

**Living on the borderline – An evaluation of the client impact and active ingredients of Dialectical Behaviour Therapy for Borderline Personality Disorder in Irish Adult Mental Health Settings**

**By**

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A thesis submitted to the School of Nursing, Dublin City University, in fulfilment of the requirement of PhD by research.

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**October 2008**

## **DECLARATION**

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of PhD by research, “Living on the borderline - An evaluation of the client impact and active ingredients of Dialectical Behaviour Therapy for Borderline Personality Disorder in Irish Adult Mental Health settings” is entirely my own work, that I have exercised reasonable care to ensure the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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## **DEDICATION**

To Audrey and Abraham Bayley – Thank you for everything.

## **ACKNOWLEDGEMENTS**

Of foremost importance is a big thank you to the research participants. Thank you for taking the time to meet me and allow me to hear your story, which at times incorporated raw emotion and pain. It was amazing to listen to your reflections on your life and on your difficulties. It was uplifting to hear how some of you conquered immense suffering to move forward in life and break away from the shackles and demons of the past.

Thank you to Maeve Kenny, my clinical supervisor, who introduced me to DBT and helped carve out the research proposal, inspire my clinical interests and helped get the research off the ground. You have been a constant source of pragmatism, realism, education, and positive energy for the last four years. You have served as a great model for my future clinical work.

Thank you to Chris Stevenson, my academic supervisor, who has diligently guided my research and writing skills. Thank you for your immense contribution and enthusiasm throughout the last three years. You constantly had your eye on the target. I have enjoyed working with you.

Special thanks to the support and love from my parents and family members.

My special appreciation is also directed to Garrett and my dear friends, who kept me grounded, entertained and supported throughout the years. Thank you for all your beautiful support and love.

Thank you to the CEO, Ned Byrne, staff of the Psychotherapy service and the Psychology Department in St. Vincent's Hospital, Fairview for your financial support, kind words and active listening. I have enjoyed many cups of tea with you all. Many thanks to Maria McCarron (SVHF/Mater DBT team) and the DBT team for your support. Thank you to Beth O'Riordain (Crumlin DBT team) and Paul Lyons (North County DBT team) and your team members. Thank you both for becoming involved in the research.

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**Living on the borderline - An evaluation of the client impact and active ingredients of Dialectical Behaviour Therapy for Borderline Personality Disorder in Irish Adult Mental Health settings.**

**Austin Bayley**

The research evaluated the client impact and active ingredients of Dialectical Behaviour Therapy (DBT) for Borderline Personality Disorder (BPD) in three Adult Mental Health settings in Dublin. A mixed methodology approach was undertaken with two phases incorporating a single case study design and qualitative investigation. Phase 1 was a qualitative investigation of DBT clients who had completed (n=16) and those who dropped out (n=6) of treatment. The interview schedule examined client perspectives of treatment components, changes occurring since before DBT and reasons for dropping out. Phase 2 was a case study approach with clients who were currently attending DBT (n=10). Outcome measurements were administered and qualitative investigation was undertaken at two-month intervals to gauge perspectives of treatment and changes occurring. Records of attendance and admissions were also used. Four conclusions from the research were drawn. 1) DBT was associated with tangible improvements in client lives and had considerable impact on level of risk, well-being and functioning. Level of hopelessness and BPD symptoms showed significant positive change between baseline and six months. 2) DBT was not suitable for all participants for specific reasons discussed within. The level of satisfaction with DBT was overall high and some useful clinical recommendations were gleaned from service user input. 3) Key active ingredients of and obstacles to treatments were evaluated. 4) Recommendations for service delivery, development and further research were outlined.

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**CHAPTER ONE**  
**OVERVIEW OF**  
**THE THESIS**

## **CHAPTER ONE**

### **OVERVIEW OF THE THESIS**

Chapter 1 describes the background and context to the study and purpose of the investigation and outlines the research questions. An outline of the structure of the thesis is provided.

#### **1.1 BACKGROUND AND CONTEXT**

The current research arose from a need for an evaluation of the Dialectical Behaviour Therapy (DBT) programme in the three Adult Mental Health sites in Dublin. Site A was established in 2002, while Site B and Site C both arose from more recent training in 2005. Hence, there had been little investigation in the Irish context of this new intervention for clients diagnosed with Borderline Personality Disorder (BPD), apart from two small scale service-based studies (Rashleigh, 2003; Lawlor, 2000). It certainly appeared through therapist and client informal anecdotal report that DBT was associated with a positive impact. However, in the absence of formal and independent evaluation research, those involved in delivering and funding the service could not substantiate the ramifications and ‘active ingredients’ of delivering such a comprehensive and expensive therapeutic model. It was proposed that the evaluation should focus mainly on the client impact and comment on the DBT model itself, due to the restricted numbers possible, ethical considerations, gaps in the research, time limitations and need for service user involvement.

A mixed methodology was chosen for the research, as it would most comprehensively and appropriately address the research questions. The research was divided into two separate but linked and complimentary phases. Figure 1 shows how the overall research is linked and sub-divided. Phase one of the research was a qualitative investigation of the impact of DBT on clients with Borderline Personality Disorder (BPD) in two Adult Mental Health sites (Site A and Site B). Participants in both sites had either completed one year of comprehensive DBT, forming the ‘DBT graduate group’, or had discontinued treatment prematurely, making up the ‘DBT drop out group’. Phase one was used to add focus to and direct the methods used in Phase two. Phase one was conceptualised to add clarity and aid analysis and interpretation of Phase two. Both phases in combination and alone stand to inform about the client impact of DBT.

Phase two was a mixed methodology repeated measures case study design, with each participant being assessed at the beginning of the skills group (baseline), and for every two month period (at end of each skills module) until the end of one year in the DBT programme. A total of seven assessments took place for the participants who stayed in treatment for one year. Participants attended either Site A or Site C.

It was maintained during the research proposal stage that the two-phase mixed methodology model of the study most comprehensively evaluated the client impact of DBT and identify the ‘active ingredients’ of the treatment.

**1.2 AIM OF THE STUDY**

The main aim of the study was to investigate the impact and active ingredients of DBT on a number of clients with BPD in Adult Mental Health settings. Client impact and active ingredients were explored through three distinct sample groups, those who completed a full year of DBT, those who dropped out prematurely and finally those who were followed through treatment. Client impact and active ingredients were explored and captured through fulfilling the following objectives or research questions, which are explored in more detail in Chapter 4: Methodology.

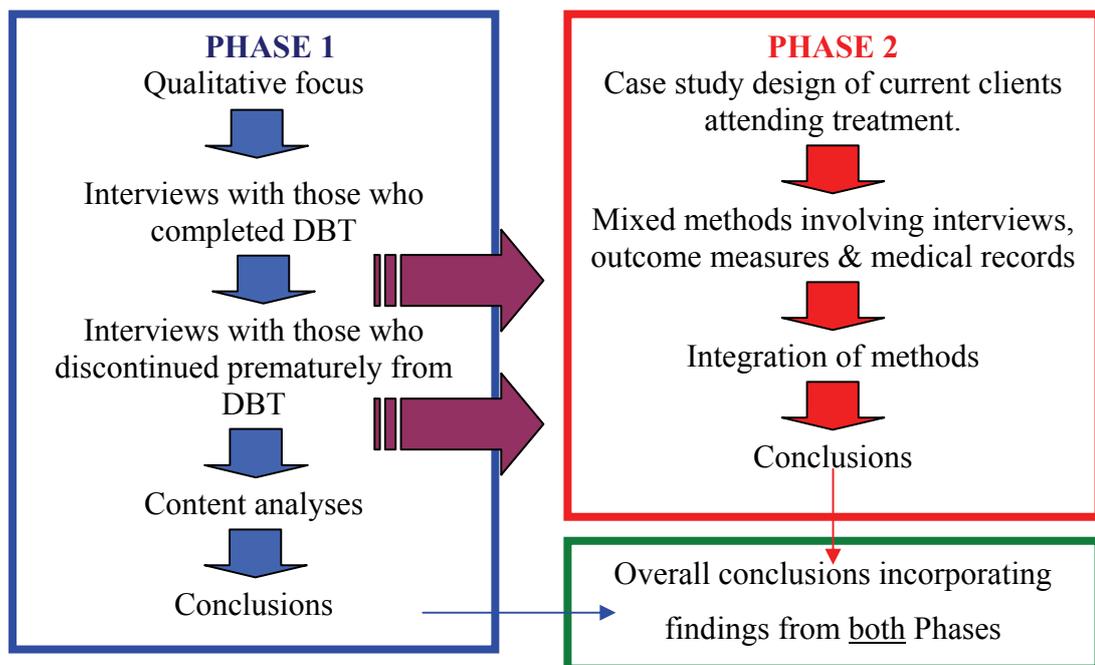


Figure 1: Subdivision and relationship between each research phase in an overall mixed methodology study.

- 1) *To assess the clients' perspective on their participation in the DBT programme.*
- 2) *To gauge the impact that DBT has had on the lives of clients.*
- 3) *To investigate reasons why clients drop out of the DBT programme.*
- 4) *To calculate statistical change in the client group.*
- 5) *To isolate the most effective components of DBT.*
- 6) *To examine the clients' experiences of the Mental Health system.*
- 7) *To determine the service and research implications of the findings.*

### **1.3 LAYOUT OF THE THESIS**

In terms of presentation, this thesis incorporates seven main chapters. Chapter 1 provides a background and an overview of the research study. Chapter 2 consists of a literature review of relevant studies in BPD. Chapter 2 presents a contextual background of the condition, including a review of the classification of the disorder, its epidemiology, its course, and suicidal and self-injurious behaviours in BPD. There is an elaboration on the complexities of co-morbidity in BPD and the challenges made to its diagnostic value. An outline of the major aetiological perspectives of BPD is provided. Staff reactions to the condition and therapeutic options form the final discussion in Chapter 2.

Chapter 3 consists of a thorough description of the DBT model, including functions, biosocial theory, dialectical world view, therapeutic style and finally an in depth description of the therapeutic components and targets. A discussion of DBT research completed to date is given including studies of effectiveness, adaptation and modification of standard DBT, dismantling studies of active ingredients and mechanisms of change and qualitative investigations.

Chapter 4 is the methodology chapter. This chapter describes the purpose of the current study and provides an explicit outline of research questions. The design, procedure and instruments used, ethical issues and data analyses are discussed. Justification of the design is also provided.

Chapters 5 and 6 include the main findings of each of the two phases in the research. Chapter 7 provides an opportunity for in-depth discussion of the overall findings, an assessment of the clinical implications, and proposal of the major research recommendations and suggestions for service delivery.

# CHAPTER TWO

# **BORDERLINE PERSONALITY DISORDER**

## CHAPTER TWO

### **BORDERLINE PERSONALITY DISORDER**

#### **2.1 EVOLUTION OF THE CONCEPT**

From the early days of being considered a variant of schizophrenia, somewhere on a spectrum between psychotic and neurotic, the symptom cluster of Borderline Personality Disorder (BPD) has evolved considerably. Grinker (1968) described the 'borderline syndrome', which included failure of identity, turbulent relationships, depression based on loneliness, and predominance of expressed anger. Throughout the 1970's the concept evolved through clinical observations and research and was eventually recognised as a distinctive diagnostic category by DSM-III in 1980 (APA, 1980). The disorder steadily gained recognition and the diagnosis was made more reliably through improved psychometrics. By the 1990's onwards, BPD became among the most controversial diagnoses, with many debates unresolved (Zittel & Westen, 1998) and misunderstandings still in existence (Hersh, 2008).

In Chapter Two, the classification of the disorder, its epidemiology, its course, and suicidal and self-injurious behaviours in BPD is discussed. The complexities of comorbidity in BPD and the challenges made to its diagnostic value are then elaborated. An outline of the major aetiological perspectives of BPD is given. Staff reactions to the condition and therapeutic options forms the final discussion. From this analysis of all the latest literature on BPD, the intricacies of BPD and how there is both an evolving understanding of the concept and yet still many questions left not fully answered are demonstrated. The immense difficulties of treatment of BPD, heavy service usage and often restrictive staff views of the disorder are highlighted. Finally, the seriousness, pervasiveness and chronicity of the self destructive and suicidal component of the disorder are emphasised, as well as the incapacitating emptiness, turbulent relationships, violent mood changes, identity disturbance and impulsivity that impacts so immensely on the person themselves and their families.

## 2.2 DIAGNOSIS AND CLASSIFICATION

A personality disorder is described in the International Classification of Mental and Behavioural Disorders (ICD-10) as “deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of social and personal situations, representing either extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels and particularly relates to others” and are “developmental conditions appearing in childhood or adolescence and continue into adulthood” (World Health Organisation, 1992a). Personality disorders are divided into Cluster A (odd and eccentric disorders including paranoid, schizoid and schizotypal personality disorders), Cluster B (dramatic, emotional and erratic disorders including antisocial, borderline, histrionic and narcissistic personality disorders), and Cluster C (anxious/fearful disorders namely avoidant, dependent and obsessive compulsive personality disorders).

Diagnostic Statistical Manual-IV or DSM-IV (APA, 1994) defines Borderline Personality Disorder (BPD) as the following “a pervasive pattern of instability of interpersonal relationships, self image and affects, and a marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following...”.

- Frantic efforts to avoid real or imagined abandonment.
- A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.
- Identity disturbance; markedly and persistently unstable self-image or sense of self.
- Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance misuse, reckless driving, binge eating).
- Recurrent suicidal behaviour, gestures, or threats, or self mutilating behaviour.
- Affectivity instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability or anxiety, usually lasting a few hours and only rarely more than a few days).
- Chronic feelings of emptiness.

- Inappropriate, intense anger or difficulty controlling anger (frequent displays of temper, constant anger, recurrent physical fights).
- Transient, stress-related paranoid ideation or severe dissociative symptoms.

## 2.3 EPIDEMIOLOGY

### 2.3.1 PREVALENCE

Studies have cited BPD rates of approximately 0.4% to 1.8% among community samples (Maier, Lichertermann, Klinger, Heun & Hallmayer, 1992; Samuels, Nestadt, Romanoski, Folstein & McHugh, 1994; Swartz, Blazer & Winfield, 1990; Torgensen, Kringlen & Cramer, 2001) and 10% to 25% among clinical samples (APA, 1994; Gunderson & Zanarini, 1987; Widiger & Weissman, 1991). The method used to assess BPD has a great impact on the frequency with which it is diagnosed (Zimmerman & Mattia, 1999). Hence, use of different assessment tools (clinician scored or self report) with varied psychometric quality, sampling method and population chosen all influence the prevalence rate reported.

### 2.3.2 GENDER

BPD is more often diagnosed in women. Two thirds to three quarters of those diagnosed with BPD are women (Zanarini, Williams, Lewis, Reich & Marino, 1997). It is estimated that 3% of females of the general population compared to 1% of the male general population have BPD. As a result, the majority of the literature focuses on its occurrence in women (Johnson *et al*, 2003). Johnson *et al* (2003) found that men with BPD were more likely to present with substance use disorders, and with schizotypal, narcissistic, and antisocial personality disorders, whereas women with BPD were more likely to present with post-traumatic stress disorder, eating disorders, and the BPD criterion of identity disturbance. The authors claimed that to date there has been very little research specifically investigating the occurrence of BPD in men. Zanarini *et al* (1998) hypothesised that gender differences found in BPD may be a function of impulsivity, in that men and women may differ in the specific type of impulse they would predominately display. Women may be more likely to use food (i.e. internalising behaviours) and men alcohol and drugs and acting out against others

(i.e. externalising behaviours) in a self destructive way. Johnson *et al* (2004) maintained that men and women with BPD are more similar in their clinical presentations than they are different. Other possible reasons for the gender imbalance in reported BPD prevalence rates include that diagnosis may be biased against females who are more emotionally expressive in nature than males, males may seek out professional help less frequently, males are more likely to be diagnosed with antisocial personality disorder, and the incidence of neglect, invalidation and abuse appears to be reported at a higher rate by females (Krawitz & Jackson, 2008).

## **2.4 COURSE OF THE DIAGNOSIS**

### **2.4.1 POOR OUTCOME**

For effective therapeutic management of BPD, it is important to be well informed about its prognosis, and consequently clinicians need to fully appreciate the extent and significance of functional impairment associated with BPD. Studies have demonstrated that individuals with BPD experience significant levels of maladjustment in several domains of functioning such as academia, interpersonal functioning and are more likely to meet lifetime criteria for a mood disorder (Trull, Ueda, Conforti & Doan, 1997). Functional impairment, referring to psychosocial functioning such as educational impairment and job attainment, is indeed worse in BPD than in Cluster C personality disorders (anxious/fearful cluster), but is comparable to the impairment observed in equally severe schizotypal personality disorder of Cluster A (odd and eccentric cluster). Bagge *et al* (2004) showed that BPD features, particularly the impulsivity and affective instability, prospectively predicted negative outcomes and led to impairments in relating well with others, in meeting social role obligations, and in academic achievements in a group of 351 young adults over a two year period.

Limited studies have assessed the performance of those with BPD in educational/occupational settings. Soloff (1981) and Trull, Ueda, Conforti & Doan (1997) both revealed academic deficits in those with BPD, with fewer years of education being reported and an increased likelihood of academic difficulties in those with BPD. However Zimmerman & Coryell (1989) and Torgensen, Kringlen &

Cramer (2001) found that community members with BPD had no less education than those who did not have BPD. There is substantially more evidence that patients with BPD have more unemployment, frequent job changes, or periods of disability compared to patients with no personality disorder or with axis I disorders. Poorer work functioning, less occupational satisfaction and achievement has been demonstrated among those with BPD compared to others (Skodol *et al*, 2002). In one Finish study, it was shown that 33% of the sample with BPD were continually fit for work, while 46% chronically incapable of working (Antikainen, Hintikka, Lehtonen, Koponen & Arstila, 1995).

Social functioning is also poorer in those diagnosed with BPD. An array of studies have shown that patients with BPD are more likely than others to be never married, or separated, or divorced (Soloff, 1981; Torgensen *et al*, 2001; Modestin & Villiger, 1989). Most studies also report poorer quality of social relationships (Skodol *et al*, 2002).

Measures of global functioning, such as the Global Assessment Scale (GAS), assess social and occupational functioning and are influenced by the severity of psychopathology. On measures of global functioning, patients with BPD have been found to be significantly impaired (Paris, Brown & Nowlis, 1987), as well as having a reduced quality of life (Torgensen *et al*, 2001).

Functional impairment in BPD appears to be more persistent and changes more gradually than the symptomatic manifestations of the disorder (Skodol, 2005, cited in Zanarini, 2005). Improvements in psychopathology are accompanied by increments in functioning, but not immediately. BPD does have severe, persistent, and pervasive impact on an individual's life.

#### **2.4.2 “BURNS-OUT”**

Despite deficits in terms of functioning clearly reported in those with BPD, there is also considerable literature, which describes a life-time reduction in symptoms or “burn out”. Zanarini, Frankenburg, Hennen, Bradford Reich & Silk (2006) followed 290 inpatients meeting the criteria for BPD, assessing this group 5 times over 10 years. 88% of patients with BPD studied achieved remission, of this figure 39.3% first

remitted by the 2 year assessment, 21.9% first remitted at the 4 year follow up. A number of factors were found to be significant predictors of earlier time of remission including younger age, absence of childhood abuse, no family history of substance misuse, good vocational record, an absence of anxious personality disorders in their presentation, low neuroticism, and high agreeableness. Zanarini, Frankenburg, Hennen & Silk (2003) concluded that symptomatic improvement was both common and stable, even among the most disturbed BPD patients, and that the symptomatic prognosis for most, but not all, severely ill BPD patients is better than previously recognised. Stone (1993) reported that 50% to 60% of patients with BPD experienced clinical recovery in a 10 to 25 year period. Short term improvement has also been shown in patients with BPD. Najavitis & Gunderson (1995) demonstrated that by just 3 years BPD patients can be expected to move from a poor to fair level of functioning. Paris & Zweig-Frank (2001) followed 64 patients with BPD for a mean of 27 years. They asserted that most patients showed significant improvement with only five currently meeting criteria for BPD. Paris commented that gradual improvement over time seems to be characteristic of all disorders in the “impulsive spectrum”, although the mechanism of improvement is not absolutely clear, and may be a combination of factors. Both biological maturation reducing impulsivity levels and social learning helping patients develop more adaptive behavioural patterns or to avoid the situations they find most problematic have been put forward as explanations (Paris, 2002).

Rosowsky & Gurian (1991) identified eighty elderly patients with BPD, finding that a number of features of BPD appear to stay constant throughout life. This study delineated only two major areas of change in BPD in late life – a decline in apparent impulsivity (acting out, self mutilation, risk taking behaviours, substance misuse) and in uncertain, angst provoking, labile identity disturbances. Stevenson, Meares & Comerford (2003) investigated the hypothesis that BPD “burns out” with age. They reported that older patients with BPD showed less impulsivity than younger patients, but there was no difference in terms of affect disturbance, identity disturbance, and interpersonal disturbances. Hence, according to this research the view that BPD burns out with age is supported in terms of impulsivity. More research is required to understand the mechanisms behind the natural course of BPD and what can be done in order to speed up potential recovery (Paris, 2005).

## 2.5 SUICIDE & DELIBERATE SELF HARM

### 2.5.1 PREVALENCE OF SUICIDAL BEHAVIOURS IN BPD

The previous section demonstrated that BPD does tend to improve over the long term especially in terms of impulsivity. However, it is important to note that in the lengthy period that a person meets the criteria for BPD, there is a high likelihood of completed suicide, repeated hospitalisation, minimal functioning, social impairment, extreme despair and suffering.

Personality disorders are estimated to be present in more than 30% of individuals who die by suicide, 40% of individuals who make suicide attempts, and about 50% of psychiatric outpatients who die by suicide (Oldham, 2006). Rates of suicide among patients diagnosed with BPD have been estimated between 3%-9.5% (Akiskal, Chen & Davis, 1985; Fryer, Francis, Sullivan, Hurt & Clarkin, 1988). In comparison to the general population this suicide completion rate for individuals with BPD is 400 times greater and 800 times greater than the rate for young females (Gunderson & Ridolfi, 2000).

Paris, Brown & Novlis (1987) completed a 15 year follow up of 162 patients with BPD and found a completed suicide rate of 9% and after 27 years the rate had increased to more than 10% (Paris & Zweig-Frank, 2001). Stanley & Brodsky (2001) maintained that this 10% suicide rate in BPD represents a higher number of individuals with BPD who commit suicide than those diagnosed with schizophrenia. Gunderson (1984) reported that levels of individuals making at least one suicide attempt (low lethality suicide attempt) reached 75% of those patients with BPD in an inpatient setting, with 50% of BPD patients making a severe attempt at some point in their life. Soloff, Lis, Kelly, Cornelius & Ulrich (1994) published similar findings with 73% of BPD patients reporting a history of suicide attempts, and this group of patients had an average of 3.4 attempts. These figures are higher compared to 22% of those suffering an affective disorder and 30% of those diagnosed with schizophrenia making at least one suicide gesture.

