Components of DBT* and the *Effects of DBT*. Within the *Components of DBT* theme, participants described two main subordinate themes which they felt impacted on their experiences and their evaluation of DBT as an intervention: *building relationships;* and *knowledge*.

With respect to the theme of building relationships, participants described three main factors associated with DBT which enhanced working relationships. The strong and consistent boundaries used within DBT, the clear and transparent communication used by staff and feelings of validation and normalisation helped many participants to develop effective therapeutic relationships. The ability to trust staff delivering DBT allowed participants to develop hope for the future and a belief in the service and intervention being provided to them. In conjunction with this, participants highlighted the benefit of specialist knowledge on the change process. Participants described three aspects of knowledge that were important to making positive changes in DBT. The first two related to the specialist knowledge of staff about BPD and the

acquisition of skills by the patients. However, the third aspect, which related to emotional understanding, appeared much more critical in effecting change and appeared to underpin much of the positive change experienced by patients. It was identified by participants that it was this understanding which allowed them to understand the purpose and use of the DBT skills and apply them appropriately.

Such findings have supported previous literature conducted in outpatient settings where participants have placed a high degree of importance on their relationship with the individual therapist. Cunningham et al. (2004) attributed this to the dialectic strategies discussed by Linehan (1993b), which recognised the desire of the client to gain balance between acceptance and change. It is the development of a solid therapeutic relationship and feelings of trust and validation which allow such a balance to be achieved, explaining the importance and recurrence of this theme in the literature. The specialist knowledge of staff and the importance of practical skills acquisition to enhance coping ability have also been highlighted (Cunningham et al., 2004; Hodgetts et al., 2007; Perseius et al., 2003).

In previous qualitative research of patients' experiences of DBT, one central theme has emerged which relates to the Effects of DBT on the participant. That is, many participants described DBT as lifesaving due to their perceived life progression before DBT. Participants reported that the specific targets of DBT, which include decreasing impulsive behaviour, improving emotional regulation (e.g. self control) and increasing interpersonal effectiveness (better relationships with family and others) reduce overall levels of suffering and self harm. By achieving these goals it was described that DBT provides a changed view of the self and hope for a better future. For all participants, it

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was the sense of empowerment gained from DBT and the validation and respect which they obtained from staff which was seen as central in both the current study and previous literature (Cunningham et al., 2004; Hodgetts et al., 2007; Perseius et al., 2003). Many participants described feelings of hopelessness prior to DBT based on their previous experiences of ineffective interventions. As DBT gives patients skills to help them change their behaviours, it appeared to have succeeded where previous interventions have failed. By helping individuals to act in more emotionally balanced ways, using skills such as mindfulness, it is not surprising then, that DBT is considered life saving.

11.1.2 The journey of inpatient DBT

Throughout the interviews, as participants recounted their experiences of inpatient DBT, a journey appeared to emerge within their narratives, which was represented by the six superordinate themes that were developed. These were: *A Hopeless Beginning; the DBT Programme; Promoters of Inpatient DBT; Obstacles of Inpatient DBT; A Brighter Future; and Preparing for Discharge.* Many participants spoke about how they had started in the service feeling hopeless and resistant to treatment, believing nothing would help *(A Hopeless Beginning)*. Participants also spoke about the changes that had occurred since starting in DBT, from building better relationships with others and feeling validated and supported by staff (*Promoters of DBT*) to overcoming various obstacles, such as fighting with staff (*Obstacles of DBT*). As a result of their experiences, participants described feeling more optimistic about their future and positive in their ability to cope with life's difficulties *(A Brighter Future)*.

The consideration of clients' experiences of therapy is crucial in understanding and examining treatment outcome as clients are not passive recipients of the therapeutic process. They are individuals with their own beliefs and values who make an active contribution to therapy and this can hugely impact on outcome (Macran, Ross, Hardy, & Shapiro, 1999). Within much of the research on clients' views of therapy, several universal and common themes have been identified with respect to what clients find helpful. In a review of qualitative literature on clients' experiences of therapy, Elliot and James (1989) and Hubble, Duncan and Miller (1999, cited in Hodgetts & Wright, 2007a) found several main categories which underpinned effective therapy. These relate to: therapist characteristics; client understanding / insight; client self expression; a supportive relationship and encouragement from the therapist; and model / technique factors. As can be seen from the current report, the themes that emerged (which related to both the DBT programme and the journey of inpatient DBT) map well onto such constructs and provide evidence for the acceptability of inpatient DBT.

As noted in the previous section, participants' experiences of mental health services before DBT were very negative. In many cases participants felt judged by staff, interventions were found to be ineffective and there was a lack of information about BPD available from services. Due to the specialist knowledge held by those delivering DBT and the focus on validation of individual experiences, this led many patients to report significant improvements in their difficulties. Although such themes have been found in the previous literature, (e.g. qualitative studies which have examined patients' experiences of DBT in outpatient settings), these studies have not taken the severity of the client's presenting difficulty into account. Participants within the current report noted that DBT was only offered after a period of escalating

symptoms which failed to be managed during standard outpatient care and interventions. As there was a complex referral pathway to the service, it was generally accepted that individuals in this environment experience more severe difficulties than those in standard (treatment as usual) services. Given that DBT appeared to be acceptable to the participants in the current study, where presenting problems are more severe, this bodes well for other inpatient DBT groups.