Yet despite this relatively high level of suicide in BPD, such behaviour is often dismissed as non-serious, especially in light of the high number of suicide threats and gestures that occur far more than suicide attempts. Gunderon & Ridolfi (2000) claimed that 90% of patients diagnosed with BPD make these gestures and threats repeatedly. Clinicians and family tend to diminish such behaviour as attention seeking or manipulative (Stanley & Brodsky, 2001). Individuals with BPD are often misjudged as being healthier than they are because they appear 'normal' in many ways (Stanley & Brodsky, 2001), which can lead to an impression that such a client is exaggerating how terrible they feel and they are not trying hard enough to overcome their obstacles.

### **2.5.2 AGE OF SUICIDAL GESTURES IN BPD**

Paris (2002) commented that although there is a higher frequency of suicidal threats and attempts typically when BPD patients are in their 20s, the mean age of actual completed suicide has been calculated at 30 (Stone, 1990) and at 37 (Paris & Zweig-Frank, 2001). Hence clients with BPD may not succeed in taking their lives when their risk is considered highest and they most alarm therapists, but later in the course of their illness, when recovery has not occurred and when interventions have been unsuccessful.

### **2.5.3 RISK FACTORS INVOLVED IN SUICIDAL BEHAVIOUR IN BPD**

A range of correlates of suicidal behaviours in subjects with BPD, excluding personality traits, have been identified including age, education level, lack of treatment contact before hospitalisations, more frequent childhood losses, and co-morbid axis I of major depression, substance misuse, and eating disorders (Brodsky, Malone, Ellis, Dulit & Mann, 1997). Stanley & Brodsky (2001) also highlighted correlates of suicidal risk in BPD including presence of childhood trauma or neglect, life event triggers such as loss of support network, family history of suicidal behaviour, co-morbid depression and/or substance misuse. The role of childhood sexual abuse as a risk factor for suicidality has been corroborated in individuals with BPD (Sansone, Songer & Miller, 2005).

Co-morbidity is very prevalent with those already diagnosed with BPD. Compared to those with the BPD condition alone, there is a higher level of lethality of suicide attempts with patients with co-morbidity (Soloff, Fabio, Kelly, Malone & Mann, 2005). Soloff, Lynch, Kelly, Malone & Mann (2000) concluded that co-morbidity of BPD with major depressive episode increases the number and seriousness of suicide attempts. Hopelessness and impulsive aggression independently increase the risk of suicidal behaviour in patients with BPD. It has also been documented that co-morbidity with substance misuse increases a BPD client's risk for impulsive suicidal behaviour and for impaired judgement (Zanarini *et al*, 1998). Clients with such co-morbidity have less hopeful prognosis and are at risk of suicide or death from injury or accident.

The number of suicide attempts is the strongest predictor of suicide and future suicidal behaviour in BPD (Paris, Novlis & Brown, 1989; Shearer, Peters, Quayman & Wadman, 1988; Kjelsberg, Eikeseth & Dahl, 1991; Stanley & Brodsky, 2001). 60%-70% of completed BPD suicides have a history of at least one previous attempt (Kullgren, 1988). The severity of self harm, although being distinct from suicide attempts, may also be a predictor of subsequent suicide attempt (Carter, Reith, Whyte & McPherson, 2005; Stanley & Brodsky, 2001). The presence of self injurious behaviours in a given patient doubles the patient's risk for suicide (Stone, 1987).

Table 1: Summary of the main risk factors involved in completed suicide in BPD.

Risk factors for suicidal behaviours in clients with BPD
Prior suicide attempts (and self injurious behaviours)
Co-morbid mood disorder
High levels of hopelessness
Co-morbid substance misuse
Family History of completed suicide or suicidal behaviour
History of sexual abuse
High levels of impulsivity and/or antisocial traits

#### **2.5.4 CHRONIC V ACUTE SUICIDE IN BPD**

Paris (2002) compared acute and chronic suicidality as two distinct clinical populations. Completers, falling into the category of 'acute suicide', tend to be older and male, and use more lethal methods, associated with disconnection, and to die on first attempt, whereas attempters, belonging to the 'chronic suicide' group, are likely to be younger and female, use less lethal methods, seek treatment, and embark on a "suicide career". Yet there is no sharp line between the two types and much clinical judgement is needed to decipher level of risk. Suicidality in BPD is best seen as a means of communicating distress to a significant other (Paris, 2002). Threats of suicide can be understood as an individual's attempts to 'raise the volume', in the belief that this is the only way to be heard. Much suicidal behaviour in BPD has an interpersonal context, and some take place in front of other people (Paris, 2004). Clients with BPD are well known for taking overdoses or self mutilating following disagreements with their loved ones, yet such an attempt will often contain some level of 'protection', that is they are likely to have articulated their actions. Hence in most cases the attempter is saved. According to Paris (2004), with those individuals with BPD who complete suicide, it is likely to have happened by accident rather than complete intention.

Gunderson & Ridolfi (2000) reflected on the high rate of unsuccessful attempts in BPD, concluding that this pattern suggests that suicide attempts in BPD clients are often ambivalent. Gunderson commented "It is not that the borderline patient wants necessarily to die; it is that s/he wants to die if no one is willing to accept the responsibility for their living. If someone convinces them that they are 'loved' by overt saving/rescuing/reassuring responses, then they will want to live, however miserably" (2000, p.71).

Chronic suicidal behaviour has been explained in terms of being part of personality structure (Schwartz, Flinn & Slawson, 1974) and a characterological symptom which can be easily removed as it performs a function for patients (Fine & Sansone, 1990). Paris (2004) proposed that the main functions of chronic suicidality in BPD were a means of escaping suffering or painful affects, communicate distress and to grasp a sense of control. With an inner experience that often consists of isolation and despair, it could be suggested that BPD patients are 'half in love with an easeful death' (Paris,

2004). The quality of life of BPD patients is typically low, with tempestuous intimate relationships, turbulent emotions, unemployment, constant emptiness, and a feeling of the meaninglessness of life. It is understandable that when clients are not in control of their lives, dying can be an attractive alternative (Paris, 2004).

Brown, Comtois & Linehan (2002) examined self-reported reasons for both non-suicidal self injury and suicide attempts in 75 patients with BPD. The major functions of non-suicidal self harm were anger expression, self punishment, normal feeling generation, distraction and relief from negative emotions. Suicide attempts were more often intended to make others better off and to relieve negative emotions. Authors advised that clinicians should explore the multiple reasons behind both types of self destructive behaviours in order to determine precise treatment targets.

It is essential that mental health professionals dealing with suicidal BPD patients explore the motivations behind their behaviour rather than attempting to come up with their own hypotheses without consultation to the client. There appears to be a worthy distinction between chronic and acute suicidal behaviour in BPD, however the two concepts are difficult to separate. Each suicide attempt in BPD should be treated as possibly a forerunner to a completed suicide.

### **2.5.5 EXAMINING THE RELATIONSHIP BETWEEN BPD CRITERIA AND SUICIDAL BEHAVIOUR**

Yen *et al* (2004) investigated associations between each of the Diagnostic Statistical Manual (DSM–IV) BPD criterion and suicidal behaviours. With the self injury criterion excluded, the BPD criteria of affective instability, identity disturbance, and impulsivity significantly predict suicidal behaviour. However, only affective instability and childhood sexual abuse were significantly associated with suicide attempts (i.e. behaviours with some intent to die). Yen *et al* (2004) concluded that affective instability is the BPD criterion (excluding self injury) most strongly associated with suicidal behaviours. In addition, since major depressive disorder did not significantly predict suicidal behaviours, affective instability (more so than negative mood states) appears to be a critical element in predicting suicidal behaviours. Brodsky *et al* (1997) concurred with the finding of childhood abuse being correlated significantly with number of suicide attempts in BPD. However, in this

study impulsivity was found to be the only characteristic of BPD (excluding self destructive criterion) that was associated with a higher number of previous suicide attempts after control for lifetime diagnoses of depression and substance misuse. Hence, although there appears to be some discord about which BPD criterion (other than self destructive criterion) is the closest predictor of suicidal behaviours and attempts, it would be appropriate to consider both impulsivity and affective instability as considerable contributing factors in suicidal behaviour in BPD. Such results would certainly indicate the importance of identifying either affective instability or impulsivity, or an interplay of the two components, as risk factors for subsequent suicidal behaviours and to target them in treatment.

#### **2.5.6 PREVALENCE AND TYPES OF DELIBERATE SELF HARM IN BPD**

Non-suicidal self injurious behaviour is characteristic of patients with BPD and is sometimes referred to as the BPD client's "behavioural speciality" (Oldham, 2006; Gunderson, 2001). Its presence is tentative signal to clinicians whose patients present with depression, anxiety, eating disorder or substance misuse, that an underlying BPD is likely, a disorder that if ignored, will complicate treatment of these axis I disorders and can render their usual therapies harmful (Gunderson & Ridolfi, 2000).

Eighty percent of hospitalised BPD patients have been reported to engage in some form of self mutilation including cutting, burning, hitting oneself without intention to die (Simeon *et al*, 1992; Stanely, Winchel & Stanley, 1991). The most frequent forms of non-suicidal self injury are cutting (80%), burning (20%), self hitting (24%), while skin picking and head banging (15%) are less common (Shearer, 1994). Incidences of self mutilation in the general psychiatric population are much lower at 3.4% to 7.7% (Stanley & Brodsky, 2001).

#### **2.5.7 REASONS BEHIND SELF INJURIOUS BEHAVIOUR IN BPD**

Self injurious behaviours are distinctly variable. Shearer *et al* (1988) investigated the functions of self injurious behaviours, finding that the frequency of reasons included to feel pain (60%), punish self (50%), control feelings (40%), exert control (22%), express anger (22%) and to feel (20%). Zanarini *et al*, 1998) explored the cognitions and affects experienced by a group of clients with BPD. The range of dysphoric

thoughts and feelings and the percentage of time feeling them are so extraordinary that it is surprising that patients with BPD do not spend an even higher percentage of time thinking of killing themselves (Zanarini *et al*, 1998). Paris (2005) summarised that the functions that self mutilation serves include regulation of dysphoric affect, communication of distress, expression of emotions, and coping with dissociative states. Management of this behaviour can certainly be informed by understanding its psychological functions.

A question arises at this point, why is it that some patients with BPD do not self injure? Paris (2005) discussed this query and concluded that self mutilation was associated with lower levels of overall functioning, higher levels of impulsivity, presence of a history of childhood abuse and social learning. Bray, Barrowclough & Lobban (2007) suggested that individuals with BPD may have social problem solving deficits, with higher levels of negative problem orientation and a more impulsive/carelessness style towards solving social problems.

## 2.6 CO-MORBIDITY

Co-morbidity refers to the co-occurrence of two disorders in the same individual. However the relationship between these two disorders can often be unclear. BPD was initially conceptualised as a mild form of schizophrenia, later as a variant of an affective disorder, and more recently as a variant of a post traumatic stress disorder (Golier *et al*, 2003). The original concept of BPD as the border of neurosis and psychosis led to the term “pseudoneurotic schizophrenia”. Despite patients with BPD often having psychotic symptoms, neither family history studies nor biological markers support a link to schizophrenia.

BPD has negative implications for the outcome of most psychiatric disorders (Tyrer & Mulder, 2006). It is recognised that BPD is difficult to assess and does not have easy treatment options, yet its impact on other mainstream psychiatric conditions is substantial with the potential to create havoc in traditional treatment settings (Tyrer & Mulder, 2006). Therefore it is important to discuss the prevalence of, impact of and explanations of co-morbidity of BPD with both Axis I and Axis II disorders. The level of complication added through co-morbidity should not be underestimated.

### **2.6.1 BPD & AXIS I DISORDERS**

Zanarini *et al* (1998) assessed the lifetime prevalence of the full range of Axis I disorders in a group of BPD patients and comparison subjects with other personality disorders. Four important findings emerged from this study. Anxiety disorders were found to be almost as common (almost 90%) as mood disorders in patients with BPD. This finding would suggest that clinicians should pay more attention to the anxiety symptoms and syndromes of their patients with BPD. PTSD was found to be a common (56% met diagnosis) but not universal disorder among BPD patients, which is a finding inconsistent with the view that BPD is actually a form of chronic PTSD. A third finding was gender related, in that male and female BPD patients were found to differ in the type of impulse disorder in which they 'specialised'. Substance misuse was significantly more common among male patients, while eating disorders were significantly more frequent among female borderline patients. This finding was consistent with the clinical observation that male patients are typically overrepresented in substance abuse programs while female patients are typically overrepresented in eating disorder programmes. The final finding was that complex co-morbidity of an impulse disorder and affective disorder had strong predictive power for the BPD diagnosis as well as a high degree of specificity and sensitivity. Taken together, the findings of this study propose that Axis I co-morbidity of BPD follows a pattern of complexity that clinicians can use as a marker for underlying BPD psychopathology. As a six year follow up to the previous work, Zanarini, Frankenburg, Hennen, Bradford-Reich & Silk (2004) reported that although BPD patients experienced declining rates of many Axis I disorders over time, the rates of these disorders remained high, particularly rates of mood and anxiety disorders. It was discovered that those whose BPD condition went into remission experienced substantial decline in all co-morbid disorders assessed. Zanarini *et al* (2004) also highlighted that the absence of substance use disorders was a far stronger predictor of remission from BPD than the absence of PTSD, mood disorder, other anxiety disorders, or eating disorders respectively. Hence this study revealed an important finding that substance use disorders were most closely associated with the failure to achieve remission from BPD. This finding runs counter to clinical lore, which suggests that BPD is most affected by the course of mood disorders or PTSD. However, this finding makes sense because abusing alcohol or drugs could easily lead

to greater impairment in BPD clients. Zonarini *et al* (2004) advised that substance misuse co-occurring with BPD should be one of the main foci of treatment.

## **2.6.2 BPD AND ANXIETY DISORDERS**

### **2.6.2.1 POST TRAUMATIC STRESS DISORDER (PTSD)**

Many studies have made the connection between higher levels of trauma and neglect in the histories of those diagnosed with BPD and posttraumatic stress disorder, which is discussed in more detail in the section on aetiology. BPD has been viewed as a Complex PTSD (McClellan & Gallop, 2003), a diagnosis encompassing Axis I and Axis II symptoms. Complex PTSD is currently described as having experienced an interpersonal stressor (e.g. childhood sexual or physical abuse), disorders of affect regulation, dissociation, somatization, and altered perceptions of self and others.

It has been reported that the additional diagnosis of PTSD or BPD does little to augment the pathology or dysfunction of patients who have either disorder without the other (Zlotnick, Franklin & Zimmerman, 2002). The association between personality disorder with early trauma and PTSD in one study was reported to be evident but modest in BPD and was not unique to this type of personality disorder (Golier *et al*, 2003). According to the results of this study, PTSD in BPD did not appear substantial enough or distinct enough to support singling out BPD from other personality disorders as a trauma spectrum or variant of PTSD.

## **2.6.3 BPD AND MOOD DISORDERS**

### **2.6.3.1 MAJOR DEPRESSIVE DISORDER (MDD)**

The hypothesis that affective disorders contribute to the development of BPD is best examined by calculating the lifetime prevalence of affective disorders among BPD patients. Zonarini *et al* (1998) reported an 83% lifetime prevalence of Major Depressive Disorder and a 39% lifetime prevalence of dysthymia of their cohort of 329 BPD patients. Co-morbidity of BPD with major depression is considered most common, with rates between 53%-83% (Bellino *et al*, 2005). Bellino *et al* (2005) concluded that co-morbid MDD and BPD present differential diagnoses that indicate

a more serious and impairing condition with a stronger familial link with mood disorders than is shown by depression patients with other Axis II co-diagnoses.

Koenigsberg *et al* (1998) investigated the relationship between depression and BPD and concluded that the disorders co-occur, both because they share common biological features and because the psychosocial consequences of each can contribute to the development of the other. However, the link between BPD and depression is not a specific one, BPD occurs with a number of axis I disorders, and depression can be co-morbid with a variety of personality disorders.

### **2.6.3.2 BIPOLAR DISORDER**

Delito *et al* (2001) found that a total of 44%-69% of BPD patients belong to the bipolar spectrum. It was also shown that most responded negatively to antidepressants (e.g. hostility and agitation) and positively to mood stabilisers. Delito *et al* (2001) concluded that BPD patients more often than not exhibit clinically ascertainable evidence for bipolarity and may benefit from known treatments for Bipolar Spectrum Disorders.

Paris (2004) questioned whether or not in fact BPD could be understood as a variant of bipolar disorder. The proposal of BPD as being within the Bipolar spectrum originates from the assumption that affective instability develops through the same mechanism in the two disorders. Paris alleged that affective instability does not account for the full range of BPD pathology seen in these patients, missing out the important component of trait impulsivity. Paris emphasised the major differences in phenomenology, family history, longitudinal course, and treatment response between Bipolar disorder and BPD. Paris asserted that the findings of co-morbidity studies are to date equivocal. According to Paris, there is no advantage of redefining BPD as bipolar spectrum disorder, especially since it does not respond to the same medications. It is therefore maintained that there is insufficient evidence to support BPD falling into the bipolar spectrum (Paris, 2004).

Birnbaum (2004) tackled this controversial issue and contrasted the two conflicting arguments of Smith, Muir & Blackwood (2004), favouring placement of BPD within the bipolar spectrum, and Paris (2004), who disputed the view of BPD as a bipolar

variant. The first perspective argues that there are numerous features in common between BPD and bipolar disorder. Smith collated evidence about comorbidity, pharmacologic response to anticonvulsant and mood stabilisers, genetic aggregation studies, neurophysiological response such as P300 event related potentials, and neuroendocrine challenge studies. However, although commonalities may exist, it is unclear whether the interpretation should be constrained to a physiological framework (Birnbaum, 2004). Paris refuted much of the proposals of Smith, suggesting that the impulsivity instead plays a role in the family history and medication response cited by Smith, and if we impose an arbitrary construct of bipolar spectrum on BPD it could render it so widely applicable as to be meaningless, and an ‘impulse spectrum disorder’ diagnostic schema would be far more effective and valid. Hence it appears that both sides present some robust and complex arguments, and as yet no fixed answers appear to be reached in this controversial debate.

#### **2.6.4 BPD AND SUBSTANCE USE DISORDERS (SUD’s)**

Half of those diagnosed with BPD also have a lifetime SUD diagnosis, with alcohol misuse being the most common variety (Feske, Soloff & Tarter, 2007). Trull, Sher, Minks-Brown, Durbin & Burr (2000) reported high level (57%) of substance use in the BPD samples across 17 studies. Across these studies, 49% of BPD participants met the criteria for alcohol use disorder and 38% met the criteria for a drug use disorder. This high prevalence rate is true across settings – outpatient, inpatient or community. It is premature to conjecture whether BPD leads to SUD or vice versa.

Skodol, Oldham & Gallaher (1999) determined the extent of co-morbid substance use disorders in a sample of patients referred for treatment of personality disorders. They found that BPD was significantly associated with current substance use disorders, excluding alcohol and cannabis, and with lifetime alcohol, stimulant and other substance use disorders, excluding cannabis. However, they found no evidence that BPD increased the chronicity of substance use disorders, but BPD was associated with greater global impairment. Darke, Ross, Williamson & Teeson (2005) found that in a cohort of 495 heroin users, 45% met the criteria for BPD. They found that retention in treatment of the BPD heroin user appeared possible in the medium term, and reductions in drug use mirror those of other patients. Despite this, however, those with BPD maintained higher levels of risk behaviours (e.g. needle sharing, overdose)

compared to other patients and had a more unstable treatment history over the follow-up period, with a high risk of suicide.

Staiger, Kambouropoulos & Dawe (2007) argued that interventions matched to personality traits may improve treatment outcomes for substance users. They proposed that refining and tailoring treatment approaches to individuals with BPD and co-morbid substance misuse would be more effective. Screening for BPD is warranted in order to identify a group who may overtly respond to drug/alcohol treatment in terms of level of use, but who remain at risk in terms of overdose, suicide, risky usage and psychological distress (Darke *et al*, 2005).

### **2.6.5 BPD AND EATING DISORDERS**

BPD can have significant impact on the treatment of eating disorders. In bulimia nervosa, trait impulsivity seems to be related to early termination from therapy and often poorer response to treatment. BPD features, generally more common in binge-eating disorder and bulimia, clearly predict a protracted course for eating symptoms (Bruce & Steiger, 2005). Bruce & Steiger (2005) noted that two influential bodies – the American Psychiatric Association (APA, 2000) and the United Kingdom National Institute for Clinical Excellence (NICE, 2004) both included the concept of “trait oriented” interventions, targeting personality linked components including instability, impulsivity and interpersonal disturbances, in order to optimise treatment effects. The negative influence of Cluster B traits, particularly BPD, on the treatment of bulimia symptoms has been reported in numerous studies (Steiger, Stotland & Houle, 1994). Similarly, other research has documented the negative impact of co-morbid BPD on the treatment of Binge Eating Disorder. Wilfey *et al* (2000) found that BPD predicted significantly worse binge eating.

### **2.6.6 BPD & AXIS II DISORDERS**

Zanarini *et al* (1998) assessed the prevalence of the full range of Axis II disorders in a sample of BPD patients and Axis II controls. Odd and anxious Cluster disorders were significantly more common among BPD patients than controls. Paranoid, avoidant, and dependent personality disorders were most highly discriminating disorders between BPD patients and controls. Gender differences in Axis II co-morbidity were

observed. Male BPD patients were significantly more likely than female BPD clients to meet criteria for paranoid, passive-aggressive, narcissistic, sadistic, and antisocial personality disorders. In conclusion, Zanarini *et al* (1998) commented that there is a particularly strong relationship between anxious cluster disorders and BPD, and that gender plays an important role in the expression of the Axis II co-morbidity, particularly in relation to dramatic cluster disorders. In a follow up to the previous work, Zanarini *et al* (2004) examined both remitted and non-remitted BPD patients over a six year period and found that both groups experienced declining rates of types of Axis II disorders over time. However, the rate of avoidant, dependent, and self-defeating personality disorders remained high among non-remitted borderline patients. Additionally, the absence of these three disorders was found to be significantly correlated with a BPD patient's likelihood-of-remission and time-to-remission. This finding could suggest that anxious Cluster disorders are the Axis II disorders which most impede symptomatic remission for BPD.

Becker, Grilo, Edell & McGlashan (2000) examined the co-morbidity of those meeting the diagnosis of BPD with other Axis II disorders in hospitalised adults (n=50) and adolescents (n=68), with a similar group who did not meet BPD criteria. In the adult group, there was significant diagnostic co-occurrence with antisocial personality disorder only, whereas in the adolescent sample, BPD co-occurred with passive-aggressive and schizotypal personality disorders. The research team concluded that BPD diagnosis may represent a more diffuse range of psychopathology in adolescents than in adults.

The differences in the results across studies of Axis II co-morbidity are possibly due to methodological differences and varying base rates of the personality disorders.

## **2.7 CHALLENGES TO THE DIAGNOSTIC VALUE OF BPD**

BPD is a disorder which has been considerably disputed (Dahl, 2008). Several commentators are vigorous in their criticism of the diagnosis. The validity of the BPD condition remains in question in the minds of numerous professionals, and some doubt of its existence altogether (New, Triebwasser & Charney, 2008). Tyrer (1999, p.2095) described BPD as a 'motley diagnosis in need of reform', referring to a range

of evidence including the affective physiological responses remaining normal despite high degree of expressed emotion, extensive co-morbidity and possible dubious validity of structured questions for BPD. Tyrer (1999) surmised that the value of the BPD diagnosis has probably run its course, and reclassification is needed. Tyrer also criticised BPD as not being a representative personality disorder, given its course, presentation to psychiatric services and unpredictability. He concluded harshly with the following “indeed there may be no BPD at all, the disorders that form its borders may be the only ones that exist...if a core still remains after their removal, it can no longer be called ‘borderline’ (p.2096)”.

The major challenges to the construct of BPD have included that “borderline” is a misnomer; that the category has not been validated; the diagnosis lacks precise boundaries and that cases may be atypical forms of other mental disorders (Paris, 2005). BPD has been described as “an adjective in search of a noun” (Akiskal, 1985). However, Paris pointed out that BPD is far from the only misleading term in psychiatry. Paris asserted that any name change, even to ‘emotionally unstable personality’, is premature until the aetiology is better understood. In terms of validation of the disorder, Paris commented that BPD is no worse in this respect than other widely used diagnoses. Psychiatry has still not achieved the stringent criteria of diagnostic validity including evidence from laboratory studies, delimitation from other diagnoses, follow-up studies documenting a characteristic outcome and family prevalence studies.

In recent times, it has also been suggested that BPD be reclassified as an Axis I disorder (New *et al*, 2008), referring to evidence from its specificity, course, heritability, treatment response and biological markers. These authors claimed that BPD’s present status as an Axis II disorder is problematic, as BPD does not always fit with the traditional conceptualisations of personality disorders. They surmised that BPD should be included in the mood disorders, because of the centrality of affective disturbance symptoms and level of co-morbidity with major depression.

Due to the heavy overlap between BPD with Axis I and II diagnoses, it has been suggested that dimensional rather than categorical classification would be more effective. However, the co-morbidity of BPD, both on Axis I and II, does not invalidate the diagnosis, anymore than the co-morbidity of major depression. Paris

asserted that that the real problem lies in lack of basic knowledge about the pathology being observed. Paris (2005) also denied the possibility of BPD being a variant of an Axis I disorder. Paris asserted the independence of the diagnosis of BPD, giving several good reasons for retaining the diagnostic term until a better one becomes available. It is argued that the literature criticising BPD placed too much emphasis on co-morbidity and focused on only one aspect of symptomology, which is a perilous approach to classification.

It has been shown that the BPD concept does in fact reflect a statistically coherent construct. Three homogeneous components were supported empirically, lending conceptual clarity to different classes of the criteria for BPD (Sanislow *et al*, 2002). Arntz, Dietzel & Dressen (1999) investigated the specificity and stability of a set of assumptions hypothesised to be characteristic of BPD. It was concluded that BPD is relatively stable despite the instability of the behaviour of people diagnosed as having BPD.

## 2.8 AETIOLOGY

Aetiology refers to the causes, origins and evolution of BPD. There are several models in the explanation of the aetiology. All models carry weight and cannot be fully disputed as playing a contributory role in the development of BPD.

### **2.8.1 TEMPERAMENTAL MODEL OF BPD**

Temperament refers to personality traits identified in infancy and childhood with a strong biological component and has been proposed as possibly serving as a predisposition or vulnerability to BPD, that is presence of such traits makes the development of BPD more likely. Childhood temperament is generally considered to provide the emotional substrate from which personality develops (Zanarini, 2005). Impulsivity and affective instability have been highlighted as being consistently associated with the development of BPD.

Neurobiological studies have focused on the role of the neurotransmitter serotonin in behavioural disinhibition and impulsivity. Decreased glucose uptake in medial orbital frontal cortex may be associated with diminished regulation of impulsive behaviour in

BPD (Soloff *et al*, 2003). Patients with BPD have diminished response to serotonergic stimulation in areas of prefrontal cortex associated with the regulation of impulsive behaviour (Soloff, Meltzer, Greer, Constantine & Kelly, 2000). Medications enhancing serotonergic functioning have been reported to attenuate impulsive and aggressive behaviours in BPD patients.

Some evidence supports an association between the BPD diagnosis and affective instability, demonstrated through measures of neuroticism or negative emotionality. Farchaus-Stein (1996) suggested that BPD is associated with a unique pattern of affect dysregulation. Norepinephrine activity in the locus coeruleus has been implicated (Siever & Davis, 1991). It must be noted that prospective studies indicating that impulsivity or affective lability lead to BPD in adulthood do not exist at this time. Therefore it is possible that personality traits are concomitants or consequences of BPD. Anxiety sensitivity, a cognitive bias toward the evaluation of anxiety-related symptoms as aversive or threatening, has also received attention as contributing to the temperamental vulnerability of BPD and may play a role in the pathogenesis of BPD (Gratz, Trull & Gunderson, 2008).

### **2.8.2 NEUROLOGICAL MODEL OF BPD**

The neurological model proposes that the development of BPD can be traced to neuroanatomical and neurobiological abnormalities, which have been in place prenatally possibly through genetic predisposition or have evolved in early life as a result of certain environmental conditions or possibly a combination of both of these. Brain imaging studies of clients with BPD have proposed both structural and functional irregularities. Reduced volume of limbic structures, namely the hippocampus and amygdala, have been discovered (Schmal, Vermetten, Elzinga & Douglas, 2003; Rüscher *et al*, 2003; Driessen *et al*, 2000), as well as altered amygdala activation (Herpertz *et al*, 2001) and hippocampal hypometabolism (Juengling *et al*, 2003). Studies investigating frontal lobe involvement in the development of BPD made associations with dysfunctional medial orbital frontal cortex and impulsive behaviour (Soloff *et al*, 2003) and frontal lobe involvement has also been linked to decreased decision making and planning ability in patients with BPD (Bazanis *et al*, 2002). Decreased binding of a serotonin precursor has been reported in the medial prefrontal cortex and cingulate cortex in patients with BPD (Leyton *et al*, 2001; Paris

*et al*, 2004). It has been suggested that the patterns of volume loss of the hippocampus, amygdala, left frontal and right anterior cingulate cortex may differentiate BPD from other neuropsychiatric conditions (Tebartz *et al*, 2003). De La *et al* (1997) reported relative hypometabolism in patients with BPD in the premotor and prefrontal cortical areas, the anterior part of the cingulate cortex and the thalamic, caudate and lenticular nuclei.

The role of an abusive environment in the development of BPD has been documented at a neurobiological level (Minzenberg, Poole & Vinogradov, 2008). Hyperresponsiveness of the Hypothalamic-Pituitary-Adrenal (HPA) axis has been shown in chronically abused BPD subjects (Rinne *et al*, 2002). Animals exposed to early trauma show this pattern due to an enhanced level of corticotropin-releasing hormone (CRH) drive and glucocorticoid feedback.

### **2.8.3 GENETIC MODEL OF BPD**

The genetic model proposes that BPD originates from genetic linkage with family members with the same or similar psychiatric disorders, so the person may be left more biologically predisposed to developing BPD in later life. Family history studies assess the prevalence of a variety of mental disorders (including BPD) in the first degree relatives of BPD probands (subjects). It has been consistently found that disorders of mood and Substance Use Disorders aggregated in the families of BPD patients (Widiger & Trull, 1993).

Several studies assessed the prevalence of BPD in first degree relatives with prevalence rates between 11% (Links, Steiner & Huxley, 1988) and 18% (Baron, Gruen & Asnis, 1985; Zanarini, Gunderson, Marino, Schwartz & Frankenburg, 1988) being reported. BPD has been found to be significantly more common in the first degree relatives of BPD subjects than in first degree relatives of schizophrenia, bipolar, axis II or normal comparison subjects. Zanarini *et al* (2004) found that prevalence rates of BPD were significantly higher (16.1% v's 9.1%) in among the relatives of inpatient BPD subjects compared to Axis II subjects.

In one of the few twin studies published comparing dizygotic (DZ) and monozygotic (MZ) BPD twins, Torgensen *et al* (2000), showed a 35% MZ concordance for BPD

compared to a DZ concordance of 9%. A model of heredity estimate of 0.57 and a shared environment of 0.11 was proposed. Several possibilities could exist including the transmission of a genetic vulnerability from parent to child or an unstable home environment that fosters the development of BPD pathology. The BPD disorder has a substantially heritable component (Torgensen *et al*, 2000). However there seems to be a simultaneous influence of shared environment. It is early days in genetic and aetiological research in BPD for deciphering how much BPD development is due to genetic, shared environment and individual non-shared environmental factors.

#### **2.8.4 EARLY ENVIRONMENT MODEL OF BPD – NEGLECT, ABUSE, PARENTAL PSYCHOPATHOLOGY AND ABANDONMENT**

Existing studies indicate that both physical and sexual abuse are relatively prevalent among BPD patients, although only rates of sexual abuse are significantly higher than those in depressed or other (non-BPD) personality disorder controls (Zanarini & Frankenburg, 1997). BPD has been viewed as an “adaptation” to a home environment that is characterised by fear, betrayal and lack of nurturing or reliable caregivers (Perry & Herman, 1993). Trauma has also been hypothesised to lead to neurobiological alterations within the individual, with noradrenergic hypersensitivity and hypothalamic-pituitary adrenal (HPA) having been implicated (Figuroa & Silk, 1997). Although many commentators believe that trauma and abuse may be a contributing factor in the development of BPD, it does not appear to be the primary cause of BPD (Paris, 1997). There are a significant number of individuals diagnosed with BPD who do not report a history of abuse or neglect.

Despite the challenges of its importance in the development of BPD (Bailey & Shiver, 1999), the high prevalence of abuse or neglect in the history of those diagnosed with BPD is undeniable. Weaver & Clum (1993) compared a group of depressed individuals with and without the diagnosis of BPD, finding that significantly more BPD individuals reported histories of sexual abuse, physical abuse and witnessed violence. Of those trauma variables, sexual abuse emerged as the only significant predictor of the dimensional BPD score. Johnson & Smailes (1999) used community-based longitudinal data and showed that childhood abuse and neglect increased the risk for personality disorders during early adulthood. Persons with documented childhood abuse or neglect were more than 4 times as likely as those who were not

abused or neglected to be diagnosed with personality disorders during early adulthood.

Bandelow *et al* (2003) used retrospective interviewing with controls and patients diagnosed with BPD (n=66) and found that the latter group reported significantly more traumatic events in their childhood (in particular childhood sexual abuse), more unfavourable parental attitudes (strictness, restriction to autonomy, or weak character) and higher rates of psychiatric disorders in their families, namely anxiety disorders, depression and suicidality. Bandelow *et al* (2003) completed a logistical regression model of all aetiological factors examined, demonstrating that familial neurotic spectrum disorders (that is panic disorder, generalised anxiety disorder and BPD), childhood sexual abuse, separation from parents (incarceration, hospitalisation, marital separation) and unfavourable parental rearing styles were factors with significant influence on the development of BPD. They concluded that BPD aetiology is multi-factorial and that sexual abuse and familial psychiatric disorders are contributing factors. However, these findings must be considered in the light of the hazards of self report and retrospective data.

Reich & Zanarini (2001) investigated the developmental aspects of BPD comparing a sample of patients with BPD (n=290) and those with other personality disorders (n=72) using an instrument to rate memories of separation difficulties, temperamental problems, and onset of symptoms before age 18. Patients with BPD recalled more difficulties with separation between the ages of 6 and 17 years, more mood reactivity, poorer frustration tolerance, and the onset of more symptoms (sadness, self harm, dissociative episodes, depression, anxiety, and suicidality) before adulthood than did patients with other personality disorders. Such findings may suggest an early onset of the roots of BPD, which could be differentiated from other Axis II disorders and may be used as good predictors of BPD in adulthood. However, possible inaccuracies of retrospective self report data should be considered.

Trull (2001) sampled approximately 5,000 18 year old non-clinical young adults who were screened for BPD features. A total of 421 participants who endorsed significant BPD features completed a series of self report measures and interview assessments based on personality, psychopathology in themselves and their biological parents and childhood physical/sexual abuse. The study reported that parental psychopathology

was strongly related to BPD features and its effects on BPD features were mediated by personality variables of disinhibition and negative affectivity. Childhood abuse was significantly related to such personality traits and there was a significant relationship between childhood abuse and BPD features. Although not the strongest correlate of BPD features, childhood abuse does justify unique variance in BPD features that cannot be accounted for by parental psychopathology. Hence this study created a multivariate model of BPD aetiology that included parental psychopathology, childhood abuse, and personality factors.

Some aetiological theories propose that BPD is a disorder of developmental trauma (Murray, 1993). Many BPD patients report childhood histories of sexual abuse (Paris & Zweig-Frank, 1992). Girls are more likely than boys to be victims of abuse, and women more often than men have been assigned the BPD diagnosis (Herman, Perry & Van der Kolk, 1989). In one Canadian study, 88 patients diagnosed with BPD when compared with 42 inpatients matched in socioeconomic class and education level were significantly more likely to have been a victim of sexual abuse by caretakers (Links, Steiner, Offord & Eppel, 1988). It has also been reported that sexual abuse is among the strongest predictors of a diagnosis of BPD, and vice versa (Murray, 1993).

While the cause of BPD is not agreed upon, Murray (1993) estimated that there is between 60%-80% prevalence of childhood abuse, particularly sexual abuse, in adults with BPD, which has been accumulated from data from both inpatient and outpatient psychiatric settings. It has been proposed that some of the symptoms of BPD may reflect a history of severe and repetitive trauma and some of the trauma of abuse may contribute to the BPD patients' difficulties in handling emotions. However, patients who meet the criteria of BPD are heterogeneous, and no one factor is recognised as the cause of BPD. Graybar & Boutlier (2002) proposed that despite the high prevalence of reports of emotional, physical and sexual abuse in the history of those with BPD, there is also a significant minority of borderline individuals who have not suffered childhood abuse, neglect or abandonment and in such cases a non-traumatic pathway to BPD is in existence.

An alternative explanation for the link between childhood sexual abuse and BPD may lie in family background (Murray, 1993). Using this marker, the sexual abuse frequently reported in client histories, could be viewed as a prevalent marker for a

severely dysfunctional family environment, which plays a major role in the origin of interpersonal problems leading to development of psychiatric problems. Family life, within an abuse context, was fragmented, chaotic, less cohesive and less adaptable. Sable (1997) judged BPD to be a condition of profound insecure attachment. BPD is at risk of developing in the absence of a secure base to establish consistency, reliability and affirmation.

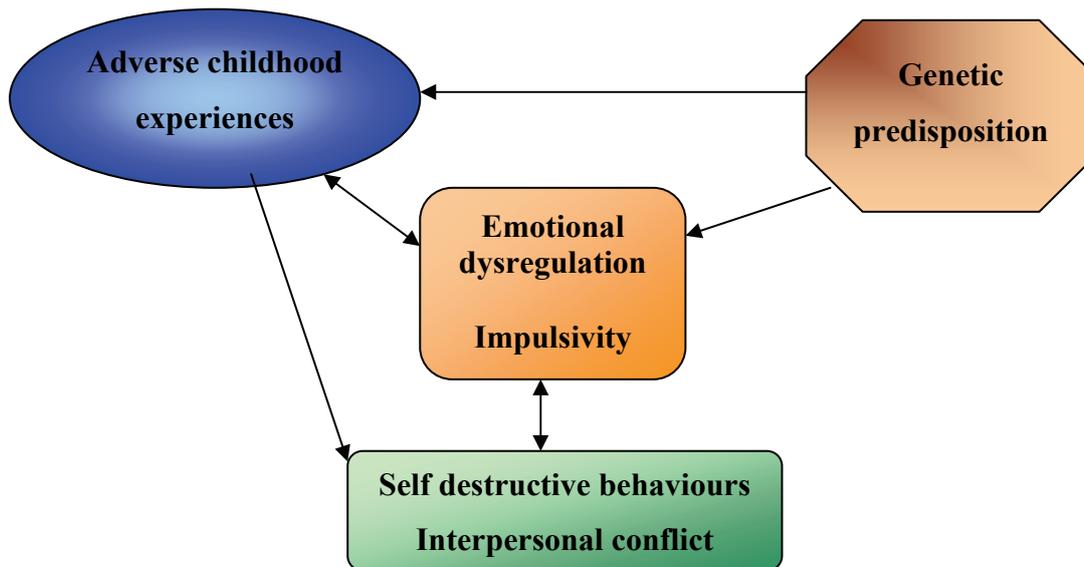


Figure 2: Multi-components contributing to BPD development.

### 2.8.5 AETIOLOGICAL CONCLUSIONS

There have been some major changes in the conceptualisation of the aetiology of BPD, with each side of the argument moving towards a more complex interactional approach, in which BPD is viewed as developing through a combination of factors, as indicated in Figure 2. Multiple lines of evidence indicate that BPD is psychobiological entity (Livesly, 2004). One dimensional models of aetiology are no longer tenable. Heritability of BPD characteristics does not imply genetic determinism or that personality cannot be changed. However, it may require some rethinking with regard to the goals of therapy and nature of change (Livesly, 2004). Hence, it is no longer a question whether it is nature or nurture that leads to the development of BPD. It is unquestionably nature and nurture together that synergistically produce the condition (Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004).

## 2.9 STAFF REACTIONS TO BPD

Several studies have examined the experience of professionals working with BPD patients. Markham & Trower (2003) reported that the label BPD attracted more negative responses from staff than the diagnosis of schizophrenia or depression. Causes of patients' negative behaviour were rated as more stable and they were thought to be more in control of the causes of their behaviour and the behaviour itself. Staff reported less sympathy and optimism towards patients with the diagnosis of BPD and rated their personal experiences as more negative than of working with patients with a diagnosis of depression or schizophrenia. Gallop, Lancee and Garfinkel (1989) reported that the diagnosis of BPD was associated with stereotypic responses from staff and less empathic care far more than with other serious psychiatric diagnoses (Fraser & Gallop, 1993). Cleary, Siegfried & Walter (2002), in a survey of 516 Mental Health staff, revealed that 4 out of 5 respondents found dealing with clients who have BPD to be moderately to very difficult. One study looked at a sample of 240 psychiatrists, who were asked to read a case vignette and indicate likely management and attitudes to the patient on a number of semantic differential scales. Patients given the prior diagnosis of personality disorder were seen as more difficult and less deserving of care compared to control subjects who were not. The personality disorder cases were regarded as manipulative, attention seeking, annoying, and in control of their suicidal urges (Lewis & Appelby, 1988). They stated that "those labelled as personality disordered appear to be denied the benefits of being regarded as ill, but also denied the privilege of being regarded as normal (p.47)". This assumption by clinicians that personality disorder is not a form of mental illness leads to clinicians viewing clients as more capable of controlling symptoms and behaviours. There appears to be fervent debate whether BPD should be treated like other personality disorders and not be considered a mental illness (Kendell, 2002). Hence, clinicians may interpret the intense and problematic behaviour of individuals with BPD as the patient's choice to make an interpersonal demand upon the clinician, rather than as a symptom of the personality disorder.

The perception that patients have control over their own behaviour can perpetuate the stigmatisation of personality disorders. Forsyth (2007) showed that clients perceived to have controllable and stable reasons for non-completion of a therapy task received

less empathy from mental health workers. There was a greater tendency to help an individual diagnosed with Major Depressive Disorder compared with those diagnosed with BPD. Similarly, staff showed greater negative reactions for non-compliance with a therapy task with those with a diagnosis of BPD.

The stigma associated with BPD goes beyond that which is associated with other mental illnesses (Aviram, Brodsky & Stanley, 2006). Minimisation of symptoms, overlooking of client strengths, and clinicians emotionally distancing themselves from clients in order to protect themselves have been reported. Training and professional support systems need to be established in order for clinicians to be mindful of the role of stigma in his/her perceptions and interpretations of significant behavioural symptoms of BPD. Awareness of negative staff perceptions of BPD may be a crucial factor for increasing successful therapeutic rates in service users. The effect of education and training programmes may well alter these enduring and starkly negative views and attitudes towards BPD clients (Miller & Davenport, 1996; Krawitz, 2001 & Krawitz, 2004).

## **2.10 TREATMENT OPTIONS**

### **2.10.1 TREATMENT CHALLENGES**

Clients with BPD tend to terminate treatment within the first three months and utilise multiple services and therapists (Gunderson *et al*, 1989). In comparison to depressed clients, BPD individuals receive significantly more psychosocial treatment and try more medication regimes (Sansone & Sansone, 1996). Psychotherapeutic change with BPD patients has been reported as being slow. Studies of more extended treatment have suggested that substantial improvement may not occur until after approximately 1 year of psychotherapeutic intervention has been provided. Many patients require even longer treatment (APA, 2001). Patients with BPD were found to have significantly more impairment at work, in social relationship and in leisure activity than patients with Obsessive Compulsive Personality Disorder or Major Depressive Disorder (Skodol *et al*, 2002).

Patients with BPD have more extensive histories of psychiatric outpatient, inpatient, and psychopharmacological treatment than patients with major depressive disorder

(Bender *et al*, 2001). Patients with BPD were significantly more likely to have received every type of psychosocial treatment except self-help groups than those diagnosed with depression. Similarly, patients with BPD were more likely to be prescribed anti-anxiety, antidepressant, mood stabilising and anti-psychotic medications (Sansone, Rytwinski & Gaither, 2003). Early surveys indicated that 97% of BPD patients who presented for treatment in the United States received outpatient care from an average of six therapists (Bateman & Fonagy, 2006). Bender *et al* (2001) queried whether those diagnosed with BPD are receiving adequate and appropriate mental health treatments.

BPD is also a diagnosis that is associated with premature termination of intervention. Skodal, Buckley & Charles (1983) compared premature drop out rates for individuals diagnosed with BPD, other personality disorders and schizophrenia in an outpatient clinic. The BPD clients showed the highest drop out rate at 67%, which was mostly within the first three months, and was significantly higher compared to other diagnoses. Gunderson, Frank & Ronningstam (1989) found that 2 out of every 3 BPD clients terminated prematurely within the first six months. Premature termination correlates with level of self harm and increases likelihood of completed suicide (Dahlsgaard, Beck, & Brown, 1998). Ben-Porath (2004) and Horvath (1995) pointed to the importance of a strong therapeutic alliance in order to reduce the likelihood of drop-out.