The current research highlighted the journey patients experienced when undertaking DBT in an inpatient setting and shed light on benefits and challenges related to this. Research on the effectiveness of DBT has suggested that inpatient uses of DBT can be as acceptable to patients as outpatient uses (e.g. Swenson et al., 2001). However, this research by Swenson et al. (2001) has neglected to discuss the impact of the inpatient system itself on DBT therapeutic outcomes. As DBT programmes in inpatient settings operate within larger systemic structures, involving a broad range of professionals there is therefore, a need within research to consider the impact of these systems, on the DBT programme.

Inpatient units are traditionally closed environments and as a result, issues such as the boundaries of confidentiality between nursing care and therapy are ultimately raised. Because such issues have the potential to influence and affect therapeutic intervention and outcomes, this raises the need for careful consideration of their management to ensure safety and care is maintained for the patient, in conjunction with therapeutic progress. As it can be seen in the present research, many patients highlighted the challenges they faced as a result of the risk status system and the dilemma this raised for them about lying to staff to protect their leave status against being honest and

addressing their issues. However, despite the challenges created by the inpatient system itself on the DBT programme, Swenson et al. (2001) reported that, the inpatient unit itself provides a powerful role in the overall treatment of the BPD patient and the incorporation of other disciplines into DBT (such as nursing and occupational therapy) only serve to further strengthen the DBT programme.

The current participants identified several promoters of inpatient DBT throughout the interviews. One of the main benefits discussed, related to the support and containment offered in inpatient settings through the 24-hour availability of staff and other patients, which they felt created a stable environment for learning the skills. In addition, participants also described the improved working relationships that were achieved within the inpatient setting because of the specialist knowledge of the staff and the presence of others with similar difficulties. This, patients felt, often led to a global validation and normalisation of their difficulties and also themselves as individuals.

In the early stages of inpatient DBT, participants acknowledged the need to pass responsibility and control for their safety to staff, allowing them space to focus purely on learning DBT. Saverman, Hallberg and Norberg (1993) described this concept as 'involvement' in which the caregiver shares responsibility of the patient's wellbeing with the patient. As a result, the importance of a strong therapeutic relationship between both DBT and nursing staff was highlighted. As many participants noted, it was the lack of a dual system of care which they felt had led other interventions to fail because they had had to manage their own containment and safety as well as learning the skills; which for many, felt too much to cope with. Consequently, many saw the

dual system of care in an inpatient setting as the factor which had been previously missing (in particular during the initial stages of therapy), which allowed them to focus on and learn the skills they needed to manage their own behaviour. However, as a caveat, patients also noted that they could only pass their responsibility for their safety and care on to staff in the context of a trusting and solid therapeutic relationship, which the 24-hour availability of staff and DBT therapists allowed to occur.

Individuals with BPD can often be seen as difficult to engage in therapy and they often have long histories of damaged relationships (Benjamin & Karpiak, 2001). With respect to therapeutic interventions for BPD, Linehan (1993b) stated that "the strength of the therapeutic relationship is what keeps such a patient in therapy… effectiveness of many DBT strategies and procedures depend upon the presence of a positive relationship between the patient and therapist" (Linehan, 1993b, p. 514). In the present study it was highlighted that the proximity of staff and the need for everyone to get along in such a contained small environment, enhanced the opportunities of patients to practise skills in relationship building. As a result many participants described feeling more confident in their ability to use this skill and more optimistic about their ability to build relationships when discharged back into the community. As Linehan (1993) suggested, strong therapeutic relationships are needed for DBT to be effective and so the enhanced therapeutic relationships created in inpatient settings may provide greater support for inpatient use of DBT.

Three main obstacles emerged in the current participants' experiences of undertaking DBT in an inpatient setting. These related to: *managing the dual system of care;*

living together; and the impact of *being an inpatient.* Although in certain respects, living with other patients and the dual system of care were considered promoters of inpatient DBT, in other respects they posed some challenges for patients.

Participants identified how boundaries with staff could become blurred, especially if staff were undertaking dual roles in nursing and as a DBT therapist. In such instances, participants acknowledged that when they approached a member of staff for support on the ward (who was also a DBT therapist), the question would always be raised if their issue related to DBT or nursing need, which many felt were often not separate and difficult to tease apart. The need for clear communication and explicit boundaries and role identification was therefore highlighted. Additionally, participants also discussed how issues such as confidentiality were affected as a result of the dual system of care. Participants described that the dual roles of some staff could leave patients feeling inhibited to share their issues in therapy for fear they will be taken into nursing roles and treated as an issue of risk. It was felt that the limits of confidentiality could become blurred for patients and they described feeling exposed, choosing to lie to staff to prevent the information they shared to impact on their nursing care.