Treatment of BPD can be controversial and even create animosity in a multidisciplinary team. Conflict between staff members can arise when a BPD client is chronically suicidal or self harming. Some staff members can lean towards rescuing the client from self destructive behaviour of ever-escalating severity and admit the patient, while other staff will want to encourage the client to take responsibility for staying alive and finding their own alternatives to acting on self destructive impulses (Quaytman & Sharstein, 1997).

### **2.10.2 TREATMENT GUIDELINES**

Mohan (2002) proposed that the emphasis should really be on providing integrated as well as targeted packages. Treatment for this particular condition needs to be well planned and coordinated, anticipate problems, and combine drug and

psychotherapeutic interventions. The importance of a multidisciplinary team using a synergistic approach to reduce risky behaviour, offer better mood control, and work on improving skills to cope with difficult situations, should not be understated (Mohan, 2002). Clarkin (1998) in his review of treatment options for BPD emphasised the importance of beginning an intervention with an explicit treatment contract.

Livesley (2004) asserted that a rehabilitative model was best used in the treatment of BPD and that comprehensive treatment requires an eclectic approach that uses an array of interventions drawn from different therapeutic models that are delivered in an integrated and coordinated way. Livesley (2004) added that according to a rehabilitative model, an intervention should also assist a BPD client to live with their basic personality and learn more adaptive ways of expressing these traits.

### **2.10.3 PHARMACOLOGICAL INTERVENTIONS**

Pharmacological treatment is very common in those diagnosed with BPD, especially when a co-morbid mental illness has been found. Benefits tend to be targeted symptom areas and it is often difficult to distinguish whether the impact of drug treatment is affecting the mental state or personality disorder (Roy & Tyrer, 2001). Four streams of pharmacological intervention for BPD include mood intervention with antidepressant medication, affect regulation with mood stabiliser medication, transient, psychotic-spectrum symptomology with antipsychotic medication and impulsive and self injurious behaviour with anticonvulsant medications (Sanislow & McGlashan, 1998).

#### **2.10.3.1 ANTIDEPRESSANT DRUGS**

Selective Serotonin Reuptake Inhibitor's (SSRI) have been used in the treatment of BPD. There has been good evidence to suggest that SSRI medication reduces impulsiveness and anger as well as increasing mood (Yerkes, Van der Mast & Kerkhof, 1998). Several studies have examined the effect of fluoxetine in BPD, with significant decrease in anger independent of changes in depression in one study, and decreases in aggressive behaviour and irritability shown in another study (Mohan, 2002). In a recent placebo controlled clinical trial, Rinne, Van den Brink, Wouters &

Van Dyck, 2002) showed that fluvoxamine produced a robust and long lasting reduction in the scores of rapid mood shifts compared to placebo. However, fluvoxamine did not lead to improvement in measures of impulsivity and aggression.

Tri-cyclic antidepressants have also been applied to the treatment of BPD. Soloff (1989) reported positive symptoms in depressive symptoms only. Generally evidence for the efficacy of tricyclics is equivocal or negative,

Evidence is strong for the monoamine oxidase inhibitor (MAOI) anti-depressants, although side effects make their use difficult (Sanislow & McGlashan, 1998). Tranylcypromine has shown impact on measures of depression, anger, loneliness and rejection sensitivity (Cowdry & Gardner, 1988), while phenelzine has demonstrated advantages in self reported anger and hostility (Parsons *et al*, 1989). Opiate antagonists, in particular naltrexone, have shown impact in reducing self injurious behaviours (Roth, Ostroff & Hoffman, 1996) and dissociation.

#### **2.10.3.2 MOOD STABILISERS (ANTICONVULSANTS)**

Lithium (Links, 1990) and sodium valproate have all been used to treat BPD. Results from Lithium have so far been inconclusive. Sodium Valproate has been used in the treatment of agitation and impulsive aggression in BPD (Stein, Simone & Frankel, 1995). A double blind placebo controlled trial using divalproex sodium treatment (sodium valproate and valproic acid) was reported as more effective than placebo in global symptomology, level of functioning, aggression and depression (Hollander, Allen & Lopez, 2001). However, it must be noted that these findings were based on a small sample. Lamotrigine has emerged with impressive findings, with 50% of those prescribed this drug achieving sustained remission for the period of follow up of 1 year, although this was small sample (Pinto & Akiskal, 1998).

#### **2.10.3.3 ANTIPSYCHOTIC DRUGS (NEUROLEPTICS)**

Among the largest amount of trials have focused on antipsychotics, which target transient and stress related psychotic or schizotypal symptoms. Findings of neuroleptics suggest that their use should be reserved for the most disturbed patients exhibiting transient, stress induced disorganisation or dissociation. Thiothixene has

was impactful on psychotic symptoms in a double blind controlled study (Goldberg *et al*, 1986). Halperidol (Soloff *et al*, 1986; Soloff *et al*, 1993) in an initial investigation showed improvement in depression, anxiety, hostility, paranoid ideation and psychoticism. However, such increments were not replicated against another drug and placebo in the second study. Success shown with flupenthixol deconate (Montgomery & Montgomery, 1982) with reducing suicidal behaviour over six months has failed to be replicated.

There has been a movement to investigate the effects of atypical antipsychotics. Olanzapine has demonstrated improvement in symptoms of psychoticism, depression, interpersonal sensitivity, and anger (Schulz, Camlin, Berry & Jesberger, 1999). Atypical neuroleptic, Clozapine, has also shown positive results and both drugs deserve further exploration (Frankenburg & Zanarini, 1993).

#### **2.10.3.4 LIMITATIONS OF DRUG TREATMENT**

Taken altogether the evidence base underpinning psychotropic intervention falls a long way short of supporting a general treatment for all patients with BPD (Paton & Okocha, 2006). Data accrued from randomised double-blind, placebo-controlled pharmacotherapy trials have been largely inconclusive in identifying preferred agents for particular domains of dysfunction (Dimeff, McDavid & Linehan, 1999). Even though BPD patients are heavily prescribed medications with greater frequency than any other diagnostic group, much of this is based on hunches or anecdotal evidence rather than on rigorous or widely replicated data (Triebwasser & Siever, 2007). Only moderate effectiveness in circumscribed symptom areas has been demonstrated for a range of ubiquitous medications (Triebwasser & Siever, 2007). Research needs to clarify the neurobiological roots of the disorder in order to better treat the problem areas. According to Paton & Okocha (2006), polypharmacy is likely to be elevated in BPD patients as they show high initial placebo response rate that is often transient leading to the tendency to prescribe more psychotropic drugs and reluctance to stop the ineffective drug as an initial response was seen. Widespread and sustained gains for BPD clients are likely to be minimal, while due to the possibility of overdose, non-compliance of medication regimen, ‘paradoxical’ medication effects and side-effects of medication, the risks of prescription medication may outweigh possible benefits.

Pharmacological research has a number of limitations. Existing studies have used various diagnostic and outcome measures, which make comparison difficult. The presence of Axis I disorder in some but not all patients can complicate interpretation. A heavy reliance on treatment resistant patients in trials may have led to more modest or pessimistic conclusions (Zanarini, 2005). Dimeff, McDavid & Linehan (1999) constructed a list of guidelines and recommendations when prescribing psychotropic medication for individuals for BPD, with the emphasis on the safe, conservative and effective use of medication.

#### **2.10.4 PSYCHOTHERAPEUTIC INTERVENTIONS**

The following psychotherapeutic models are common in the treatment of individuals with BPD. The psychotherapeutic interventions fall roughly into three general categories, cognitive behavioural (including Dialectical Behaviour Therapy, Systems Training for Emotional Predictability and Problem Solving, Schema-Focused Therapy), systemic/supportive (Supportive Psychotherapy, case management and Family Therapy) and psychodynamic (including Cognitive Analytic Therapy, Transference Based Psychoanalytic Therapy, Psychoanalysis and Mentalisation-Based Therapy). An in depth discussion of Dialectical Behaviour Therapy (DBT) is available in the subsequent chapter.

##### **2.10.4.1 COGNITIVE-BEHAVIOURAL APPROACHES**

###### **2.10.4.1.1 STEPPS (Systems Training for Emotional Predictability and Problem Solving)**

STEPPS is a manual based cognitive behavioural group intervention, normally accompanying other interventions (Blum, Pfohl, St.John, Monahan & Black, 2002). It focuses on educating participants and their families about ‘emotional intensity disorder’ and how it can be better dealt with using effective emotion and behavioural skills to temper emotion (Krawitz & Jackson, 2008). STEPPS has become popular in the Netherlands and United States with some pilot studies suggesting efficacy. However, randomised controlled trials have not yet been published (Van Wel *et al*, 2006).

#### **2.10.4.1.2 Schema focused therapy (SFT)**

SFT is an integrative cognitive focused treatment (Young, 1994). The intervention hangs on four concepts including the ‘abandoned child’, requiring empathy from the therapist and client self-nurturing; the ‘angry child’, focusing on finding more effective ways to express angry while simultaneously validating its existence; the ‘punitive parent’, refers to the client being their own worst critic which needs to be diminished; and lastly the ‘detached protector’ stands for emotional detachment to reduce pain that needs to be explored and released. Giesen-Bloo *et al* (2006) compared SFT and transference-focused psychotherapy in the treatment of BPD and found that over a three year period both interventions were shown to be effective in reducing BPD specific and general psychopathologic dysfunction and improving quality of life. However, SFT was shown to be superior on all measures. In another study, Nordahl & Nyaester (2005) showed that following a year of schema-focused therapy 50% of their sample no longer fulfilled the criteria for BPD at the end of the treatment.

#### **2.10.4.2 PSYCHODYNAMIC APPROACHES**

##### **2.10.4.2.1 Psychoanalysis & Transference Focused Psychotherapy (TFP)**

Psychodynamic therapy focuses on fully understanding of the past and present client’s behaviours, emotions and thoughts (Gabbard, 2001). Much work is done to create a safe and secure core therapeutic relationship in order to achieve this understanding. Transference refers to the transferring of feelings that belong in the past to people in the present. Clarkin *et al* (2001) showed the effectiveness of Transference-Focused Psychotherapy for the treatment of BPD in an outpatient setting. In a non-randomised uncontrolled quasi-experimental pre-post trial, the sample (n=23) demonstrated significantly reduced suicide attempts, less severe self-harm, and fewer and shorter psychiatric admissions compared to the year prior to treatment. In a later study, improvements in BPD symptoms, global symptomology, depression, and state anxiety were reported in a group receiving TFP (Clarkin & Levy, 2003). In a non-randomised comparison with treatment as usual, TFP was shown to be superior in reducing the number of hospitalisation days (Levy, Clarkin, Foelsh & Kernberg, 2005).

#### **2.10.4.2.2 Cognitive Analytic Therapy (CAT)**

CAT utilises a combination of psychoanalytic and cognitive therapy. It is time-limited and lasts for 16-24 sessions. Following sessions focused on hearing the client's narrative, the therapist writes a letter to the client known as a reformulation, which outlines the patterns and barriers to recovery, which are illustrated in a diagram. Therapy then focuses on means by which new strategies can be developed or 'exits'. At the conclusion of treatment, both the therapist and client outline the journey in therapy in writing. Anthony Ryle (1997) has been the main advocate of this intervention for individuals diagnosed with BPD. Effectiveness of brief CAT with BPD clients has been demonstrated (Dasoukis *et al*, 2008). Other non-randomised quasi-experimental pre-post effectiveness studies include Ryle & Golynkina (2000). No control group was reported in these studies.

#### **2.10.4.2.3 Mentalization Based Treatment (MBT)**

MBT focuses on how we can improve our ability for psychological experiencing and psychological consideration (Bateman & Fonagy, 2003; Bateman & Fonagy, 2004; Moran, 2008). Practising mentalising will aid self awareness, increase awareness of the world and the development of effective relationships. The therapeutic alliance is seen as essential and is a base for exploring and practising mentalisation. Bateman & Fonagy (1999) compared the effectiveness of MBT with standard psychiatric care for the treatment of individuals diagnosed with BPD. An improvement in depressive symptoms, a decrease in suicidal and self harm episodes, reduced admission duration, and better social and interpersonal functioning was reported for the sample who completed the MBT programme (n=38) compared to the control who demonstrated limited change or deterioration over the same period. Bateman & Fonagy (2001) compared the effectiveness of psychoanalytically oriented partial hospitalisation (MBT), including individual and group psychotherapy, with that of standard psychiatric care for BPD patients. They demonstrated that the therapy group demonstrated significant decrease in frequency of suicide attempts, acts of self harm, the number and duration of inpatient admissions and use of psychotropic drugs. Significant positive change was also shown in self report measures of depression, anxiety, general distress, interpersonal function and social adjustment. After three years the improvements were maintained or strengthened in the psychotherapy group

as compared to those who received treatment as usual. Bateman & Fonagy (2006) documented that clients with BPD (n=43) who completed a psychoanalytic partial hospitalised programme showed significant gains at 18 months follow up compared to those treated with standard psychiatric care who showed only limited change in the same period. Improvements in frequency of suicidal acts, level of self harm, duration of inpatient admission, service utilisation, and interpersonal functioning.

### **2.10.4.3 SYSTEMIC/SUPPORTIVE APPROACHES**

#### **2.10.4.3.1 Supportive Psychotherapy & Case Management**

Supportive Psychotherapy focuses on needs-based practical and common sense issues in the client's present. Cognitive-behavioural therapy methods, education, skills training, advice, empathy, support and encouragement will be used as flexibly as possible (Krawitz & Jackson, 2008). Case managers can often use the above techniques in order to utilise whatever resources are available in the community, which may mean accessing funds, housing, legal advice etc. Day hospital admissions have also shown effectiveness in stabilising risk behaviours (Bateman, 2005, cited in Zanarini, 2005).

#### **2.10.4.3.2 Family Therapy**

Family Therapy and couples therapy can often be effective in tackling relationship difficulties, in particular oscillating attachments. It can be useful to augment client outcomes, alleviate stress and burden in family members and improve overall family functioning (Oliver, Perry & Cade, 2008). James & Vereker (1996) emphasised the usefulness of a systemic intervention as part of an overall treatment package. Miller, Glinski, Woodberry, Mitchell & Indik (2002) indicated the effectiveness of using DBT alongside Family Therapy, particularly with an adolescent population. Hoffman & Fruzzetti (2005, cited in Zanarini, 2005) discuss how each model can complement the other. Apart from these recommendations of the usefulness of the systemic approach in the treatment of BPD allied to DBT, there is not yet a body of research examining the effectiveness of this approach in treating the symptoms of BPD.

## 2.11 SUMMARY OF CHAPTER

A number of areas have been covered in this chapter on BPD and the following issues are the particularly pertinent ones. The disorder has evolved hugely and has been recognised in DSM for almost three decades. Despite vehement criticism of the diagnosis, much research has been presented which has fervently defended its value. BPD is extremely common in the Mental Health services, and for a variety of reasons is more often diagnosed in females. BPD has been renowned for its poor outcome, low global functioning and resistance to treatment. However, there is a considerable body of evidence that suggests it “burns out”.

The seriousness of the BPD diagnosis is particularly emphasised through its high completed suicide rate. It is a condition synonymous with attempted suicide and non-suicidal self injurious behaviour, which can cause undoubtedly high level of distress for clients, families and staff. BPD is not only a complex disorder itself, but it rarely presents in isolation. Co-morbidity is very common in BPD, with particular common co-occurrence with mood disorders, eating disorders, substance use disorders, anxiety disorders and other personality disorders. This can certainly lead to challenges in the treatment of BPD and can in some cases result in less hopeful prognosis of both diagnoses. The relationship between BPD and many Axis I disorders and its alleged unrepresentativeness as an Axis II disorder have also produced some curiosity in deciphering whether BPD is in fact a variant of an Axis I disorder. BPD as a complex PTSD, part of the Bipolar spectrum and impulse control spectrum were speculated.

The aetiology of BPD is complicated and interactional. Traumatic early childhood experiences are frequent in the histories of BPD. However, a contributory role in development alongside other factors appears more sensible than relying on this explanation in isolation, considering the possibility of a non-traumatic pathway to BPD development. Biological models point to research on neurochemical and neuroanatomical differences between BPD individuals and controls. Similarly, genetics have a strong role to play. Research on BPD temperament, particularly the role of impulsivity and affective dysregulation, would appear to be important.

Staff reactions to BPD appear to be worthy of further research, particularly given the impact this can have on successful treatment. Treatment of BPD individuals has numerous trials including high attrition rate, numerous ineffective psychosocial and

pharmacological treatments in the histories of clients, tempestuous therapeutic alliance, and risk of staff splitting. Pharmacological interventions, although widespread, are currently premature and many drug treatments need testing with larger samples. Moderate success for target symptoms has been shown, however risks for side-effects, overdose, non-compliance and 'paradoxical' effects must also be taken into account. A variety of treatment models have emerged in the treatment of BPD. Some have shown effectiveness in large scale randomised controlled trials, while others are yet to do this.

# **CHAPTER THREE**

**DIALECTICAL**

**BEHAVIOUR**

**THERAPY**

## **CHAPTER THREE**

### **DIALECTICAL BEHAVIOUR THERAPY**

#### **3.1 THEORY AND BACKGROUND**

Dialectical Behaviour Therapy (DBT) was developed by Marsha Linehan (1993a; 1993b; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991) as a comprehensive principle-driven outpatient treatment program for individuals meeting the criteria for Borderline Personality Disorder (BPD) who have chronic suicidal problems (Swales, Heard & Williams, 2000). DBT combines basic behavioural procedures of skills training, exposure based procedures, cognitive modification, contingency management, and problem solving with validation, mindfulness practices, reciprocity, and a focus on the patient-therapist relationship. Standard DBT service delivery has the following modes, individual psychotherapy, telephone consultation and group skills training. There is also a team consultation element built into DBT (Koerner & Linehan, 2000).

Many authors have given descriptions of the model (Palmer, 2002; Koerner & Linehan, 1997; Swales, Heard & Williams, 2000; Linehan, 1998; Kiehn & Swales, 1995; Blennerhassett & Wilson O'Raghallaigh, 2005; Feigenbaum, 2008), as it has steadily become viewed as a therapeutic innovation and treatment of choice for BPD. In this chapter, I will give a thorough description of the DBT model, including functions, biosocial theory, dialectical world view, therapeutic style and, finally, an in depth description of the therapeutic components and targets. Following this I will move on to discuss DBT research completed to date including studies of effectiveness, adaptation and modification of standard DBT, dismantling studies of active ingredients and mechanisms of change, and qualitative investigations.

#### **3.1.1 FUNCTIONS OF DBT**

DBT is based on comprehensive treatment of severely disordered clients (Linehan, 2000) and must serve each of the functions as shown in Figure 3. DBT is based on the model of BPD as a combination of motivation problems (to stay alive, replace BPD

behaviours with skilled ones building a life worth living) and capability deficits (self regulation, interpersonal and distress tolerance skills).

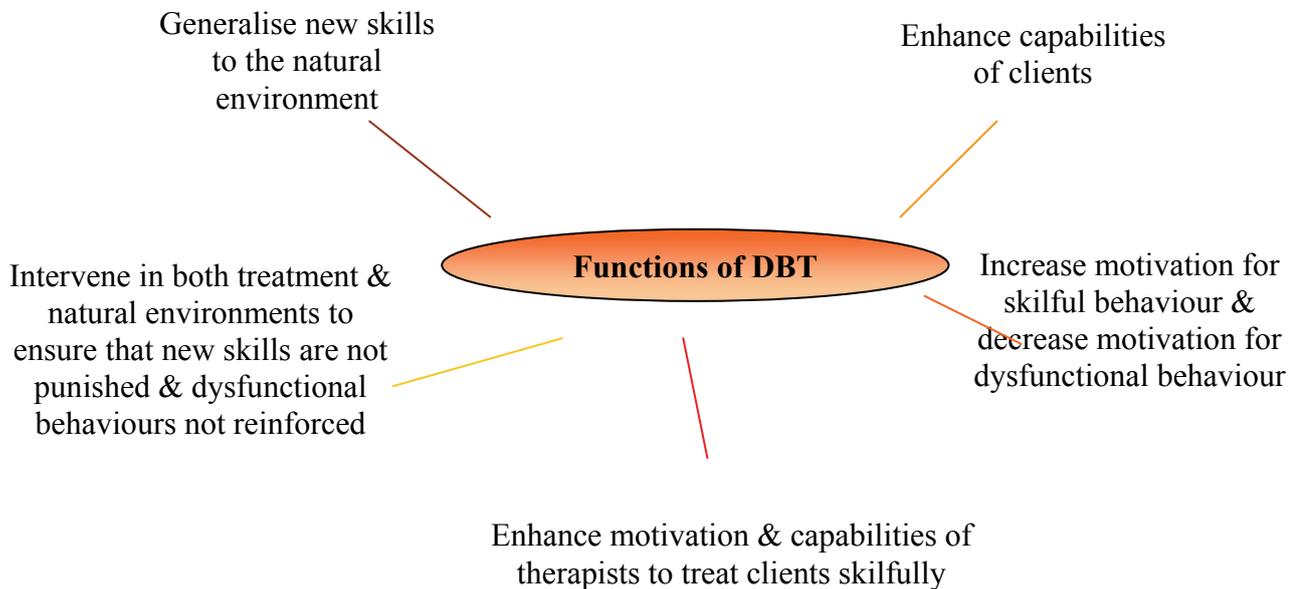


Figure 3: The five functions of DBT.

### **3.1.2 BIOSOCIAL THEORY OF BPD**

BPD is hypothesised to arise through emotional dysregulation, where there is difficulty regulating several if not all emotions. It is proposed that emotional dysregulation arose jointly through biological disposition and environmental context (Linehan, 1993a). Emotional dysregulation in BPD is the combination of an emotional response system that is oversensitive and overreactive with an inability to modulate the resulting strong emotions and actions associated with them. The disposition to emotional dysregulation is biologically based, providing the basis for emotional vulnerability and subsequent difficulties modulating emotions.

Linehan purported that emotional dysregulation is produced through an invalidating environment, which is particularly damaging for those who are highly emotionally vulnerable, who in turn elicit invalidation from the environment that would otherwise be supportive. Linehan defined an invalidating environment as the tendency to respond erratically and inappropriately to private experience (beliefs, thoughts, feelings, sensations especially those without public accompaniments), and also respond in extreme fashion (under or overreacting). By contrast, in an optimal family,

one that fosters adaptive emotional regulation skills, the child's preferences are taken into account, the child's beliefs and thoughts are elicited and responded to seriously, and the child's emotions are viewed as important communications. Another characteristic of the invalidating environment is controlling emotional expressiveness, where painful emotions are trivialized and attributed to negative traits such as lack of motivation, lack of discipline etc, and simultaneously positive emotions are paralleled with impulsiveness and lack of judgement. The child's demands on the environment are restricted, with discrimination and punishment being common to control behaviour.

The result of the invalidating environment is a child who cannot label and modulate emotional arousal, tolerate distress or trust her own emotional responses as valid interpretations of events, so that the child will then invalidate her/his own experiences and must look to the environment to provide cues as to how s/he feels and acts. The suppression of negative emotions and erratic reinforcement of emotional communication leads to a child having an emotional expression style that vacillates between extreme inhibition and disinhibition (Linehan, 1993). Emotion control strategies used in an invalidating environment may have little impact on, or may even be useful to, some children who are physiologically well equipped to regulate their emotions. However, such strategies are hypothesised as having a devastating impact on emotionally vulnerable children. Hence, in this transactional model it is the interaction of biology and environment that is thought to result in BPD (Linehan, 1993).

### **3.1.3 DBT STRATEGIES**

Treatment strategies can be divided into the following five sets (Linehan, 1997).

- a) Dialectical strategies
- b) Core strategies (validation and problem solving)
- c) Change procedures (skills training, exposure, cognitive modification, operant learning principles)
- d) Communication strategies (irreverent and reciprocal communication)
- e) Case management strategies (consultation to the client, environment intervention, team consultation)

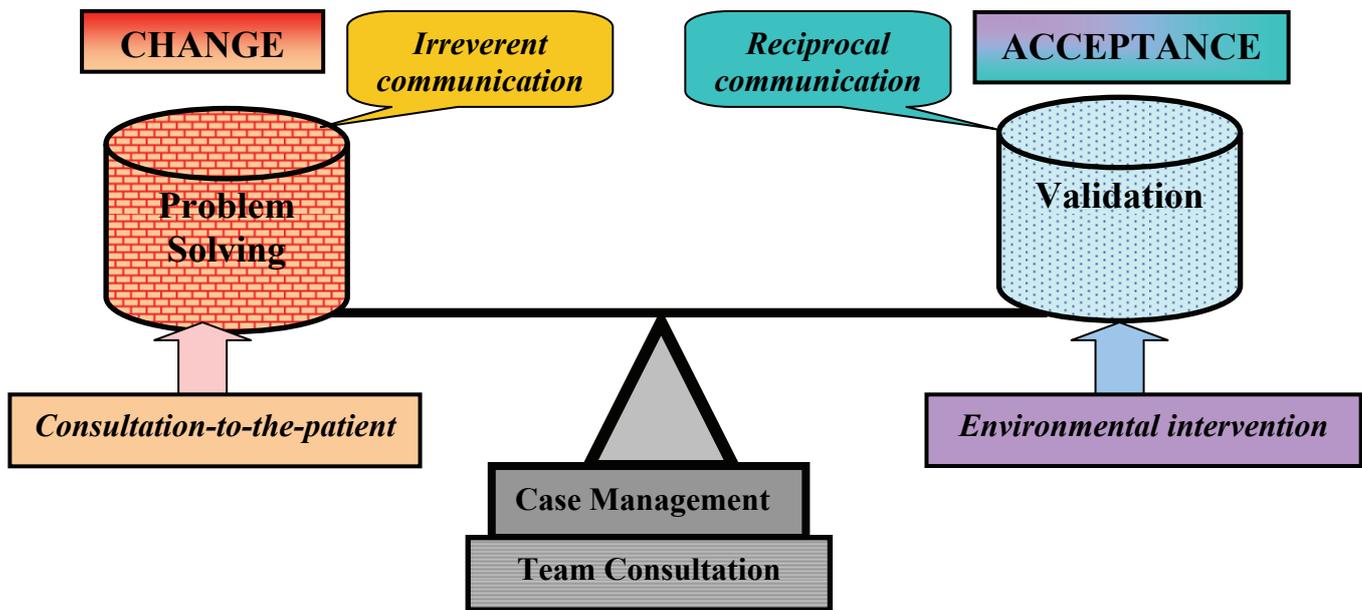


Figure 4: Dialectical communication.

### 3.1.3.1 DIALECTICAL STRATEGIES

DBT works from a central framework of the dialectic between acceptance and change, as illustrated in Figure 4. Balance is essential, therapy leaning too much towards change may result in the client feeling invalidated and the client will cease to work effectively in therapy, whereas therapy adopting excessive validation could lead to a client feeling hopeless and will again cease to work in therapy (Swales *et al*, 2000). Each pole of the dialectic has its own intervention strategies (validation versus problem solving), style of delivering the intervention (irreverent versus reciprocal) and its own environmental strategies (consultation-to-the-client versus environmental intervention).

Dialectical strategies tend to combine both acceptance and change strategies by highlighting opposites in an attempt to generate syntheses. Three essential characteristics of dialectical strategy include speed of movement between strategies, staying mindful of the client's response and maintaining focus, and also moving with strength, commitment and certainty (Swales *et al*, 2000). Metaphor is heavily adopted in such strategies like 'making lemonade out of lemons', 'activating wise mind', and 'devil's advocate'.

### **3.1.3.2 PROBLEM SOLVING – CHANGE STRATEGIES AND IRREVERENT COMMUNICATION STYLE**

Similarly to Cognitive Behaviour Therapy (CBT), DBT emphasises ongoing assessment and data collection on current behaviours, with clear and precise definitions of target behaviours in a collaborative interaction between client and therapist (mutual commitment to treatment goals and attention to orienting the client). CBT tools are used, such as exposure, problem solving, skills training, contingency management and cognitive modification.

Stylistically DBT blends irreverence (off-beat dead pan style, which is often challenging) to dysfunctional behaviours with reciprocal communication (warmth, flexibility, responsiveness, flexibility and strategic self disclosure). Often suicidal or other dysfunctional behaviours are reframed in terms of problem solving repertoire, balanced with emphasis on validating of present emotional, cognitive and behavioural responses as they are. This process uses collaborative behavioural analysis, formulates hypotheses about possible variables affecting the problem, generating and evaluating possible solutions. The behaviour analysis makes minute links in the chain between environmental trigger for self-injury and the episode itself and all incidents following the episode. The therapist must include the environmental trigger, affect change, cognitions and action precipitating the target behaviour, as well as the consequences that follow. Solution analysis elicits a range of solutions, especially in the form of skills. As part of this process, factors interfering with the implementation of solutions are tackled. Cognitive restructuring, contingency management and exposure to avoidance may be necessary strategies at this point to deal with the interference of the desired response. Attention is paid to contingencies operating within the therapeutic environment, looking at the reciprocal influence therapist and clients have on each other. The tendency to avoid threatening situations is a continuing focus of therapy, which is tackled using exposure techniques.

### **3.1.3.3 VALIDATION – ACCEPTANCE STRATEGIES AND RECIPROCAL COMMUNICATION STYLE**

Validation involves the DBT therapist looking for the grain of wisdom or truth inherent in each client response and communicating that wisdom to the client.

Frequent sympathetic acknowledgement of the client's emotional desperation is undertaken. Hence, validation used in DBT goes beyond basic empathy of communicating understanding of thoughts or behaviour, but includes acknowledgement of the accuracy or truth in the client's responses. There exists a belief in the client's inherent capabilities to change, and an impetus to build and maintain a positive interpersonal collaborative relationship between client and therapist. The therapist is viewed as a consultant to the client not to other individuals, and consistently takes the side of the client.

Validation is viewed to exist on six levels (Linehan, 1993b; Linehan, 1997). Most psychotherapy operates on the initial four, including listening and observing of client's responses, accurate reflection, articulating the unverballed, and validating in terms of past experiences (Linehan, 1997). The fourth level emphasises that given their past learning history or biological predisposition they cannot currently be otherwise (Swales *et al*, 2000). However, this level of validation does not preclude possible changes due to new learning experiences or biological changes. The fifth level consists of validation in terms of current circumstances, essentially normalising the current situation. The therapist attempts to highlight aspects of the behaviour which are functional, despite other elements of the behaviour being invalid and dysfunctional. Radical genuineness is the pinnacle of the validation strategies, and is the highlighting of the inherent capacity of the client to overcome their difficulties, while simultaneously understanding the level of difficulties. Hence, the client is not regarded as fragile, but innately capable of effective behaviour. Validation is also implemented strategically. The therapist is mindful of the impact of each level of validation, and utilises it to achieve certain goals, including enabling the client to self-validate, strengthening clinical progress, enhancing the therapeutic alliance, and providing feedback on the impact of the client's behaviour on themselves and others (Linehan, 1997).

#### **3.1.3.4 CASE MANAGEMENT STRATEGIES AND ENVIRONMENTAL STRATEGIES**

Case management consist of consultation-to-the-client strategies that aim to change the client's passive problem solving approach. It blends both validation and problem solving. The therapist encourages the client to implement their own solution to a

problem, instead of intervening. On rare occasions, the therapist will intervene in the client's environment when the client is not capable to do it themselves, yet will encourage some client involvement simultaneously.

### **3.1.4 DIALECTICAL WORLD VIEW**

Dialectics form the foundations of DBT. The dialectical perspective encompasses the following three assumptions (Linehan, 1993a).

1. *Fundamental interrelatedness or wholeness of reality.* Skills deficits are viewed as interrelated, where the learning of one set of new skills is difficult without learning other related skills simultaneously (Linehan, 1993a)
2. *Reality is not static.* Reality is compromised of internal opposing forces (thesis and antithesis) out of which synthesis evolves a new set of opposing forces. Extremes of thinking, behaviour and emotions are interpreted as dialectical failures, where the individual is stuck in polarities unable to move to syntheses. The therapist aims to bring client to a workable synthesis.
3. *Fundamental nature of reality is change and process rather than content and structure.* Since the world is continuous evolving, the client must become comfortable with change, rather than focusing on maintaining a stable and constant environment (Linehan, 1993a).

## **3.2 TREATMENT COMPONENTS**

### **3.2.1 INDIVIDUAL THERAPY**

A client in the DBT programme attends weekly individual sessions, which typically last between 45-60 minutes per week and begins with collaborative agenda setting. Among the first issues to be discussed is the review of the previous week by reference to the diary cards. Chain analysis is utilised when clarifying a self-destructive behaviour in the previous week. Attention is paid to immediate antecedents of troublesome feelings and actions, identifying clearly how a crisis arose. Following this there is a promotion of greater use of skills to survive and manage such difficult feelings. The individual therapist is cautious also to ensure that sessions are a validating setting for the client.

### 3.2.1.1 COMMITMENT

Both the therapist and client make explicit commitments in the initial sessions of DBT. Often a “hard to get” policy is taken to convince the client that the programme is in fact justified. The new therapeutic endeavour is presented in a realistic way as promising but also demanding. Time spent in commitment is a good investment. If the therapeutic alliance begins to breakdown, time is spent on recommitment. The following agreements are made by both parties, listed in Table 3 and 4.

Table 2: Commitments the patient agrees to make.

Stay in programme for specific amount of time, attending scheduled sessions.
Work on reducing suicidal behaviours and therapy interfering behaviours as a goal of therapy.
Participate in skills training for a specific amount of time.

Table 3: Commitments the therapist agrees to make.

Make every reasonable effort to conduct competent and effective therapy, obeying ethical and professional guidelines.
Be available to a client on a weekly basis and give needed therapy back up.
Maintain confidentiality and obtain consent when needed.

As part of this commitment contract, there is a strict in-built non-attendance rule, that is, if four consecutive sessions of one kind are missed the client is out of therapy.

### 3.2.1.2 STANCE OF THE INDIVIDUAL THERAPIST

The therapist should aim to interact with the client in the following ways:

- a) accepting of the patient in the moment, yet encouraging change of behaviours
- b) centred and firm, yet flexible when the circumstances require it
- c) nurturing yet benevolently demanding

Essentially at all times the individual therapist must remain non-pejorative and open-minded. In order to be working from a DBT model the individual therapist must work from key assumptions including:

- a) The patient wants to change and, in spite of appearances, is trying her best at all times.
- b) The patient's behaviour is understandable given her background and present circumstances. The aim is to make the patient's a life worth living.
- c) Although the client may not be entirely to blame for her difficulties, she must take personal responsibility to change them.
- d) Client can not fail DBT. If things are not improving it is the therapeutic model that is failing.

### **3.2.1.3 INDIVIDUAL THERAPY STRUCTURE**

During the initial pre-treatment commitment phase the focus is to attain agreement between the client and therapist on the goals of treatment, including reduction of parasuicidal behaviours, therapy interfering behaviours and learning of behavioural skills. If the above targets are not agreed, therapy is abandoned. If it is found at a later stage that the focus of treatment is deviating from the above goals, then the therapist returns to this commitment stage. It is during this stage that much of the foundation work is begun in establishing a durable therapeutic alliance.

Stage one, as shown in Figure 5, focuses on behavioural skill acquisition, and targets life threatening, therapy interfering and quality of life interfering behaviours respectively. The therapist aims to decrease problematic behaviours and substitute these with more adaptive skills taught in the skills group. All barriers to treatment are defined behaviourally, for example 'client resistance' would be defined as 'failed to attend therapy session', 'rejects therapist suggestions' (Swales *et al*, 2000). The therapist always operates from a target hierarchy in any individual session, concentrating firstly on life threatening behaviours, then therapy interfering behaviours and finally quality of life interfering behaviours.

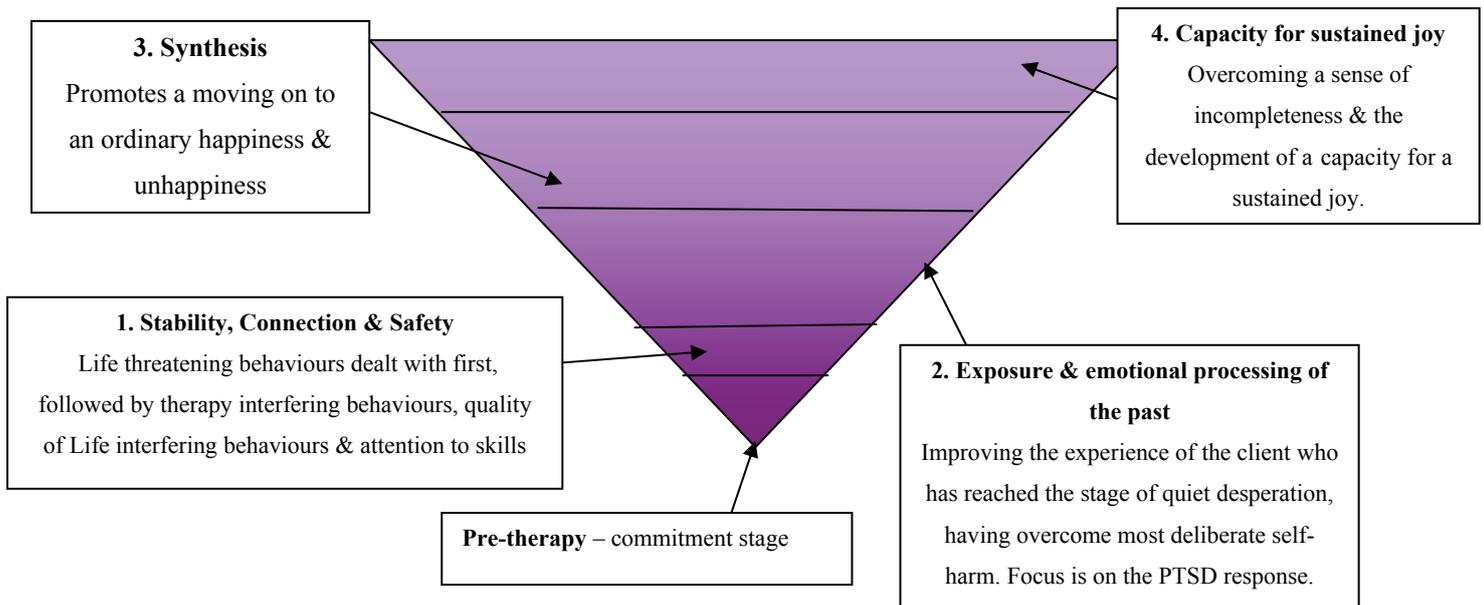


Figure 5: Hierarchical treatment stages in DBT individual therapy.

Stage two, usually begins in the second year of treatment, and concentrates on dealing with post-traumatic stress, when the client clearly demonstrates that she has the supports and capabilities to cope with the intensity of this stage. During this phase sessions will deal with memories of any traumatic events or objects, and will modify any problematic behaviours subsequently. Stage three of treatment aims to increase client self respect and ability to trust and validate themselves. Work also takes place on client goals during this stage. Stage four of treatment deals with higher level existential difficulties. These latter two stages are in place to develop the individual's well being, and Linehan believes that this can occur through DBT, another therapeutic model or external to treatment (Swales *et al*, 2000).

### 3.2.1.4 SECONDARY TARGETS IN INDIVIDUAL THERAPY

The following secondary targets in individual sessions form three dimensions, each containing its own polarity or dialectical tension, as illustrated in the Figure 6.

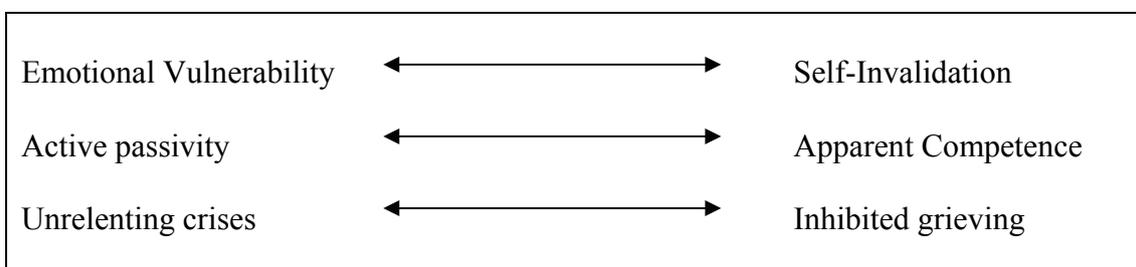


Figure 6: Secondary targets in individual therapy.

The first dialectic is between a biologically driven emotional vulnerability (emotional sensitivity, emotional intensity, and strong negative emotional responding) in clients with BPD and opposed to this a tendency to invalidate their own emotional experiences with accompanying attempts to inhibit emotional experiencing and expression. The second dialectic refers to a tendency to approach life in a passive way and intense reaching out to others to solve problems, while on the opposite pole to this is apparent competence, an illusion of coping with life's problems when they cannot. The third dialectic denotes the tension between the behaviours in response to a state of perpetual crisis, and inhibited grieving – restrained expression of extreme and emotional reactions to stressful and traumatic situations. The three dialectics provide a useful framework from which to understand the rapid oscillation from two poles of a continuum. Therapy aims to use inherent tensions to forge a more balanced, flexible, and effective repertoire of coping behaviours (Swales, *et al*, 2000).

### 3.2.2 SKILLS TRAINING GROUP

The overall objective of skills training is to learn and refine skills in changing behavioural, emotional and thinking patterns. This is achieved through the teaching of the following eight week skills modules:

- **Interpersonal Effectiveness:** targeting interpersonal chaos.
- **Emotion Regulation:** targeting fluctuating intense emotions, problems with anger.
- **Distress Tolerance:** affecting impulsiveness / self-destructiveness.
- **Mindfulness:** confusion about self / depersonalisation.

### **3.2.2.1 DIARY CARDS**

The purpose of the diary cards is to decipher whether skills were used and how effectively. Other sections of the diary cards are discussed in Individual Therapy. Diary cards are a core component of skills training. Practice of skills is vital in learning and change. Diary cards play a role in self monitoring, feedback and reinforcement, which are important in recovery.

### **3.2.2.2 RULES OF THE SKILLS TRAINING GROUP**

Within the Skills Training Group (STG), there is a rule of non-disclosure, physically or verbally, of deliberate self harm. There is also a four consecutive missed session drop out rule.

### **3.2.3 SKILLS TAUGHT**

#### **3.2.3.1 MINDFULNESS MODULE**

The overarching objective of this skills module is for all group members to learn to be in control of their mind, instead of their minds being in control of them. Mindfulness is a form of meditation, that has proven effective in chronic stress, pain management and emotional disorders (Brown & Ryan, 2003). Among the skills and concepts learned in mindfulness include “Reasonable mind” (rational thinking, logical mind – I think), “Emotion mind” (emotional, feeling mind, emotions are in control of behaviour and thinking – I feel), and “Wise mind” (Integration of emotion and reasonable mind – I know, knowing in a centred calm way, like intuition). The latter is the preferred state of being and DBT believes that we all have the potential to adopt an effective “Wise mind”, which can be described as a feeling of making the right

choice in a dilemma. “Wise mind” is most likely to prevail when the person is feeling calm and secure.

Further mindfulness skills include the “what” and “how” skills. “What” Skills encompass observing (experiencing without describing or labelling, noticing or attending to something), describing (using words to represent what you observed), and participating (entering wholly into an activity, spontaneous behaviour done mindfully). “How” Skills include being “non-judgmental” and “one-mindful”. “Non-judgement” is described as avoiding all or nothing thinking and distinguishing judgements from facts. “One-mindful” is elucidated as focusing attention on just one thing at a time and becoming fully aware of it.

### **3.2.3.2 EMOTIONAL REGULATION MODULE**

The aims of the emotional regulation module are to understand emotions, reduce emotional vulnerability (increasing positive emotions and decreasing negative emotional vulnerability) and decrease emotional suffering (being mindful-letting go of emotions rather than fighting them/burying them, acting opposite-modulating and changing painful experiences). Hence the focus of this module is not to get rid of emotions but to merely reduce suffering.

Among the work done in this module includes challenging myths about emotions, labelling and describing primary and secondary emotions, understanding the role of interpretation of emotions and the benefits of emotions. Other emotional regulation tasks include reducing negative emotions, increasing positive emotions and abandoning emotional suffering. The emphasis is on not fighting or pushing away emotions - treating it as a wave.

### **3.2.3.3 INTERPERSONAL EFFECTIVENESS MODULE**

The interpersonal effectiveness module focuses on asking for things, making requests and saying no, resisting pressure, and keeping your own values. The module is beneficial to attending to and maintaining relationships, learning to negotiate and compromise in pursuit of a desired objective, building mastery in dealing with people and self respect.

Assertiveness is at the core of the interpersonal effectiveness module. There is also a focus on balancing the pros and cons of interpersonal decision making and being consistent with own beliefs and values. Being effective at an interpersonal level denotes being taken seriously, successfully getting what is desired out of a social interaction, and also maintaining or even improving important relationships. Self respect is also reiterated in this module.

#### **3.2.3.4 DISTRESS TOLERANCE MODULE**

The distress tolerance module concentrates on teaching skills for tolerating and accepting crises, and secondly accepting life as it is in the moment. The objectives of these skills are to survive crisis by doing what is most effective, when it cannot be changed right away, without resorting to behaviours, which are going to make things worse.