Throughout the interviews, the implications of standard inpatient regimes and protocols on DBT were raised. The major factor which was identified by participants related to the risk management system. Although many participants recognised the need for staff to maintain their risk status, the effects of this system on participants was often seen as a major obstacle. The removal of privileges and the increased levels of observation were often seen by participants as very punitive. For

participants who had reached the highest levels of the risk system, the fear of losing everything they had worked for was intolerable. As a result, participants described feeling fearful and implied that such fear could drive them to a state of secrecy, hiding problems and potential risks from staff, in order to maintain their position. Although such obstacles are expected when implementing any intervention in an inpatient setting, the need for careful consideration of the management of systems such as risk management is therefore required, to ensure these necessary safeguarding systems remain positive and useful for staff and patients (Swenson et al., 2001). In circumstances where safeguards are not in place to manage the balance between risk management and therapeutic interventions such as DBT, one might find that such systems become counterproductive as patients risk increases through the use of their lies and concealment of their self harm from staff.

As part of undertaking DBT within an inpatient setting, there is an expectation for those undergoing DBT to live together. Although participants described some benefits of this such as having more opportunities to practise their skills, it was universally acknowledged that this also created some challenges. The main obstacle identified was how patients managed the chaotic living environment of a large group of borderline patients. Related to this, participants also discussed the difficulties which arose between managing this environment and progressing in treatment. When considering the application of DBT to inpatient units, Swenson et al. (2001, pg 311), suggested that "the frequent overload of emotional triggers on inpatient units can compromise the patient's capacity to learn new behaviours". As a result, it was interesting to see during the interviews, the coping mechanisms which had evolved by patients to manage the chaotic living environment. Every participant demonstrated a

great investment and respect for the shared boundaries which had evolved between patients and it was recognised that it was the maintenance of these boundaries which allowed participants to create a sense of space and privacy in the unit and trust in one another.

As a final stage in the journey of inpatient DBT, the difficulties associated with the process of discharge and issues this raised for patients about loss were highlighted. In outpatient DBT, the process of discharge can be a big struggle for patients who may not be quite ready to manage alone. They are often faced with the loss of the support, training and understanding they had gained from the DBT staff. However, for inpatients, this process may be much worse as they also have to deal with losing their home in the inpatient unit, their social structure (i.e. their relationships with each other and also the staff) and the life they built up in the local area (particularly as many patients in the current study had been involved in various voluntary work placements, education courses and community activities such as attending their local church).

For many patients in the present study who had been in the DBT programme for several years, it appeared that a process of institutionalisation may have occurred as many patients described the reliance on the sense of security and containment they received from the inpatient unit alone as a result of the structures, boundaries and routines which operate. Although patients described how DBT had taught them the necessary skills to contain and manage themselves, many patients recognised the challenges they would be faced with on discharge following their stay as a long term inpatient. For example, one patient during her interview noted that she had found it very difficult to set up education and work placements in her local community in

preparation for her discharge due to her lack of a permanent address in the local area. As a result she noted how she had to wait until discharge to set such placements up in the local community and therefore described feelings of uncertainty about the future which was leaving the process of discharge more anxiety provoking for her. In this instance and for this patient she had to cope with and manage feelings of loss attached to: the inpatient unit and the containment and support this offers; the other patients who were an additional source of 24 hour support and validation; and her close relationship with her individual therapist, as well as managing her own feelings of uncertainty and anxiety about her future placements and ability to cope in the community. As a result, in this sense, those undergoing DBT in an inpatient setting may be worse off on discharge than those in the community as the process of developing routines and structures in their local area may only start at discharge.

11.2   Clinical implications

The findings of the present study highlight the need for improved service provision for individuals with a diagnosis of BPD. The lack of appropriate interventions in outpatient settings was a common theme in all participants' stories. Each interviewee described the huge losses and adjustments which had to be made, such as leaving one's family and home area, in order to receive help. Although it is likely that for many patients, relationships with friends and family were poor (as a result of their BPD), the benefits of moving from their home (away from their difficult relationships) appeared outweighed by their need to repair and maintain them. As a result, nearly every participant stated that they wished they could have undertaken DBT closer to home in order to achieve this.

In the past, individuals with BPD have been excluded from services because of their diagnosis (NICE, 2009) and many others are treated 'at the margins' either through services such as Accident and Emergency or admissions to inpatient units who often lack specialist knowledge (NIMHE, 2003). In response to these difficulties, NICE (2009) have developed guidelines for the management of BPD to ensure that healthcare providers produce adequate services. They suggest four key priority areas for implementation: access to services; autonomy and choice for the service user; the development of optimistic and trusting relationships through non judgemental engagement; consistency and reliability; and managing endings and supporting transitions. Inpatient DBT appears to uniquely fulfil these roles as services are able to offer a level of support and containment to individuals (through the dual system of care), which is not necessarily available in outpatient settings.

At the time of writing there were a lack of DBT services in the UK and all of the participants in the present research had to be sent out of their local area. This was a source of significant distress for them. This situation seems to fail to meet NICE (2009) standards in relation to the choice offered to patients. Given the benefits and challenges of DBT for participants in the present study, then it would be more helpful if more inpatient DBT units were developed in other parts of the UK, for which the present research provides justification.

There may also be a financial justification for the expansion of DBT services for people diagnosed with BPD. Palmer (2002) noted that wider adoptions of DBT into different settings may potentially save the NHS money given the costs of current, less effective care (Harned et al., 2008; Koons et al., 2001; Linehan et al., 1999, 2002;

Soler et al., 2009; Verheul et al., 2003). However, he also noted that, in practice such changes are often difficult to implement and require initial outlay of cost to develop appropriate services. NICE (2009) realised that the level of severity of symptoms of BPD determines the level of healthcare resources required. Therefore, DBT in inpatient services may be more cost effective for people diagnosed with BPD in contrast to the current clinical management by several services (e.g. short term inpatient units, crisis services and community mental health teams) which are unlikely to meet their needs and where resources may be quite limited and costly.

The findings of the current report support the use of inpatient DBT and suggest inpatient uses of DBT are as acceptable to patients as outpatient use. In addition, the support and containment found within inpatient units and its effect on reducing co-morbid Axis I conditions provides a further rationale for the use of inpatient DBT, when patients are often at highest risk and in need of the most containment .

11.3   Ensuring research quality and identifying limitations

To ensure the validity of the present research, the four criteria suggested by Yardley (2000), which ensures 'good qualitative research' were used. These principles are: 'sensitivity to context', 'commitment and rigour', 'transparency and coherence' and 'impact and importance' (Yardley, 2000). Although there is much debate in psychology about the validity of qualitative research (given that it struggles to yield objective, replicable findings), being transparent and systematic in ones analysis and write up allows a reader to establish rigor at each stage of the research process

(Meyrick, 2006). However, despite every effort to ensure rigour and validity in the present research, there were several identified limitations.

First, the present study was conducted in a specialist secure inpatient DBT unit. As patients had a large investment in DBT having chosen to both attend the service and as a result of their length of stay it is likely that this may have resulted in overly favourable responses. In addition, only those participants who had been in DBT over one year and had moved on to the skills application group were interviewed. As individuals were moved into this group due to their enhanced understanding and use of the DBT skills, it is likely that their investment and support of DBT biased their narratives. Interviewing those in the early skills acquisition group may have elicited less positive experiences of DBT. However, their relatively short time on the DBT programme would have limited their contributions mainly to their experiences of 'starting out' on a DBT programme rather than an overview of their experiences of DBT as a whole.

The previous qualitative literature of patients' experiences of DBT provides many examples of how it has had positive effects in patients' lives. Although much of this may be due to the DBT programme itself, other factors may account for these favourable reports. For example, poor previous experiences with mental health services and the lack of any prior validation of their personal experiences may lead to a positive view of any service taking a specific interest in their difficulties.

Although it was made clear to participants that the present researcher was not affiliated with the service, many participants still raised concerns about staff hearing

their comments. Therefore, it may be that some responses were guarded or more positive due to these concerns. Furthermore, the nature of the inpatient setting meant that the interviews had to be conducted on the ward and it was often clear to staff which patients were being interviewed. This may have impacted on patients' narratives due to potential anxieties related to staff overhearing their views.

11.4   Future research

There is much evidence which demonstrates the usefulness of DBT in the management of BPD, however there is very little which examines patients' experiences of DBT. Research into clients' experiences of therapy are an important dimension in our evaluation of any intervention, since research suggests that perceived helpfulness of therapy, and clients' perceptions of the therapeutic bond, are major determinants of therapy outcome (Clarke, Rees and Hardy, 2004; Macran, Ross, Hardy and Shapiro, 1999). Further research is therefore warranted.

As the research was conducted in a private institution with a specialist DBT unit, it would be hard to generalise these findings to individuals who have undergone DBT in an inpatient setting within the NHS. Therefore, there is a need for a replication of the present study to examine if the increased resources and facilities available to patients in the present report may have favourably affected their experiences of DBT. In addition, as the only participants included in this research had been in DBT for several years, it would be interesting to interview people in the Skills Acquisition group to get more detailed experiences of starting out in inpatient DBT and those that 'drop out'.

Although there is some qualitative research on patients' experiences of DBT in the literature, very little explores staffs' experiences of providing DBT. As discussed throughout this report, inpatient DBT poses some very unique benefits and challenges in its implementation and gaining the views of staff (either nursing staff or DBT therapists or both) would provide interesting comparator material and a fuller picture. As one aim of the current research was to identify issues for services to address and consider when running an inpatient DBT programme, gaining staff views would help us to understand the needs of staff as well as patients.

11.5   Clinical recommendations

A number of issues emerged from the present study, which lead to the development of clinical recommendations, for both the service where the research was undertaken and more generally for other services where inpatient DBT may be adopted.

11.5.1 Recommendations for the service

First, one of the main issues to emerge from the present study, related to how patients move forward from the service back to their local area and how issues such of loss and adjustment are managed. Although a long discharge pathway operates within the service, there was an identified need for the service staff to become more involved with local services to where patients were discharged, to ensure adequate support was provided during follow up care in the community. One such source of involvement which was identified in the current research was the need for the provision of training

and dissemination of information by the service to local areas, about BPD and DBT, so that local services were better able to support patients following their discharge.