Four sets of skills are taught in relation to the above objective, namely distracting, self soothing, improving the moment, and finally pros and cons. Useful tasks within this module are breathing, half smiling, radical acceptance, turning the mind (choosing to accept) and being willing (accepting and responding to what is effective and appropriate) as opposed to being wilful. Radical acceptance is viewed as eliminating suffering leaving only pain and in turn reducing the primary pain.

#### **3.2.4 TELEPHONE COACHING**

DBT is the only therapy for individuals diagnosed with BPD in which telephone coaching is employed as one of the primary modes of standard treatment. The DBT framework of telephone skills coaching has begun to spread into the treatment of other impulse control disorders, such as the treatment of eating disorders (Wisniewski & Ben-Porath, 2005). This modality has the following functions: skills coaching and generalisation, immediate crisis intervention decreasing suicidal and self injurious behaviours, teaching adaptive help seeking and repair to threats of the therapeutic alliance. Out of hours telephone coaching fosters appropriate help seeking, rather than establishing a connection between suicidal behaviour and extra attention from the therapist. Based on learning principles, the client is clearly instructed that telephone coaching only takes place prior to any self destructive behaviour, and if the client has

engaged in self injurious behaviour, then any phone contact will not be accepted until 24 hours after the self injury unless the situation is life threatening (Ben-Porath, 2004).

Telephone contact usually lasts no more than twenty minutes. The content of the telephone contact should be entirely directive and skills focused. Therapists must be cautious not to provide supportive listening or nurturance, as this could lead to reluctance to let go of crisis behaviours. Common questions might be “What skills have you used?” and “What obstacles are there to you using your skills?” Hence the therapist is matter of fact and not overly concerned in order to avoid reinforcing passivity in the client. Telephone skills coaching is solution focused and encourages the client to come with their own answer by using skills. Ben-Porath (2004) described the perceived barriers to telephone coaching, including issues of intrusion into personal time, fears of engulfment and fear of inadvertently reinforcing maladaptive behaviours. In a more recent publication, Ben-Porath (2005) introduced a “decision tree model” in order to give guidance to therapists about clarifying the types of phone contact, suggestions on what skills and DBT principles apply in these circumstances, and outline suitable courses of action in each case. Ben-Porath (2005) outlined that phone contact should be divided into calls related to suicidal or self injurious behaviour, skills generalisation calls, therapeutic repair calls, or inappropriate therapy interfering contact.

It is possible that telephone coaching is one of the “active ingredients” responsible for DBT effectiveness. Ben Porath (2004) proposes that it plays an important role in its effectiveness in reducing self-injury. Research that dismantles all the components of DBT is an important step to clarify telephone coaching’s role in treatment, as well as the role of other components.

### **3.2.5 THERAPIST CONSULTATION**

The use of a weekly DBT team consultation makes the model amendable to collaborative endeavours and gives support to all those implementing DBT (Smith & Peck, 2004). The team meeting can help to prevent and minimise ineffective client-therapist interactions and staff burnout, especially given the typically challenging nature of work and boundary setting needed with clients with BPD. Hence, this

therapeutic component facilitates monitoring of client progress and risk, while simultaneously reducing overall strain of working with such a difficult population. It can also aid staff motivation and adherence to the DBT model (Simpson *et al*, 1998).

### **3.3 DBT RESEARCH**

#### **3.3.1 OUTCOME RESEARCH**

Initial publications of DBT effectiveness indicated that the therapy successfully lowers attrition rate, parasuicidal episodes and psychiatric inpatient days (Swales, Heard & Williams, 2000). In a controlled randomised one-year study with chronically suicidal BPD patients, Linehan, Armstrong, Suarez, Allmon & Heard (1991) found that 22 individuals randomly assigned to standard outpatient DBT had more positive outcomes than those assigned to outpatient psychotherapists or mental health treatment centres in the community (n=22). Superiority of outcome was demonstrated in a number of outcome domains including a decrement in parasuicidal behaviours, length and frequency of hospitalisation, treatment drop out, and improvements in anger regulation and global and interpersonal functioning (Linehan *et al*, 1991). Later studies evaluating DBT took sharper account of the unspecific factors in the comparison group and other extraneous variables. Linehan, Heard & Armstrong (1993) demonstrated fewer psychiatric inpatient days and fewer incidences of, and less medically severe, parasuicidal behaviour in the DBT condition compared to the control group. Linehan, Tutek, Heard & Armstrong (1994) highlighted that the DBT condition had significantly better scores on measures of anger, interviewer rated social adjustment and on the Global Assessment Scale, and rated themselves better on overall social adjustment compared to those who received treatment as usual.

Koons, Robins, Tweed, Lynch & Gonzalez (2001) examined the efficacy of DBT in less severely affected women with BPD with 40% reporting a recent history of self injurious behaviour. A briefer version of standardised DBT was delivered. DBT demonstrated superiority in outcomes of hopelessness, depression, anger expression and self injury. A strong trend towards reduced hospitalisations was shown in the DBT condition. Both conditions reported significant reduction in interview rated depression and SCID-II borderline symptoms.

Another independent research team (Verheul *et al*, 2003) compared standardised DBT and treatment as usual for the treatment of women with BPD who are attending community psychiatry and substance-abuse clinics. Participants were randomised to either DBT (n=27) or treatment as usual (n=31) conditions. The study reported that subjects assigned to the DBT condition had significantly lower levels of self damaging impulsive behaviour and were more likely not to drop out prematurely. Two participants receiving DBT attempted suicide compared to eight participants in the treatment as usual condition.

Linehan *et al* (2002) examined DBT effectiveness in the treatment of women who met criteria for both BPD and opiate dependence. Participants were either randomly assigned to the DBT condition or Comprehensive Validation Therapy (CVT) condition. Both conditions demonstrated improvements in opiate usage. The comprehensive CVT condition reported no attrition in the entire 12 months of treatment, which may be attributed to its supportive and validating model. Linehan, Comtois, Murray, Brown & Gallop (2006) compared community treatment (n=49) with experts and standard DBT (n=52) with a much larger sample and rigorous control. Participants in both conditions were matched for suicidal and self harming history and co-morbidity. Although improvements were demonstrated in both conditions, those who received DBT generally exhibited better treatment response, in areas targeted by treatment and those in the DBT condition were half as likely to make a suicide attempt. The DBT condition demonstrated fewer self injurious behaviours, less usage of crisis services especially for self injurious behaviours, and were less likely to change therapists or drop out of treatment compared to the alternative condition. However, both groups reported improvements in measures of depressions, hopelessness, suicidality and reasons for living.

Although DBT has several randomised controlled trials suggesting its effectiveness, much further investigation is recommended (American Journal of Psychiatry, 2001). Randomised Controlled Trials may tell us only part of the story in relation to the changes that take place as a result of a client's participation in the DBT programme. For example symptoms may not always alter after a therapeutic year is over, but the impact of therapy may be more subtle and be evident in terms of coping strategies which may often be revealed while talking to a client and fail to be

captured in a battery of outcome measures. One of the AJP recommendations is research examining the components of DBT that are responsible for its effectiveness.

Evaluation research on DBT has had a number of limitations so far. The long term outcomes of DBT are still unknown (Westen, 2006), particularly whether positive outcomes are maintained after treatment has been discontinued. It has also been argued that treatment as usual conditions have not been fully comparable to DBT conditions in many RCT evaluations (Robins & Chapman, 2004). Other uncontrolled research without control conditions have suggested beneficial outcomes associated with DBT. However, lack of a control condition precludes firm conclusions about the efficacy of the treatment (Robins & Chapman, 2004). It is also important to note that effectiveness and efficacy evaluations should be distinguished. Effectiveness refers to an evaluation of whether an intervention works in routine practice in everyday conditions, while efficacy denotes a direct link between treatment provision and change in ideal conditions. Effectiveness evaluations are typically less stringent about inclusion criteria and are less controlled.

### **3.3.2 ADAPTATIONS OF STANDARDISED DBT RESEARCH**

Since its inception in the early 1990's standard DBT created for adult clients diagnosed with BPD and presenting with chronic self injurious and suicidal behaviours has evolved considerably. Among the first changes has been extending the treatment to the adolescent client group with BPD (Miller, Rathus, Linehan, Wetzler & Leigh, 1997; Turner, Barnett, Korslund, 1998; Katz & Cox, 2002; Rathus & Miller, 2002; Nelson-Gray *et al*, 2006; Hjalmarsson, Kaver, Perseius, Cederberg & Ghaderi, 2008). Originally DBT was applied in an outpatient psychiatric setting, and now has been successfully implemented in inpatient (Barley *et al*, 1993; Simpson *et al*, 1998; McQuillan *et al*, 2005; Bohus *et al*, 2004), locked forensic (McCann, Ball & Ivanoff, 2000; Berzins & Trestman, 2004; Low, Jones, Duggan, Power & McLeod, 2001; Trupin, Stewart, Beach & Boesky, 2002) and Accident and Emergency Department settings (Sneed, Balestri & Belfi, 2000) for treatment of individuals with BPD. Components of DBT and shortened intensive DBT have also reported success in the treatment of BPD (Sambrook, Abba & Chadwick, 2006; Harley, Baity, Blais & Jacobo, 2007)

The treatment has been adapted for the treatment of impulse spectrum disorders, namely substance misuse (Linehan *et al*, 1999; Van den Bosch, Verheul, Schippers & Van den Brink, 2002; Wagner, Miller, Greene & Winiarski, 2004), binge eating disorders (Palmer *et al*, 2003), bulimia nervosa (Safer, Telch & Agras, 2001) and offending behaviours (Shingler, 2004; Evershed *et al*, 2003).

Elements of DBT have also been relevant in the treatment of depression in older adults (Lynch *et al*, 2007; Lynch, Morse, Mendelson & Robins, 2003; Harley, Sprich, Safren, Jacobo & Fava, 2008), vocational rehabilitation of significantly disabled mentally ill adults (Koons *et al*, 2006) and for clients diagnosed with obsessive compulsive personality disorder (Miller & Kraus, 2007). Other recent developments of DBT adaptations have included in the treatment of ADHD (Hesslinger *et al*, 2002), domestic violence (Fruzzetti & Levensky, 2000) and co-morbid personality disorders (Lynch & Cheavens, 2008).

Hence, the major adaptations of DBT have been in the treatment of BPD in different settings and wider age-presentations, to other impulse spectrum disorders and then to other diverse disorders. Comprehensive and standard DBT has also been moulded to service needs and resources with many studies reporting the implementation of components or shortened intensive versions rather than standard comprehensive DBT.

### **3.3.3 CRITIQUE OF THE RESEARCH**

Scheel (2000) and other authors (Blennerhassett & Wilson O'Rashallaigh, 2005) have alleged that the enthusiasm for DBT has begun to outpace its limited empirical base. They proposed that the findings to date are encouraging but not definitive (Swenson, Torrey & Koerner, 2002). Westen (2000) calculated that there was a 20:1 ratio of theoretical/clinical papers to empirical papers on DBT. Scheel was systematic in highlighting discrepancies or inadequacies in the original studies of DBT effectiveness. It was stated that the therapy as usual condition can often be unclear as a comparison condition (Scheel, 2000; Turner, 2000). Further details about amount of therapy received, consistency and stability of treatment need to be elaborated to allow accurate comparison. The findings of lesser hospitalisation for DBT subjects when interpreted in isolation are not primarily an outcome measure of client functioning.

Similarly, reduced parasuicidal behaviour does not necessarily mean that DBT is associated with lesser suicide.

Scheel (2000) suggested that the language of DBT effectiveness should be toned down by the use of more conservative phrases such as writing “DBT is associated with”, rather than “results in”. Scheel also reported that the central skills training is perhaps not the primary “active ingredient” as suggested, and that the individual psychotherapy and extraneous factors may account for positive findings. DBT training and close supervision may also contribute to outcomes. The importance of process and dismantling research to establish effective components of DBT, and facilitate adaptation to alternative settings appears to be warranted. Widiger (2000) reiterated this proposal that dismantling studies would identify the most effective and necessary features of DBT. Feigenbaum (2008) and Lynch, Rosenthal & Smoski (2008) have indicated the need for further deconstruction of the DBT model to identify the effective components.

Swenson (2000) concurred that the DBT empirical base was at that point slim but impressive. Swenson outlined the numerous factors, which could explain DBT’s widespread popularity. The enthusiasm and investment could be clarified with reference to the treatment orientations brought together in DBT and the nature of these treatment strategies. DBT integrates numerous models of treatment including biological, behavioural, spiritual and social-environmental (Swenson, 2000). It may be through this fluid integration of numerous models that DBT has become so prevalent. The synthesis of dialectics of change and acceptance tools, and a heavy emphasis on consultation team support seems appealing to those who learn DBT. Not only is DBT theoretically complex and deep, but it supplies plentiful pragmatic and useful interventions within its model (Swenson, 2000). The focus on client involvement, skills development, and a non-judgmental stance appeals to client-centred and recovery-based services (Feigenbaum, 2008).

DBT is undoubtedly a popular intervention. However, there appears to be number of barriers to its implementation, including lack of a powerful advocacy group to provide the intervention, possible reworking needed of therapists’ belief system and DBT team drift (Swenson, Torrey & Koerner, 2002). From the client perspective, DBT can seem superficial and off the mark due to its emphasis on assessment, behavioural

change, self monitoring, skills training and homework. DBT also requires a considerable commitment from the participants (Swenson, Torrey & Koerner, 2002).

### **3.3.4 DISMANTLING STUDIES**

The effectiveness studies of Stage one of DBT for BPD are promising. However, suggestions for further research appear to be necessary. Qualitative research and longitudinal studies could add value into understanding of how DBT actually works. Smith & Peck (2004) have proposed that perhaps the most useful research would be case study methodology that examines the quality and effectiveness of the DBT model with a very limited group of subjects. Although generalisability of such research would be minimal, various aspects of the DBT therapeutic process could be illuminated (Smith & Peck, 2004).

Research on DBT can be argued to be sparse on predictors of response and also further examination of the mechanisms of change are needed in order to advance of knowledge of DBT treatment (Harned & Lynch, 2006). It appears to be the very early stages of understanding which modes or strategies might be the active ingredients for DBT effectiveness. It would be most useful if forthcoming research targeted this particular question (Nee & Farman, 2007). There appears to be a clear movement towards dismantling studies and testing mechanisms of change, in order to identify the essential features of the treatment to improve its efficiency, efficacy and generalizability (Lynch, Trost, Salsman & Linehan, 2007; Lynch, Chapman, Rosenthal, Kuo & Linehan, 2006). One approach to gauging the relative importance of the DBT components has been to compare modified and standard DBT in which one or more of the aspects of DBT are missing (Lynch, Morse, Mendelson & Robins, 2003; Telch, Agras & Linehan 2001). Linehan is currently undertaking a dismantling study with women with BPD and histories of suicidal and self injurious behaviours that compares three treatment conditions: a) standard DBT, b) individual therapy plus active group support, with no DBT skills in individual therapy, and c) DBT skills training plus case management, which includes no individual DBT therapy. Some preliminary work has investigated the relative importance of acceptance and change strategies within the DBT model. Linehan *et al* (2002) has suggested that validation strategies are vital for preventing drop-out, while Shearin & Linehan (1992) have pointed to a combination of change and validation strategies being important and

being associated with greater reduction in parasuicidal behaviour and ideation relative to sessions during which the therapist was rated as purely accepting or change focused. It has been suggested that multiple measurement points to determine a gradient (dosage effect) as well as a time line (i.e. changes in mechanisms of action precede changes in outcome) should be applied in future research (Lynch *et al*, 2007). Case studies may provide the greatest insights in understanding therapeutic change (Kazdin, 1982).

A very recent dismantling study of the skills training component of DBT investigated whether the patient's practice of the behavioural skills taught in the group may be partly responsible for the positive treatment outcomes according to the skills deficit model of BPD that underlies DBT (Lindenboim, Comtois & Linehan, 2007). Skills were recorded each week for the sample (n=49) and it was found that participants reported practising at least one skill a majority of days during their one year treatment, with a daily average of using four skills per day. Distress tolerance skills (e.g. self soothing) and mindfulness (e.g. observing, one mindfulness, wise mind) were most frequently practised. The popularity of distress tolerance could be explained through the ample opportunities for practice, a focus on this set of skills in telephone coaching and their place in the original repertoire of strategies to escape from stressful situations. The common usage of mindfulness could be interpreted by its position as a core skill and it is taught more frequently than the other modules. Interpersonal effectiveness skills were reported as least used in this study. Further research investigating skill attainment and usage is warranted.

Other recent research has concentrated on the examination of the stages of change in DBT for BPD (Soler, Trujols, Pascual, Portella, Barrachina, Campins, Tejedor, Alvaraz & Perez, 2008). Authors demonstrated the applicability of the Trans-Theoretical Model (TTM) stage of change construct to DBT, which is a framework developed to describe and predict the process of intentional change of any behavioural problem. The TTM has five stages including 1) precontemplation – no current intention to take action to deal with the problem 2) contemplation – ambivalent yet active consideration of taking action to manage problem 3) preparation – commitment to change 4) action – commitment to change and active application of change strategies 5) maintenance – change has been achieved and focus is now on relapse prevention. Soler *et al* (2008) found this stage of change model, using the University

of Rhode Island Change Assessment Scale, was a useful predictor of DBT drop-out and that patients at the precontemplation stage were prone to drop-out before completing all DBT group sessions. Soler *et al* (2008) concluded that conceptualising motivation or patient readiness-to-change in terms of TTM stages of change may enrich and augment the understanding of the process of change in people with BPD treated with DBT.

### **3.3.5 QUALITATIVE RESEARCH**

Qualitative research may be beneficial in clarifying the active ingredients of DBT. Much qualitative work and discussion has already concentrated on examining the effect of the diagnostic label of BPD from the client's perspective (Glick Miller, 1994), and assessing the possible potential stereotypic staff reactions to this diagnosis (Gallop, 1988). Much of this has been discussed in Chapter Two: BPD. Qualitative research on DBT more generally remains limited and insufficient. A study undertaken by Perseius, Ojenhagen, Asberg, Ekdahl & Samuelsson (2003) examined DBT client perceptions. The work looked at the patients' view of the therapy effect, components of therapy generally and perceptions of psychiatric care before entering DBT. A total of 11 DBT clients were sampled and were assured that there was no dependency between researchers and the clinic. The findings showed that therapy was largely viewed in a very positive light, helping in acceptance of feelings and providing skills to help conquer suicidal and self harm impulses. In terms of the patients' analyses of therapy, respect and confirmation were verbalised as fundamental, with patients viewing themselves as being responsible to take control in the stubborn struggle with oneself. The therapy contract was viewed as bringing support and a challenge. Group skills were interpreted as difficult but necessary. The telephone consultation element was labelled as an important crisis support. In contrast to this, patients experience of the psychiatric system before DBT was unanimously negative, with patients uniformly mentioning not being understood and being confronted with disrespectful attitudes. Patients also stressed the experience of discontinuity and betrayal. Tools of psychiatric care were generally viewed as poor, with some mentioning- "they just poured medicines into me" (p. 223) and talking without leading anywhere.

Cunningham, Wolbert & Lillie (2004) aimed to understand what is effective about DBT and why from the clients' perspective. They interviewed 14 women who had

completed the DBT programme. DBT was universally reported as a life-changing therapy. For DBT participants, BPD was reshaped as a controllable part of themselves rather than a condition that controls them. Individual therapy was judged to be positive. Individual therapy was described as a balance between being non-judgemental and validating, while also challenging. Equality and collaboration were asserted as fundamental to DBT individual therapy. Self-soothing and distraction were named as the most popular skills, although the preferred skills tend to vary from client to client. It was stated that certain skills are not only difficult to apply but hard to understand, for example radical acceptance. It appears that there are different levels of assimilation of skills. A diverse skills group with different levels of ability appear to be beneficial to joint learning, as well as reassuring and motivating. Telephone coaching helped service users move into more stable territory. However, many participants commented that they would prefer not only skills coaching within telephone consultation, but the inclusion of validation. Participation in DBT was related to improvements in relationships, control of emotions, increased hope and decreased level of suffering.

This work done by both groups of investigators was valuable and improves our understanding of the typical experience of a client going through DBT. However, both studies failed to ask patients to narrate their negative experiences and reactions towards the treatment or ask about things in therapy that had been difficult and troublesome. In addition to this limitation, clients in these studies had all been in therapy for at least 12 months perhaps creating a rather overly positive interpretation of DBT. Perhaps patients who had dropped out of therapy may have spoken about negative experiences, and those at earlier stages may have been more ambivalent in their judgements.

### **3.3.6 IRISH CONTEXT- SERVICES AND RESEARCH**

DBT is relatively new to an Irish context. The first initial training was commenced in 2001 with a total of nine teams taking part and was executed by Behavioural Tech, a DBT training team. However, not all teams were able to begin a DBT service within their service following training. Some DBT teams disintegrated due to staff movement to other services and not having sufficient funding or staff resources to sustain a comprehensive DBT programme within their service. Interest in DBT

remained high in Ireland and a second training was organised by St. Vincent's Hospital, Fairview in 2005. A total of seven teams completed the training with mixed reports of successful implementation of a DBT programme.

In terms of research, there has been a dearth of investigation into DBT with the exception of work done by Lawlor (2000) and Rashleigh (2003), although neither work was published at peer review level. Lawlor (2000) sampled a total of 5 patients who met the criteria for BPD diagnosis. The DBT treatment included Skills group training, individual psychotherapy, telephone consultation, with no team consultation. This study found a significant improvement in the overall level of psychopathology. Level of functioning was found to have improved post DBT and this pattern continued over four years. Reduction in depression was calculated on three different assessments. Anger control displayed a marked improvement post DBT, alongside this there were reductions in phobic anxiety, hostility, psychoticism and interpersonal difficulties. Levels of perceived stress exhibited a steady decrement over the two years of this intervention. A noteworthy reduction in the incidence and severity of parasuicidal acts was reported. This study also investigated the economic implications of the DBT programme, finding a significant reduction in the costs of bed days in the service, a reduction in medical admissions, less appointments with DBT therapists, compared to client usage of these services prior to DBT participation.

Rashleigh (2003) looked at the efficacy of use of the skills training group therapy portion of DBT to reduce the frequency and severity of chronic self-harming behaviours in psychiatric outpatients attending clinics. A total of 8 patients participated in the study consisting of 27 weeks of manualised DBT group therapy. Results showed small reductions in severity of self-harm and large reductions in inpatient admissions for those receiving treatment. No effect on psychiatric symptoms such as anxiety and depression were reported.

A qualitative investigation into the experience all clients involved in the DBT programme, combined with a quantitative evaluation, would be particularly valuable, especially to highlight the impact of DBT in an Irish setting. No such investigation has taken place to date.

### 3.4 SUMMARY

In Chapter 3, I have covered the following three sections: Theory and Background of DBT; DBT components and DBT research.

DBT has five main functions, which are based on the biosocial theory underpinning the DBT philosophy. BPD, according to this model, is a disorder of emotional dysregulation, which is both biologically based and learned due to the presence of an invalidating environment in childhood. An individual with BPD is not equipped with either the motivation and capability to deal with and manage their emotions more effectively. DBT is structured very much around the dialectical perspective, whereby balance between the therapeutic tools of change and acceptance is essential in order for the therapy to be effective. DBT is constantly flowing between these two polarities with an aim of synthesis. A DBT practitioner can be firm, challenging, irreverent, adopt matter of fact problem solving using the CBT tools, while simultaneously being warm, validating, accepting, reciprocal and cementing the therapeutic alliance.

DBT is divided into several components, which are very much linked and complimentary. Each mode is attached to the five overall functions of DBT. Individual therapy is heavily invested in commitment and orientation to the DBT model for both the therapist and the client. In order to systematically follow the DBT model the therapist must adopt a DBT outlook. DBT individual therapy is divided into five stages. Stage one is particularly regimented in its hierarchy of priorities in each individual session. Life threatening behaviours are dealt with first, followed by therapy interfering behaviours, then quality of life interfering behaviours are next. The individual sessions are flexible and depend on what is presented from week-to-week. However, the goal of individual therapy is to maintain attendance and to reduce self-destructive behaviours. Skills training is highly structured and has some strict rules of conduct. Skills are taught over six months and repeated, covering mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness. Telephone coaching is an added modality to enable generalisation and coaching of skills taught in the group at times of distress and crisis. It can also be used to preserve the therapeutic relationship. Telephone coaching follows a strict behavioural contingency and any inappropriate contacts, such as contacting following self destructive behaviour, are not accepted. The main functions of the weekly DBT team

consultation are to enhance adherence to the DBT model, create a supportive environment to minimise staff burn out and feelings of being stuck.

DBT research has been reviewed in this chapter. DBT evaluation studies have been mainly come from Linehan and her colleagues. However, some recent randomised controlled trials have originated from sources external to the creators of the model. DBT has quickly spread into diverse client groups and has been modified accordingly. DBT appears to be useful in the treatment of other impulse control disorders, as well as the treatment of BPD in other settings and at younger ages. Many authors have criticised DBT for not supplying enough empirical evidence for its immense popularity and exponential growth. Other authors have suggested that research concentrate on not merely showing effectiveness, but isolating what are the effective components of the treatment, predictors of response to treatment and mechanisms of change. A case study design has been put forward as an adequate means of examining these issues. Qualitative research has been lacking in clarifying the client impact of the treatment and the process of change for each client. In an Irish context, DBT practice is around 7 years old. Two service level investigations have looked at the quantitative effect of DBT.

There appears to be a number of gaps in our understanding of DBT at the point of writing. Research needs to move into process investigation as well as outcome. Mixed methodology research is well equipped to fulfil this requirement. It is recognised that something about DBT is effective. However, there appears to be a lack of consensus about what that set of active ingredients may be. Deciphering active ingredients and assessing the client impact of involvement in a particular intervention can be limited if it is restricted to quantitative investigation. A qualitative perspective can provide many answers, bring clarity to quantitative methods, and should no longer be ignored.

# CHAPTER FOUR

# METHODOLOGY

## **CHAPTER FOUR**

### **METHODOLOGY**

#### **4.1 INTRODUCTION**

Chapter 4 reiterates an overview of the study and outlines the research questions in depth. A justification of the mixed methodology and two-phase investigation is provided. Chapter 4 describes the methods used in each phase, including the design, procedure, sample, data analysis and ethical considerations. There is also a justification section of each design provided.

#### **4.2 OVERVIEW OF RESEARCH**

This research consisted of two main phases. Phase 1 was a qualitative investigation of the client impact of Dialectical Behaviour Therapy (DBT) for clients diagnosed with Borderline Personality Disorder (BPD). Phase 1 was divided into Section 1, which examined the subjective client impact of DBT on those who completed the full comprehensive DBT in Adult Mental Health settings in Dublin (“DBT completer group”), and Section 2, which described the client impact of DBT on those who discontinued treatment prematurely (“DBT drop-out group”). The clients’ perspective on treatment components, gauging impact of DBT, a description of life before DBT and assessing reasons behind early termination of attendance were among the themes covered in both sections. Initially, three pilot interviews were adopted to sharpen the focus of the content of the interviews in Phase 1 and were included in final analysis.

Phase 2 was a case study evaluation of the DBT programme for clients diagnosed with BPD in Adult Mental Health settings. A total of ten case studies from two sites were involved in this phase. Mixed methods were adopted with use of semi-structured qualitative interview, psychiatric admission records and outcome measurement. Case studies were integrated to evaluate change statistically, in order to decipher whether participation in DBT was linked to any change occurring in outcome measurements. In-depth longitudinal interviews also revealed changes occurring throughout treatment and contributed to an analysis of the ‘active ingredients’ of treatment. Finally the

findings for both phases were combined to comment on the overall client impact and ‘active ingredients’ of DBT.

### 4.3 OBJECTIVES

A number of objectives or research questions were outlined for this study, which can be answered through the overall mixed method design, encompassing Phases 1 and/or 2.

- 1) *To assess the clients’ perspective on their participation in the DBT programme.*

This goal was assessed by examining the clients’ reports of their time in therapy. It was believed that client views of treatment may vary depending on their progression in therapy. Hence all sample groups, that is, DBT completers, DBT drop-outs and DBT case studies, were asked to give an account of their treatment, in order to comprehensively answer the overall client perspective on the DBT programme.

- 2) *To gauge the impact that DBT has had on the lives of clients.*

The therapeutic impact on client lives was examined on multiple levels. Mixed methods were ideal for both elaborating on changes occurring as a result of therapy by describing transitions in clients’ own words and also substantiating this with outcome measurement. ‘Impact on life’ was estimated to fall under categories such as functioning/self-efficacy, well-being, level of problems, hopelessness etc. A conclusive definition for “Impact on life” prior to research was considered to be premature, and the findings in each phase brought together would themselves answer the question of the extent and content of change occurring in client lives contingent to treatment. The current client group and completers were expected to most appropriately resolve this query.

3) *To investigate reasons why clients drop out of the DBT programme.*

An objective of investigating the extent of the attrition rate that exists in the DBT programme was set out from the onset. It was believed that interviewing previous clients who dropped out would assist in constructing a picture of the reasons behind discontinuation of the DBT programme. Such findings were judged to have important relevance and pertinent for services running DBT programmes and research.

4) *To calculate change in symptoms in the client group.*

Change was calculated in the case study component of the study to gauge the overall clinical effect of treatment over the therapeutic year for those going through DBT.

5) *To isolate the most effective components of DBT.*

A joint analysis of service users' reports who completed DBT and those who were currently enrolled in treatment was completed in order to pinpoint what clients believed to be the most effectual elements of treatment. Findings from all sample groups were utilised to respond to this difficult question.

6) *To examine the clients' experiences of the Mental Health system.*

Prior experiences of treatments before being referred for DBT were included in this study. Views of the Mental Health system were taken from all DBT clients who participated in the study, because the study wanted to show what experiences of the care system clients referred for DBT typically present with and how this affected them personally.

7) *To determine the service and research implications of the findings.*

All findings for the whole mixed methods design including both phases were accumulated and compared to assess what important inferences and recommendations could be drawn that would be applicable to future empirical investigation and on a more practical level the delivery of DBT.

#### 4.4 RATIONALE BEHIND USE OF MIXED METHODS

Mixed method studies are defined as “investigations that involve integrating quantitative and qualitative data collection and analysis in a single study...the underlying logic of mixing is that neither quantitative or qualitative methods are sufficient in themselves to capture the trends and details of the situation. When used in combination, both quantitative and qualitative data yield a more complete analysis, and they complement each other” (Creswell, Fetters, & Ivankova (2004, p.7).

A vast amount of research articles have dealt with the utility of combining and integrating methods. “After a period in the pragmatic wilderness, mixed methods research has regained not just acceptability, but popularity, with a significant number of studies arguing the virtues in terms of greater understanding and/or validation of results” (Bazeley, 2004, p.2). Use of both qualitative and quantitative methods is analogous to zooming in and zooming out with a lens (Madley, 1982). He summarised that qualitative investigation provides depth to some of the causes behind changes, sharpens the focus on and provides additional explanations of the observed relationships, while quantitative methods provide a yardstick for measuring change. Madley concluded that “an integrated approach to therapy evaluation is the modality of choice where the study seeks to determine not only whether or not a complex program works, but also why and how well it works, and how it might be improved” (p.234)...when selecting methods and designing a study, evaluators should be receptive to the enormous potential that integrating methods offers to improving studies (p. 235)”.

Three different perspectives have emerged in terms of mixed methods research, namely purist, situationalist and pragmatist. Purism argues the approaches derive from different, mutually exclusive, epistemological and ontological assumptions about the nature of research. Essentially each approach is viewed as a dichotomous endeavour, in which naturalistic and experimental inquiries do not overlap. Situationalism maintains that both approaches have value, although certain approaches are more appropriate for specific situations. It is claimed that each method has usefulness in a specific situation or phase of the research process, yet this belief does extend to a view that either one method or another should be used, and that the situation dictates

when to use each. Both approaches are seen as complimentary but still as representing distinct universes (Rossman & Wilson, 1985). Pragmatism contends for integration of methods, and there is a growing impetus asserting that there are no good reasons for researchers to fear forging ahead with “what works” (Howe, 1988).

The present study concurs with the pragmatist approach. Denzin (1970, p.119) commented that “a false dichotomy exists between these two types of data”, and it should be noted that quantitative methods are not necessarily positivistic nor are qualitative ones necessarily phenomenological. Sechrest & Sidani (1995) claimed that the problems that are perceived to exist between the proponents of qualitative and quantitative appear to stem from misunderstandings and misstatements of the positions involved. Empirical inductivists and interpretists differ in their philosophical assumptions, and consequently the ways they collect and analyse data. Yet their ultimate tasks and aims are the same: describe their data, construct explanatory arguments from their data, and speculate about why the outcomes they observed happened as they did. Bazeley (2004, p.2) pointed out that “If one uses numbers, interpretation is still involved. If one’s data are texts, counting may still be appropriate”. Onwuegbuzie & Leech (2005) commented that mono-method research is the biggest threat to the advancement of the social sciences, extending this by commenting that as long as we stay polarised in research, how can we expect stakeholders who rely on our research findings to take our work seriously. They believe that the debate between the two fields has been divisive and counterproductive.

In the literature, there are extensive arguments clarifying how mixing methods allows improvement of the accuracy of conclusions by relying on data from more than one method. Among the rationale for integration of mixed methods includes:

- *Corroboration* – It brings together data collected through more than one method to see if there is convergence in the findings.
- *Elaboration* – It provides richness and detail, expanding understanding of the phenomenon through refinement and development. It can provide strength to an argument and provide a different perspective on the same phenomenon. It can be paralleled to “fleshing things out” or “putting meat on the bones”.

Clarification of results from one method with the results from the other method is possible. Mixed methods increase interpretability, meaningfulness, and validity of constructs and inquiry results by both capitalizing on inherent method strengths and counteracting inherent biases in methods (Greene, Caracelli & Graham, 1989).

- *Initiation (holistic triangulation)* – Aims to uncover paradox and contradiction, and possibly lead to a substantial alteration in the overall perspective of the problem. Divergent findings may set up dissonance, doubt and ambiguity leading to further analysis or even a recasting of the entire research question. Jick (1979, 603) commented “it is here that qualitative methods, in particular, can play an especially important role by eliciting data and suggesting conclusions to which other methods would be blind”. Hence there is a search for the confirmatory and the provocative.
- *Development* – This involves using the results of one study to help to inform or develop the other method, which helps to increase the validity of the constructs and inquiry by capitalising on inherent method strengths.
- *Expansion* - Mixed methods can increase the breadth and depth of inquiry results and interpretation by analysing them from different perspectives

Weinholtz, Kacer & Rocklin (1995) asserted another advantage of mixing methods, namely saving quantitative data by using qualitative data. Weinholtz (1995) described the “salvaging power” of qualitative methods in reference to their ability to ensure some return on an investment that might otherwise be partially or completely lost.

The present study followed a “Triangulation design model” (Creswell, et al 2004), in which neither method is given priority, both are of equal importance. Morgan (1998) gives a good description of how the level of priority and sequence of methods should be considered in mixed methodology research design. Both methods were implemented and analysed concurrently but separately. Integration of data occurred following individual analyses, and findings were considered in relation to one another, and conclusions will be formed from this, as shown in Figure 7. Integrated results encompassed both confirmatory/supportive and conflicting findings.

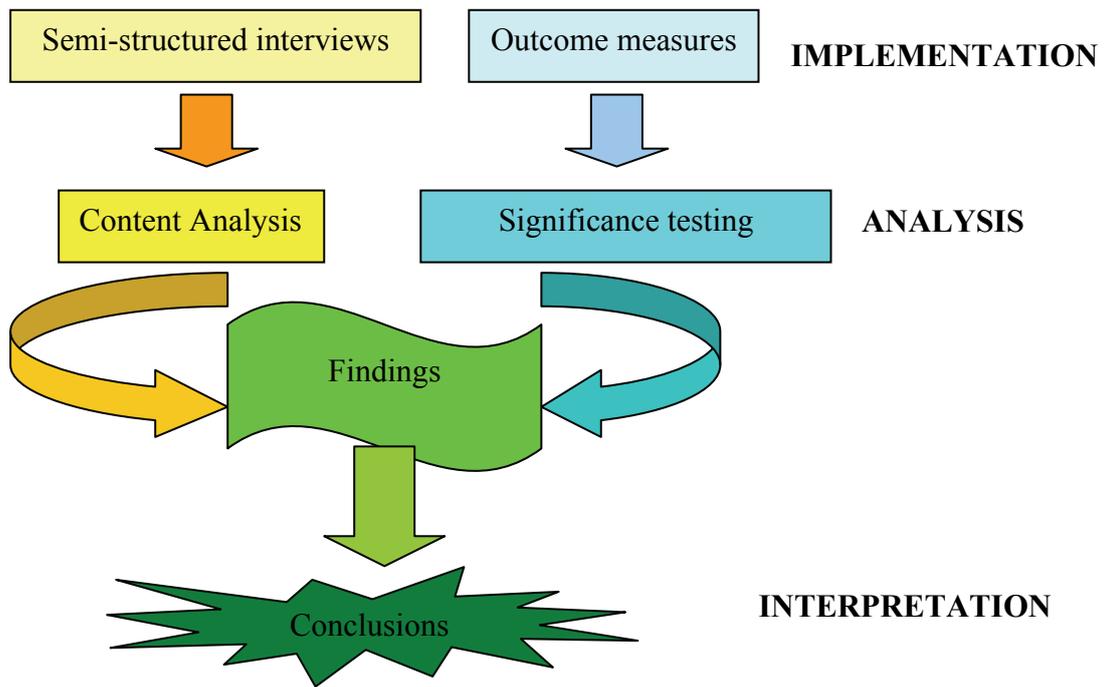


Figure 7: Use of mixed methods in the present study.

The many advantages of adopting a mixed methodology that were particularly relevant to the aims of the research can be viewed in Figure 8. It was argued that the objectives outlined earlier were best answered using mixed methods. Mono-method was enhanced, elaborated on, weaknesses were decreased by the addition and juxtaposition of an alternative method. Qualitative methods augmented quantitative components by giving a sense of completeness and plentiful illustrations. Mixed methods honed in on unexpected results more effectively than either method in isolation.

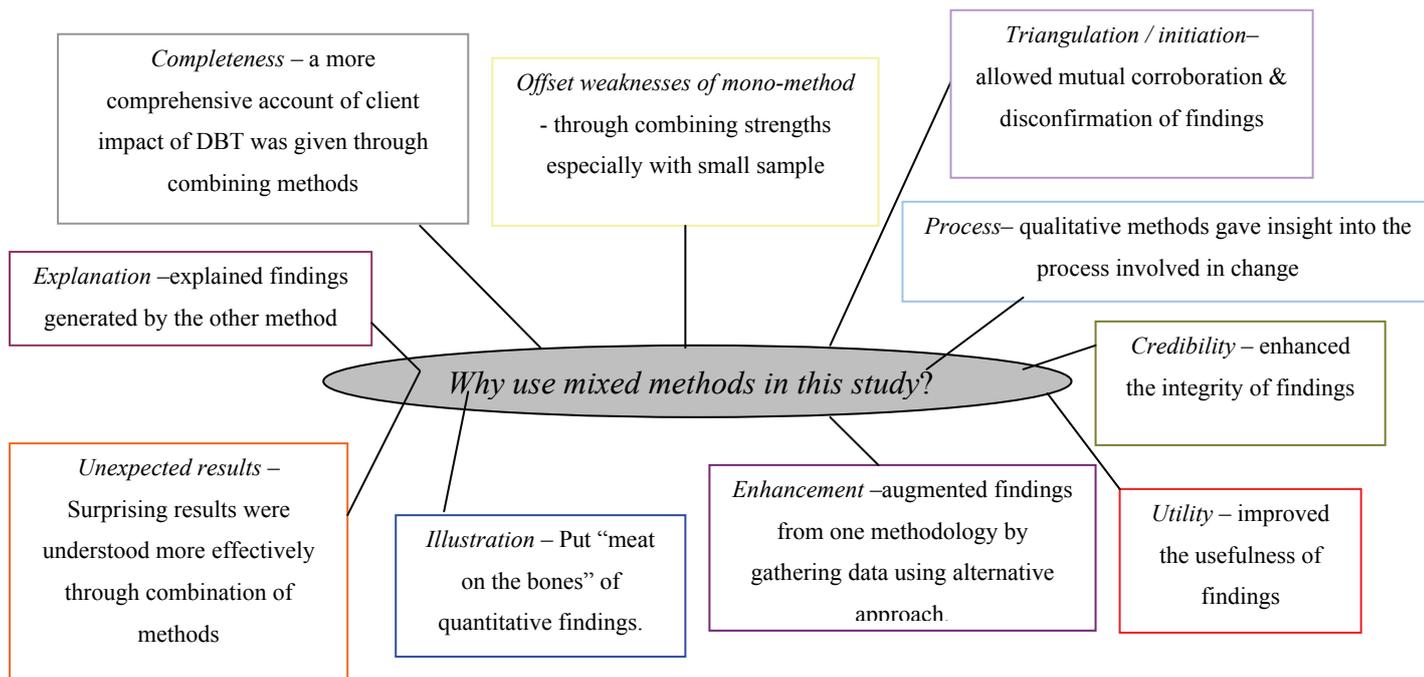


Figure 8: Benefits of adopting mixed methods in the present study.

#### **4.5 WHY NOT A RANDOMISED CONTROLLED TRIAL (RCT)?**

Randomised controlled trials are frequently considered the gold standard of research methodology, excluding the meta-analytic approach (Silagy, Jewell & Mant, 1994) as they can most effectively isolate treatment effects, predict effectiveness of treatment, have a control group for comparison, and can be statistically analysed. However, such a design for the present study was both inappropriate and unfeasible.

The throughput of clients completing a DBT programme within the study data collection would still be too small, even with the involvement of several services, to justify the implementation of such an approach. With the limited number of participants available, the present study utilised a mixed methods design with two phases, as this approach most effectively tackled the desired objectives. A mixed methods design was applied to take an in-depth analysis of the impact of DBT on clients. Although admittedly the approach has some limitations its benefits outweigh such a drawback.

Another reason a randomised controlled trial was unfeasible in the present study included the concerns around using a control group for this client group. Whether research participants were allocated to a psychiatric treatment as usual or a waiting list control group, substantial risks lay for clients not receiving the DBT treatment, creating an ethical dilemma. It could also be argued that it was too early for a randomised controlled trial. Mixed methodology design (incorporating two phases of investigation) was the most appropriate empirical examination at this stage, as the focus was of exploration of the client impact of DBT and what components of therapy may have the greatest impact. It was proposed that the study would reveal areas on which a pilot RCT study could be based in the future.

## **4.6 PHASE 1 QUALITATIVE INVESTIGATION**

### **4.6.1 DESIGN**

Phase one of the study used semi-structured interview questionnaires to investigate the impact of DBT on both the ‘DBT graduate group’ and the ‘DBT drop out group’. Both semi-structured questionnaires can be viewed in the Appendix 1 and 2.

### **4.6.2 SAMPLE**

All clients who attended the DBT programmes in either Site A between 2002-2006 (n=24) or Site B between 2006-2007 (n=10) were approached to participate in this Phase one of the study.

Inclusion criteria to gain entry into the DBT programme in both sites comprised of:

- All clients were resident within designated catchment area
- Aged between 18-65 years.
- Fulfilled criteria for the assessment interview for BPD on the SCID-II (First, Gibbon, Spitzer & Williams, 1997) or be judged to be making high demands on service and demonstrate clear BPD behaviours (e.g. regular self harming and suicide attempts)

- Were waitlisted for the DBT programme based on referral information indicating diagnosis of BPD and/or a history of parasuicidal/self harm behaviours
- Had good literacy levels and command of English

Individuals were excluded from inclusion in the DBT programme for the following reasons:

- Presence of an intellectual ability or organic impairment that would inhibit comprehension
- A present diagnosis of active psychosis
- Involvement in criminal proceedings
- Presence of severe untreated substance/alcohol abuse.

In Site A, a total of seventeen clients who completed the DBT programme were contacted to participate, two refused, one could not be contacted and one client was unable to participate due to illness. 13 agreed to participate in the study (76% of the total who completed the DBT programme). This figure consisted of 12 females and 1 male, aged 20 – 60 (mean=39.5 years, SD=11.2). Seven clients, who discontinued DBT treatment prematurely, were contacted, one refused to participate and two could not be contacted. Four former clients agreed to participate (77% of the total who dropped out of the DBT programme). This figure consisted of 3 females and 1 male, aged between 39-45 (mean=42 years, SD= 2.25).

In Site B, a total of five clients who completed the DBT programme were contacted to participate, two refused to participate. Three agreed to participate in this study (60% of the total who completed the DBT programme). This number was made of 2 females and 1 male, aged between 27-52 (mean=41 years, SD=9.3). Five clients who discontinued DBT treatment prematurely were contacted, three refused to participate. Two clients agreed to participate (40 % of the total who dropped out of the DBT programme). This total consisted of two females, aged between 39-55 (mean 47 years).

Taking the two Adult Mental Health sites together, the ‘DBT graduate group’ consisted of a total of 16, 14 females, 2 males, aged 20-60 years (mean=39.8 years,

SD=9.2). While the ‘DBT drop-out group’ consisted of a total of 6, 5 females, 1 male, aged 39-55 years (mean=44.2 years, SD=5.5). This information is shown below in Table 6. More detailed information is supplied in Table 4 and 5.

Table 4: Demographic information for the “DBT completer group”.