Although patients are informed that they may contact the service on discharge for support and guidance on an outreach basis, it was identified that there may be a role for staff to initiate this contact with patients for the first year after discharge. This would ensure that patients, who may feel uncomfortable about recontacting services after their discharge, are provided with this opportunity for additional support. This support and contact with the service for the first year after discharge may also provide a secondary gain to patients, by easing their process of transition from the service back into their local community.

Second, many patients within the service are sectioned and funded for treatment at the service by their local area, due to a limited availability of placements or resources for their suitable management. Consequently, it was identified within the present study that services and commissioners need to work more closely together to consider best practice for how patients are guided between services, to ensure the least amount of impact and distress for patients. In addition, as part of this process, there is also an identified need for training for commissioners about BPD and DBT, which may be provided by service staff to ensure that appropriate alternative community placements are found when funding for patients at the service is withdrawn.

Third, when considering the issues that arose for patients with respect to managing being an inpatient and living together with other patients in the unit, there was an identified need for staff to encourage patients to generalise their DBT skills for use in

the unit. This may be supported by training for non DBT ward staff (e.g. training in completing brief behavioural chain analysis and offering DBT skills as solutions with the aim of generalising skills further) and posters to remind patients of the DBT skills and protocols and offer "cheerleading" statements. Furthermore, training for non DBT ward staff would ensure that the feelings of patients who ask for support are not invalidated, as staff will be more aware of the DBT programme and the needs of the patients in relation to support and guidance which is needed on the ward to manage ward issues and conflicts with other patients.

11.5.2 Recommendations for services undertaking inpatient DBT

Although many of the recommendations outlined above are pertinent to any service undertaking DBT in an inpatient (hospital) setting, many of the promoters and obstacles of inpatient DBT must be considered to ensure an effective programme is implemented. In addition to the service specific recommendations made above, additional recommendations include:

- When a patient commits to join an inpatient DBT, staff must support the transition for patients by providing relevant and appropriate information and constant support, empathy and understanding.

- Solid and consistent boundaries must be developed and maintained between staff and patients and also between patients themselves to ensure feelings of safety and containment for patients.

- Whilst it is unavoidable that patients undergoing DBT in an inpatient unit must live together, there must be both therapeutic and personal support available from both DBT and ward staff to provide guidance to patients to help them manage and resolve any interpersonal difficulties and conflicts.

- When using risk management procedures in conjunction with DBT, there must be a careful consideration from the staff team about how dual systems operate to ensure that the patient's safety and progress in therapy is maintained. There must also be careful consideration of how behaviours that may interfere with therapy (such as lying by patients to conceal their risk behaviours) which occur as a result of the risk management system, are managed and reduced.

- As patients progress though DBT and have reduced their risks of self harm, there must be an integrated occupational therapy pathway to ensure that patients learn to generalise their skills in to the community through the use of college and voluntary work placements.

- The process of discharge also requires careful planning and preparation to ensure that patients have the opportunity to re-integrate themselves back into their local community and set up adequate resources for support. This is particularly important where there has previously been fraught or poor relationships and contact with family members. Where possible, the service discharging the patient should attempt to consult and provide outreach support to receiving services in order to smooth the transition between services for patients. Furthermore, receiving services should ensure that patients have

access to a DBT trained therapist, where possible, who will provide support for the patient's progress.

11.6 Conclusion

The present research described a qualitative study using IPA to examine the experiences of patients undergoing DBT in an inpatient setting which has not previously been explored.   Although this was the first research paper to examine inpatient experiences of DBT, there were many similarities between the experiences of the inpatients in the current research with those in outpatient DBT. This suggests that inpatient uses of DBT are as acceptable as outpatient uses. The journey participants described as part of inpatient DBT highlighted the unique benefits and challenges of inpatient DBT therapy which are generalisable to other inpatient interventions. Consequently, this raised several issues for services to consider when implementing or developing services, for example how to best manage issues like confidentiality within a dual system of care.   The clinical implications of such findings support the use of DBT in inpatient settings and provide a rationale for the development of more services countrywide to ensure that patients develop autonomy and choice for their care.

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Paper Three: Critical Appraisal

13. Overview

This final paper provides a critical evaluation of the research process. It is largely based on a reflective journal which was kept throughout the course of the research project. Throughout this paper I will reflect on how my experiences may have influenced the research, in order to address issues related to personal reflexivity.

14. Developing the research topic

I started clinical psychology training with ideas about the research project, which were developed during my last assistant psychologist post. I worked in an inpatient hospital and as part of this role I became involved in conducting assessments for and running the community Dialectical Behaviour Therapy (DBT) programme. I was often struck at the experiences of treatment that individuals had had prior to starting DBT. The stories for many painted a very bleak picture as patients discussed how they had often felt untreatable and judged by services until they started DBT. For this reason, I became interested in DBT and why, for many, this was the only intervention which had created hope and a belief that it would work.

DBT is a well researched area and has demonstrated significant improvements in treatment outcome when compared against treatment as usual or comparator interventions (Harned, Chapman, Dexter, Comtois, Linehan et al., 2008; Linehan et al., 1999, 2002, 2006; Soler, Pascual, Tiana, Cebria, & Barrachina et al., 2009; van den Bosch, Stijnen, & Verheul et al., 2004). However, idiographic approaches which explore clients' experiences have not been as well researched. The consideration of

clients' experiences of therapy is crucial in understanding and examining outcome as clients are not passive recipients of the therapeutic process. They are individuals with their own beliefs and values that make an active contribution to therapy and this can hugely impact on outcome (Macran, Ross, Hardy, & Shapiro, 1999). Hubble, Duncan and Miller (1999, cited in Hodgetts & Wright, 2007a) suggest that four main factors often underlie successful therapeutic interventions: client/therapeutic factors, relationship factors, placebo, hope and expectancy and model / technique factors. As relatively few of these factors can be measured using outcome assessments, the importance of gaining a client's personal experience of therapy is highlighted.

Inpatient DBT poses very different challenges than outpatient DBT for patients. Swenson, Sanderson, Dulit and Linehan (2001) stated that certain typical features of DBT are challenged by the inpatient unit. They identify that the power differentials between staff and patients and the frequent overload of emotional triggers for the patient (as a result of living with other BPD patients) which compromise their capacity to learn new behaviours, are among a few of the challenges patients face. Although there is a range of literature that examines the efficacy of DBT in an inpatient unit, none examines patients' experiences. Considering DBT is increasingly being used by services in longer term inpatient units (in response to NICE (2009) guidelines), it was felt that this research would provide valuable insight into the benefits and challenges of inpatient DBT to inform service development.

14.1. Choice of methodology

The research question clearly indicated a qualitative method of enquiry. Although a

range of sources to obtain qualitative information exist, I selected semi structured interviews on the basis that they are the most suitable way to access the subjective meaning of participants' experiences. Although I appreciated that similar narratives might be present in the interviews, I felt that I needed a method of data collection which would allow me to be flexible and tailor the interviews to each individual's experience. Furthermore, as it was hoped that the findings of this research might later inform service development, I felt that a qualitative method of enquiry would be most enlightening.

Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2008) was selected as the most suitable method of data analysis for the present research, due to its focus on understanding the subjective meaning behind peoples' life experiences (in this case, patients' experiences of DBT in a secure inpatient unit). I also appreciated that by using IPA I could allow the data to emerge from the transcripts and draw on my own knowledge of DBT and BPD to help me in interpret the meanings and phenomena behind participants' stories.

The epistemological stance chosen for this research was largely dictated by the choice of IPA for data analysis. IPA is concerned with the meanings of experiences, perceptions and accounts of events rather than objective records. The use of an epistemological position therefore, which assumes that reality exists and the perception of knowledge is shaped in part by subjectivity and social forces (Guba and Lincoln, 1994, cited in Denzin & Lincoln, 1994), seemed most appropriate. As a result the Critical Realist (CR) perspective was adopted. In addition, the individuals in the research were part of a population who were defined by and sought help for the

diagnostic label "borderline personality disorder" as defined by the DSM-IV (APA, 2000). Due to this shared meaning of the nature of reality by patients and clinicians (i.e. BPD is a condition which exists and has shared difficulties for those within this category as determined by the DSM-IV (APA, 2000)); this further supported the use of a CR perspective.

15. Conducting the research

15.1. Obtaining Ethical Approval

Obtaining ethical approval for this project was a lengthy process as I was required to submit proposals to three different services (the Research Ethics Committee (REC), Leicester Partnership Trust – Research and Development and the service) and gain CRB clearance from the research site. In addition, this process was made slightly more complicated, because the service was a private organisation (outside the knowledge and remit of the NHS REC) which accepted patients on a section, funded by the NHS. As a result of this, obtaining ethical approval took longer than expected and delayed the start of the data collection phase. Although I found this quite a frustrating process, it was worthwhile as it taught me the importance of careful planning in research, to ensure deadlines are met.

15.2. The development of the interview schedule

The interview schedule was developed during the design stages of the project in conjunction with both supervisors, but was often amended after each interview. By

using semi structured interviews I found I often added questions to the schedule to gain future participants' experiences of issues/ themes that had emerged during previous interviews. After the first (pilot) interview, I left the session feeling that the data I had obtained was bland and missed much of the detail about the participants' experiences. In order to address this I re-listened to the tape and examined the questions I had asked and the points I had followed up. Although this initial interview schedule asked questions about DBT and what it was like going through DBT in an inpatient unit, it seemed to be missing depth in the participant's response as I was not asking them to recall specific incidents or issues which would give their narrative context. I also realised that I was only really gaining a positive account of DBT and not gaining any information from the participant about any obstacles she had faced. During the next supervision session with my academic supervisor I raised these concerns and discussed how I might improve the interview schedule. I realised during this session that I had slightly lost my way in the research and the aims and focus of what I was examining (what it was like to be a patient undergoing DBT and more specifically how the inpatient system was impacting them). As a result, I left this session much more focussed and clear in the changes I needed to make to the interview schedule to improve the quality of the information I was gaining.

15.3. Recruitment of participants

During the initial stages of this project, I met with my field supervisor on several occasions to discuss the overall design of the research. As the overall aim of the research was to gain participants' experiences of DBT in an inpatient unit, it was decided that it would be best to interview only those participants who had a good

understanding of DBT and had been appropriately applying the skills. It was decided to interview only those patients who had graduated from the Skills Acquisition Group into the Skills Application group. As there were no drop outs from therapy in either group, every individual who had graduated from the Skills Acquisition group were available for selection.

The field supervisor of the project initially approached each patient within the skills application group for their interest and provided them with an information sheet. I understood that having the clinical lead for the DBT programme approach participants may bias their decision to take part in the research; however, I wanted the request to come from someone they knew in order to help them feel comfortable. As I was requesting that participants talk about their experiences of DBT in a secure inpatient unit, which I knew would involve discussions about difficulties they had had and relationships with staff, I considered that participants may worry about their comments being fed back to the team. In order to make participants feel comfortable to speak openly and honestly, I knew it was important for me to be seen as a complete outsider from the team. As a result, I ensured that participants only saw me around for the interviews and that I did not appear to spend any time with staff teams on the wards. In addition, to solidify this point for participants, at the start of each interview, I made my roles, affiliations and responsibilities explicit. I repeated this again at the end of the interview and informed participants about how their data would be used.

15.4. The interview process

Interviewing raised several interesting issues. First, while I had background experience in DBT and was aware of my positive feelings towards DBT as a therapy, I did not want this to impact on the act of asking research questions. Therefore, a cautious, open style of questioning was used (Smith, Flowers & Larkin, 2009) to shape the interview to participants' experiences in an effort to gain honest accounts. To ensure this occurred throughout the interviews, I frequently informed participants that I was interested in both positive and negative experiences and the reasons behind this. Interestingly, I found that when I linked the purpose of the research to service development for future patients, participants were much more open to share their negative experiences with me.

Second, I also found myself in a dilemma about sharing my background experience in DBT with participants. On one hand I understood that if I told participants that I previously delivered DBT, this may promote rapport. However, on the other hand I also realised that this may impact on participants' accounts, leading them to be overly positive. As I sought a balanced account from participants, I decided not to inform them of my background in DBT. Instead, I ensured that I only shared themes and ideas with patients that I had gained from previous interviews, and framed these ideas as such.

Conducting the interviews was a great source of learning for me which allowed me to develop confidence in my interviewing style. At the start of the interview process I did not deviate far from the interview schedule to ensure that I did not miss anything

in order to get 'good' data for my thesis. As I conducted more interviews and became aware of the themes that were emerging, I was able to move away from the schedule more, expanding my questions to focus on the content of the narratives which produced deeper more meaningful accounts. Smith, Flowers and Larkin (2009) suggested that when conducting interviews for IPA, the researcher has to let go of preconceived notions and 'learn in practise'. They highlighted the need to understand the interview dynamics, noting how general comments move to specific comments. They suggested that it is only by doing this that the researcher is able to leave their research world and come round the hermeneutic circle to the participants' world. Although I understood from the outset that this method was required, I felt I was only able to start undergoing this process as I developed my confidence and my understanding of the themes that which were emerging.

As a final consideration I was aware during the interview process of the conflicting pressures I was under with regards to completing good quality interviews and working to tight deadlines. As gaining ethical approval took longer than hoped for, I was not able to transcribe each interview before the next, which would have allowed me more time to reflect and develop the interview schedule further. However, I don't feel this greatly impacted on the quality of the data collected as I ensured that I took time after each interview to reflect on the questions I had asked and the information I had gained.

15.5. Data analysis and write up

As I had no previous experience using IPA, I found the data analysis and write up of

the research challenging. Although I used information from both journal articles and textbooks to guide me in using IPA (Eatough & Smith, 2008, cited in Willig & Stanton Rogers, 2008; Smith, 2004; Smith, Flowers & Larkin, 2009), I was aware that I often worried about 'doing it right' and my interpretations of the data being 'good enough' to reflect the true and full meaning in participants' accounts. Throughout data analysis, I remained mindful of the need to interpret only what was in the accounts, and so I went back to the transcripts regularly to check my interpretations fitted with what participants had actually said. Although, I was aware that in using IPA I could use my previous experiences and knowledge to help me analyse the data, I did not want to make interpretations based on any assumptions I might have made, which were not grounded in participants' experiences.

In using IPA I was aware of the need for me to become immersed in the data, however, I found this process slightly overwhelming due to the sheer quantity of data I collected. In the first instance to create intimacy with the data I listened to each tape again whilst reading the transcript to ensure accuracy between the two. I found this process very useful as it allowed me to start the process of becoming immersed in the data. I then read each transcript twice to develop a list of themes. As time progressed and I became more immersed in my data and analysis, I found I really began to enjoy this creative process. I quickly learnt that I needed to let go of my notions about doing things right as I became more confident in my understanding of the data and the themes that were developing. I was also often surprised at how constantly evolving the data analysis process was and how my understandings and interpretations changed as I progressed though the research. Using my reflective journal, I was able to see the progression of ideas I had had from the limited interpretations I had made during the

initial stages of data analyses to the more complex ones I had made during the final stages of writing up the results.

I found my write up of the research to be an essential part of tightening my analysis as I was often to make new interpretations and merge themes even at this late stage. By structuring the results to use participants' quotes to illustrate the themes, I was able to draw parallels between ideas, which I had previously not seen. To illustrate, at the first write up of the results I had a total of five different sub themes for the both the *obstacles* and *promoters* of inpatient DBT themes. As I progressed through the write up and links between ideas became clearer I was able to group themes more effectively and was left eventually with three different sub themes in each subordinate category.

15.6.   Ensuring research quality

Meyrick (2006) suggested that in order for qualitative research to be considered rigorous, the researcher must be transparent and systematic throughout every stage of the research process. Using this principle and the four criteria suggested by Yardley (2000), 'sensitivity to context', 'commitment and rigour', 'transparency and coherence' and 'impact and importance', I endeavoured to produce quality research.

'Sensitivity to context' was demonstrated by grounding the research in the theoretical literature and by considering the sociocultural setting of the inpatient unit and its impact on the both the patient and the DBT programme. An example of this was the decision to interview long term secure inpatients about their experiences of DBT, as

this had not previously been considered in previous research. Furthermore, the choice of IPA as a method of data analysis provided further evidence of sensitivity to context due to its close engagement with the subjective meanings within participants' accounts (Smith et al. 2009).

'Commitment and rigour' throughout the research was illustrated by the attentiveness to the participant during the interview (to tailor the questions to their individual experiences) and by the depth and breadth of the analysis conducted. The careful selection of an appropriate sample for interview, to match the research question (i.e. the decision to interview only those in the Skills Application group due to their enhanced understanding and application of DBT compared to those in the Skills Acquisition group) further demonstrates the rigour with which this research was undertaken.

To adhere to the third principle 'transparency and coherence', examples of how the data was analysed and coded were made available in the research report. Furthermore, the use of my reflective diary throughout the research process allowed me to reflect on the thoughts and assumptions I had made during data analysis and how these had translated into the final themes which has been discussed at length, in this paper. Coherence was demonstrated throughout the research paper by linking the findings of this study to the existing literature of patients' experiences of DBT in an outpatient setting.

For the final principal 'impact and importance', Yardley (2000) noted that the main test of the validity of qualitative research is whether the data informs us of anything

interesting or important. As the present research was the first study to examine patients' experiences of DBT in a long term secure inpatient unit, the results are important to clinicians in the field. They provide evidence of the benefits and challenges which need to be considered when implementing DBT in inpatient units and support the development of more local inpatient DBT services in the UK.

16. Supervision

I had the benefit of two very dedicated and supportive supervisors throughout this project who were committed to producing a quality piece of research suitable for publication. Both my supervisors were extremely knowledgeable about DBT, BPD and qualitative research and as a result, my supervision sessions with both supervisors complemented each other extremely well. I feel the discussions I had in supervision, with both supervisors about my area of research, clinical implications, academic requirements etc, was what underpinned much of my developing confidence as I was able to gain feedback on my thoughts and ideas. It was largely through this process that I developed a deeper understanding of my subject area and in addition, the support I gained in supervision was what allowed me to stay motivated and enjoy the research process.

17. Development of research knowledge

Several learning points emerged from this study; the first related to my development as a researcher and clinician. As a researcher I learnt the value of using clients' experiences of therapy to promote evidence based practise and service development. I

became very aware of how therapy effectiveness is so often determined by services using nomothetic approaches, and how little value is placed on the clients' experiences and interpretations. As so much of therapeutic outcome is often determined by a patients' perception and experience (Hubble et al., 1999) using client feedback as a means of evaluating outcome was highlighted for me. In addition, I feel that through the process of research I was able to build on my clinical skills such as interviewing, formulations and evaluations. By conducting a qualitative study, I developed confidence in myself to trust my own understandings and judgements and was able to let go of some of my previous anxieties which I have held throughout clinical training, for example, about "doing things right".

Throughout training, I have always worried about being good at reflexivity and as such, I have always endeavoured to develop my skills in this, using supervision sessions to support me. Reflexivity strengthens qualitative research by enabling the researcher to acknowledge and take account of the many ways in which they influence the research findings (Sandelowski & Barroso, 2002). Throughout the research process, I became more aware of the influence of my background in DBT and BPD and my research and clinical interests. Consequently, by using my research diary, I was able to be explicit about the origins of my ideas and consider how my own understandings of participants' narratives were shaping my data analysis.

18.   Conclusion

The research process was challenging for me, in particular with the amount of data created and subsequent analysis of it. However, as a result of this process I feel I have

developed confidence in my self and an ability to trust my judgements. In addition, I also feel the research has been invaluable to my professional development by allowing me to build on my clinical skills such as formulation and evaluation. I was aware at the start of the research process that I was quite anxious and caught up in the idea about doing things right and was not allowing myself to focus and gain confidence about what I had achieved. I am aware that this has often been a theme for me during training and has previously underpinned much of my lack of self confidence. As a newly qualified psychologist, it is important to have confidence in ones knowledge and abilities and I think that the process of research (which has relied on my personal interpretations and understanding) has allowed me to start letting go of some of these notions and develop confidence in myself which I feel will stand me in good stead for becoming qualified.

19.   References

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