Participant Number	Location	Age	Gender
1	Site A	60	F
2	Site A	40	F
3	Site A	43	F
4	Site A	20	M
5	Site A	50	F
6	Site A	38	F
7	Site A	37	F
8	Site A	33	F
9	Site A	32	F
10	Site A	27	F
11	Site A	31	F
12	Site A	58	F
13	Site A	45	F
14	Site B	27	M
15	Site B	44	F
16	Site B	52	F

Table 5: Demographic characteristics of the “DBT drop-out group”.

Participant Number	Location	Age	Gender
1 DO	Site A	45	F
2 DO	Site A	44	F
3 DO	Site A	43	F
4 DO	Site A	39	M
5 DO	Site B	39	F
6 DO	Site B	55	F

Table 6: Overall demographic information for both participant groups in Phase one of the study.

	DBT graduate group	DBT drop-out group
Total participants	16	6
	(14 F, 2 M)	(5 F, 1 M)
Age range	20-60 years	39-55 years
	(mean 39.8 years, SD = 9.2)	(mean 44.2 years, SD = 5.5)

### **4.6.3 PROCEDURE**

Interview formats can be viewed for the ‘DBT graduate group’ (see Appendix A) and the ‘DBT drop-out group’ (see Appendix B).

The interviews with the respondents who completed the DBT programme covered the following areas:

- What kind of difficulties were you experiencing before being referred for DBT?
- How did these difficulties impact on your life?
- What have your experiences been like of the Mental Health services?
- What kind of diagnosis have you been given & how did you react to this?
- How was DBT explained to you?
- What were your expectations or first impressions of DBT?

- How did you find the individual psychotherapy?
- How did you find the skills group training?
- What skills worked for you, if any?
- How was the out-of-hours telephone consultation with your DBT therapist?
- What kind of changes did you notice over your time in the DBT programme?
- What were the frustrating or challenging parts of the DBT programme?
- What would you improve on if you designed the treatment?

Respondents who dropped out prematurely from the DBT programme were asked the following questions:

- What kind of difficulties were you experiencing before being referred for DBT?
- How did these difficulties impact on your life?
- What have your experiences been like of the Mental Health services?
- What kind of diagnosis have you been given & how did you react to this?
- What are your views of the DBT programme?
- What would you improve on if you designed the treatment?
- What were your reasons for discontinuing in the DBT programme?

Open ended questions as above were used firstly. Supplementary questions were generated according to responses from the interviewees. Interviews typically lasted 30-60 minutes and were tape recorded. The interviewer was not acquainted to any of the interviewees before the study. All interviews were held in the building where the DBT skills group had taken place.

#### **4.6.4 JUSTIFICATION OF DESIGN**

Phase 1 of the study used a qualitative investigation of both those who completed and those who discontinued the DBT programme. This design was proposed as enhancing the representativeness of the service-user evaluation of the DBT programme, as research participants provided a more balanced and inclusive evaluation of both positive and negative aspects of the DBT. The involvement of service users in the evaluation of services is becoming more expected and desirable (Stevenson, Jackson, Crowe & McGowan, 2005).

Qualitative investigation of DBT has been minimal worldwide apart from a few exceptions (Perseus, Ojenhagen, Ekdahl, Asberg & Samuelsson, 2003; Cunningham, Wolbert & Lillie, 2004) and non-existent in Ireland. Considering the exponential growth of DBT's popularity and its vast adaptations, it seems particularly unfortunate and imprudent that little research has taken place evaluating the client's perceptions of their participation in DBT. Therefore, a gap needed to be filled. Examination of the experience of the client served only to enhance our knowledge about the application of DBT.

In the last decade there has been movement towards the inclusion of service users in the evaluation and planning of Mental Health services. Service users have become recognised as worthy contributors of feedback and suggestions that can help to direct services and allow interventions to become more effective, as well as having more involvement in their own care decisions (Hickey & Kippling, 1998). Barnes & Wistow (1994) pointed out the critical significance of enabling users of Mental Health services to express a 'voice' which is acknowledged as valid by those professionally involved in their care. There is a growing consensus that involving users in the development of psychiatric services is no longer an option but a necessity (Crawford, 2001; Lammers & Happell, 2003). It is clear from these studies that assessing the client impact, which includes perceptions or perspectives of Mental Health services they receive, is not only recommended but also essential for the delivery of successful psychotherapy.

Additionally, interviewing drop-outs from treatment revealed the reasons behind such a high attrition rate in DBT and added another level of perspective. Common factors by which treatment is discontinued were revealed, which could be applied to future service development of the DBT programme. Treatment drop-out is a pervasive problem with levels estimated between 30-60% (Reis & Brown, 1999). It has already been reported in the literature that there is little concordance among the reasons cited by therapists and clients regarding clients' decisions to terminate therapy (Hunsley, Aubry & Vestervelt, 1999). Hynan (1990) reported that there is often a distinction between reasons for early and late termination. Early terminators tended to end therapy because of situational constraints and discomfort with services, whereas more late terminators left therapy because of improvement attributed to therapy than did early terminators. Later terminators also reported higher levels of belief that the

therapist respected them, therapist warmth, and therapist competency than did early terminators. This was beneficial to explore reasons why clients discontinued the DBT programme and this insight had many service and research implications.

The range of questions asked of each interviewee aimed to illuminate the typical picture of life for those referred to the DBT programme, their views of interactions with the Mental Health system to date, their perspectives on their participation in DBT, and what if any changes occurred for them since beginning in DBT. Each interviewee was encouraged to be as open and honest about their experiences as they felt comfortable to, and were specifically asked questions about the negative aspects of DBT and what they would change to allow them opportunity to give a balanced overview of their participation. All interviews and data analysis was carried out by the independent interviewer, who was not involved in anyway with the DBT teams.

#### **4.6.5 DATA ANALYSES**

Thematic content analysis was applied to all interviews (Burnard, 1991), which involved linking the themes and issues in each interview together under a reasonably exhaustive category system. An example of the analysis is provided in transcript form in Appendix F. The analysis was implemented using the following steps:

- 1) Transcripts were read through several times – notes were taken on general themes. The aim was to become immersed in data.
- 2) Re-read transcript & headings were written along side the important points made by interviewee. This was known as open-coding
- 3) A list of categories was surveyed. Similar categories were collapsed into broader ones.
- 4) A list of final categories was decided on, removing repetitious ones.
- 5) A second colleague (who was not familiar with DBT) completed same process without seeing main researcher's list. Then two lists were then discussed and adjustments were made, in order to reduce research bias.
- 6) Transcripts were then re-read to establish the degree to which final categories match original data. Each category was then highlighted according to each theme found.
- 7) These highlighted coded sections were cut out of the transcript and all items of each code were grouped together. Context was an important element to be

remembered here, as the original meaning of each interviewee must be maintained, so that individual meaning was not distorted in establishing a comprehensive overall meaning across interviews. These cut out sections were then pasted into another document with the appropriate headings and sub-headings.

## **4.7 PHASE 2 CASE STUDY DESIGN**

### **4.7.1 DESIGN**

Phase 2 is a multiple single case AB design using each subject as their own control, as measures were taken at baseline prior to participation in DBT, which could allow comparison across time. Mixed methods were used in a repeated measures format, allowing the formation of longitudinal picture of progress in qualitative and quantitative measures over the therapeutic year.

### **4.7.2 SAMPLE**

All clients who attended the comprehensive DBT programmes in Site A from November 2005 and Site C from March 2007 were invited to participate in Phase two of the study. All clients who began the DBT programme agreed to participate in the research. A total of six clients participated in Site A, aged between 23-50 years (mean = 36 years, SD = 5.9). A total of four clients participated in Site C, aged between 20-49 years (mean = 34.5 years, SD = 9.5). Taking the two sites together, the age range was 20-50 years (mean = 35.4 years, SD = 7.8). Table 7 contains the demographic information on each of the participants and Table 9 illustrates the overall information summarised. Table 8 shows the amount of time spent in the DBT programme for each research participant, which is recorded from their first attendance of the DBT skills group.

Participants 1, 2, 4, 5, 6 and 9 discontinued treatment prematurely and did not finish one year in the comprehensive DBT programme. Hence these participants no longer took part in the research assessments and only partial data could be collected. An attrition rate of 60% was calculated, which warranted discussion.

Table 7: Demographic information for each participant in Phase 2.

Participant Number	Location	Age	Gender
1	Site A	50	F
2	Site A	34	F
3	Site A	39	F
4	Site A	41	F
5	Site A	29	F
6	Site A	23	M
7	Site C	49	F
8	Site C	29	F
9	Site C	20	F
10	Site C	40	F

Table 8: Amount of time spent in therapy by each participant in Phase 2.

Participant Number	Location	Month of pre-therapy assessment	Time spent in the DBT programme
1	Site A	November 2005	8 months (D.O.)
2	Site A	November 2005	6 months (D.O.)
3	Site A	September 2006	10 months +
4	Site A	September 2006	8 months (D.O.)
5	Site A	January 2007	2 months (D.O.)
6	Site A	January 2007	4 months (D.O.)
7	Site C	March 2007	12 months
8	Site C	March 2007	12 months
9	Site C	March 2007	6 months (D.O.)
10	Site C	September 2007	6 months ++

+ The skills group ended in Spring 2007 and Case study 3 continued in individual sessions.

++ Case study 10 was no longer part of the research after this point, however continued in individual treatment.

Table 9: Overall demographic information for the DBT case studies in Phase two.

	DBT case studies
Total participants	10 (9 F, 1 M)
Age range	20-50 years (mean = 35.4 years, SD = 7.8)

### **4.7.3 PROCEDURE**

A combination of qualitative and quantitative methods were administered at each research assessment interview. Each participant was invited to a research assessment before beginning the DBT skills group (pre-therapy baseline assessment), and at the start of every new skills module (every two months) until the end of one year in treatment. Thus research assessments took place at 0, 2, 4, 6, 8, 10 and 12 months of the DBT skills group attendance, a total of seven assessments.

### **4.7.4 MEASURES USED**

Table 10 shows the timetable of administration of each measure. Certain measures were utilised every two months, while others were only given at baseline, mid treatment and at end of treatment. Each measure was chosen at the proposal stages of the research and was designated to measure a key component of the typical change observed in clients with BPD. A balance between not overloading research participants with outcome measures and also achieving the most comprehensive assessment possible was debated. The following schedule of implementation of the outcome measures was viewed as most appropriate and judicious.

Table 10: Schedule of multiple assessment points.

	Interview	CORE	ZAN-BPD	WHO-QOL	PSS	KIMS	BHS	Use of health services
1 week pre DBT*	✓	✓	✓	✓	✓	✓	✓	✓
2 months into DBT	✓	✓			✓	✓	✓	
4 months into DBT	✓	✓			✓	✓	✓	
6 months into DBT	✓	✓	✓	✓	✓	✓	✓	✓
8 months into DBT	✓	✓			✓	✓	✓	
10 months into DBT	✓	✓			✓	✓	✓	
1 week post DBT	✓	✓	✓	✓	✓	✓	✓	✓

\* = Start of clients' participation in the skills group component. Hence DBT refers to the full range of therapeutic components.

CORE – Clinical Outcome for Routine Evaluation

(Barkham, Evans, Margison, McGrath, Mellor-Clark, Milne & Connell, 1998)

ZAN-BPD – Zanarini measurement of Borderline Personality Disorder symptoms

(Zanarini & Frankenburg, 2001)

PSS – Perceived Stress Scale

(Cohen, Karmarck & Mermelstein, 1983)

BHS - Beck Hopelessness Scale

(Beck, 1978)

WHOQOL-BREF – The World Health Organisation Measure of Quality of Life

(Brief Version)

(WHO, 1996)

#### 4.7.4.1 QUANTITATIVE METHODS

##### 4.7.4.1.1 Outcome measures

The following outcome measures were administered at research assessments and can be viewed below in Table 11.

Table 11: List of outcome measurement used and accompanying rationale.

<u>Measure</u>	<u>What it measures</u>	<u>Rationale for use</u>
<u>Perceived Stress Scale</u> (Cohen, Karmarck & Mermelstein, 1983)	Clients' perceived level of stress over previous month.	Level of self-reported stress was expected to decrease as clients moved through DBT contract. Change should reflect skills developed in distress tolerance and emotional sections of skills group training.
<u>Beck Hopelessness Scale</u> (Beck, 1978)	Respondents' attitude to future	Level of hopelessness was hypothesised as decreasing as DBT may give client hope for the future.
<u>Kentucky Inventory of Mindfulness Scales</u> (Baer, Smith & Allen, 2004)	Mindfulness skills	Level of mindfulness should improve as client makes way through mindfulness training in the skill group training.
<u>CORE</u> (Barkham, Evans, Margison, McGrath, Mellor-Clark, Milne & Connell, 1998)	Global psychological functioning	Measured areas such as risk, well being, functioning, and problems, which was expected to show change following some time in treatment.
<u>ZAN-BPD</u> (Zanarini & Frankenburg, 2001)	BPD Symptoms	Monitored BPD symptoms across four key areas, with change expected in areas through the course of therapy.
<u>WHOQOL-BREF (WHO, 1996)</u>	Quality of life	Gauged clients' overall interpretation of their well-being and was expected to decrease, as therapy aims to give client a "life worth living" (Linehan, 1993).

### Perceived Stress Scale (Cohen, Kamarck & Mermelstein, 1983)

The PSS is a brief, user-friendly, commonly used self-report instrument used to assess the degree to which life is appraised as stressful. There are a total of 10 items on the scale and they are designed to tap into how uncontrollable, unpredictable and overloaded respondents perceive their daily lives. The questions cover the period of the last month and in each case respondents are asked how frequently they feel a certain way. The scale ranges from '0 – never' to '4 – very often'. The total score of perceived stress is the sum of all the items and high total scores denote high perceived stress. A score range of 0-40 is possible.

In terms of psychometric qualities, the PSS has been proven to possess substantial reliability and validity (Cohen et al, 1983). The PSS has adequate internal and test-retest reliability. Coefficient alpha reliability for the PSS was between 0.84-0.86 for three samples and test-retest correlation was 0.85. The PSS was correlated with life-event scores, depressive and physical symptomology, utilisation of health resources and social anxiety. The PSS was judged to be a better predictor of the outcome in question than life-event scores. When compared to a depressive symptomology scale, the PSS was found to be a measure a different and independently predictive construct.

In a later study, Hewitt, Flett & Mosher (1992) administered the PSS to a sample of 96 psychiatric patients. They found that the PSS consisted of primarily two factors, items reflecting adaptational symptoms and those reflecting coping ability. They reported that both factors have adequate degrees of internal consistency. In a similar study, Pbert, Doefler & DeCosimo (1992) discovered that perceived stress was significantly correlated with self-reported negative affect and physical symptoms. A major finding of this study was that perceived stress scores were significantly correlated with affective and physical symptoms even after the variance associated with life events had been taken out.

*Rationale for use of PSS for this study* - Perceived level of stress was certainly of particular relevance to the BPD population, since they experience “unrelenting crises”, that is a series of stressors which appear to be unmanageable, unpredictable and extremely burdensome. Typically clients with BPD are ill-equipped with the

skills to manage these stressors effectively and they tend to have strong emotional responses to such stress, which can be related to self destructive behaviours. Therefore it was expected that as clients are taught new skills to cope with this stress, that their level of perceived stress will decrease accordingly. The PSS was administered every two months to capture any shifts in the level of perceived stress that could be correlated with the assimilation and application of the skills. The PSS did not provide information on cut off points or interval levels to allow interpretation of clinical significance.

#### Beck Hopelessness Scale (Beck, Weissman, Lester & Trexler, 1978)

This scale was designed to quantify hopelessness and has been shown to possess a high degree of internal consistency. The scale showed a relatively high correlation with the clinical ratings of hopelessness and other self-administered ratings of hopelessness (Beck et al, 1978). Furthermore the scale was sensitive to changes in the patient's state of depression over time. The scale consists of 20 true-false statements of which 9 are keyed in false and 11 keyed true. Each response is assigned a score of 0 or 1, and the total hopelessness score is the total of all the positively scored individual items. The higher the total score the more hopeless the respondent is considered. A range of 0-20 is possible.

A coefficient alpha score yielded a reliability coefficient of 0.93, which can be considered very good. Concurrent validity of the scale was shown to be good, with clinical ratings of hopelessness correlated at 0.74 in a general practice sample and 0.62 in an attempted suicide sample. Inter-rater reliability of two judges was calculated to be 0.86. Construct validity was also tested and numerous hypotheses were supported. Among these hypotheses were that depressed patients have an unrealistic negative attitude from the future, which is reduced when the patient recovers clinically from his depression. Seriousness of suicidal intent is more highly correlated with negative expectancies than with depression.

Factor analysis was completed on the scale, and three distinct factors were identified, affective, motivational and cognitive respectively. The affective component or 'feelings about the future' was defined by items 1, 6, 13, 15 and 19, revolving around

associations such as hope, happiness, faith and enthusiasm. The second factor was labelled 'loss of motivation' and is associated with items 2, 3, 9, 11, 12, 16, 17 and 20, encompassing concepts such as giving up, deciding not to want anything and not trying. The third factor was described as 'future expectations' and is defined by the remaining items 4, 7, 8, 14, and 18 and is linked with concepts such as 'dark future', 'things not working out' and 'future being vague and uncertain'.

*Rationale for use of BHS in this study* – The BHS is a strong scale with very good psychometric qualities. The concept of hopelessness or negative expectations about the future is particularly pertinent in treating clients with BPD. The BHS can be used as a sensitive indicator of suicide potential (Beck, Brown, Berchick, Stewart & Steer, 2006). From a sample of almost 2,000 participants this team of researchers found that level of hopelessness was significantly related to suicide. A scale cut-off score of 9 or above identified 16 (94.2%) of the 17 patients who eventually committed suicide, thus replicating a previous study with hospitalised patients. The high-risk group identified by this cut-off score was 11 times more likely to commit suicide than the rest of the outpatients.

The BHS has also been shown to be of particular importance in clients who self harm. Palmer & Connelly (2006) found that BHS was significantly higher among a prisoner sample who self harmed than those who did not. They concluded that prisoners with a previous history of self harm are more likely than those without to show a range of depressive symptoms than their imprisoned peers without such a history, suggesting a continued vulnerability to self harm and perhaps suicide.

Thus, considering the relevance and utility of the BHS in relation to both indicating suicide risk and being linked to self harm, this scale was used in the present study. The BHS was insightful not only to reveal a client's level of hopelessness, but it could be linked to treatment progression, engagement and suicide risk. The BHS was administered at every two-month assessment, as the level of hopelessness was judged to be so important, informative and indicative of change. Clinically significant change within the BHS was judged to be movement from one interval level to the next (e.g. moderate to mild).

### Kentucky Inventory of Mindfulness Scales (Baer, Smith & Allen, 2004)

The KIMS is a 39 item self report inventory that is used for the assessment of mindfulness skills. Mindfulness can be defined as focusing ones attention in a non-judgemental way or accepting the experience occurring in the present moment (Baer et al, 2004). The scale can be used to clarify strengths and weaknesses in clients' development of different mindfulness skills. Items are rated on a 5 point Likert scale ranging from 1 (never or rarely true) to 5 (always or always true). Each item describes either the presence or absence of skills and is scored accordingly. High scores reflect more mindfulness. A total score of 39 – 195 is possible.

The KIMS is used to assess 4 mindfulness skills:

- Observing: mindfulness involves observing, noticing or attending to various stimuli including internal phenomena (cognitions, bodily sensations) and external phenomena (sounds, smells). Items: 1, 5, 9, 13, 17, 21, 25, 29, 30, 33, 37, 39.
- Describing: involves participant describing, labelling, or noting of observed phenomena by applying words in a nonjudgmental way. Items: 2, 6, 10, 14, 18, 22, 26, 34.
- Acting with awareness: being attentive and engaging fully in one's current activity. Includes the DBT skills of 'participating' and 'one-mindfully'. Items: 3, 7, 11, 15, 19, 23, 27, 31, 35, 38.
- Accepting (or allowing) without judgment: to allow reality or what is there, to be as it is without judging, avoiding, changing, or escaping it. Items: 4, 8, 12, 16, 20, 24, 28, 32, 36.

In terms of its psychometric qualities, the instrument has good internal consistency. Alpha coefficients for each of the four mindfulness skills ranged from 0.76 - 0.91. Good test-retest reliability with correlations for each measure ranging from 0.65 -0.86 were also reported. Good content validity has been found for the scale. Concurrent validity would appear to be good, as the scale correlates with the Mindfulness Attention Awareness Scale (MAAS: Brown & Ryan, 2003) and the Trait Meta-Mood Scale (TMMS; Salovey, Mayer, Goldman, Turvey & Palfai, 1995) a measure of emotional intelligence, and the Conscientiousness and Openness scale of the NEO-FFI (Baer et al, 2004).

*Rationale for use of the KIMS in this study* – Since mindfulness is considered a huge component of DBT, it was certainly useful to see if the level of mindfulness did change across the therapeutic year. Mindfulness is an acceptance skill and this could help clients cope with many of the typically distressing emotions in BPD. It was helpful to gauge the role mindfulness could play in change and therapeutic progression. The KIMS did not provide information on cut off points or interval levels to allow interpretation of clinical significance.

Clinical Outcome for Routine Evaluation - CORE (Barkham, Evans, Margison, McGrath, Mellor-Clark, Milne & Connell, 1998)

Global Psychological change was assessed using self-report instrument CORE, which is specifically designed to measure outcomes in psychotherapy. It examines four domains including well-being, social functioning, symptoms and risk to self and others. This scale contains a total of 34 items, which are rated on a 4 point scale in terms of frequency of experiencing each item, from 0 (not at all) to 4 (most or all the time). A total score between 0 – 136. The higher the score is, the more psychological difficulties would appear to be present in the previous week for the respondent.

The four domains include items covering:

- Well being (Items 4, 14, 17, and 31)
- Risk (Items 6, 9, 16, 22, 24, and 34)
- Problems (Items 2, 5, 8, 11, 13, 15, 18, 20, 23, 27, 28, and 30)
- Functioning (Items 1, 3, 7, 10, 12, 19, 21, 22, 29, 32, and 33)

The CORE has been tested in numerous different sites, and is considered widely acceptable (Evans *et al*, 2000). Analyses of over 2,000 responses show good reliability and convergent validity against longer and less general measures; small gender effects; large clinical/non-clinical differences and good sensitivity to change.

*Rationale of use of the CORE in this study* – It was pertinent to collect data on global psychological functioning, which perhaps would capture small changes over short two

month periods. Self-report information was gathered on functioning, problems, well-being and risk, which would be useful in deciphering change that may be occurring. In terms of clinical significance, change from clinical levels to below cut off range was interpreted as noteworthy.

### ZAN-BPD (Zanarini & Frankenburg, 2001)

The ZAN-BPD is a clinician administered scale for the assessment of change in DSM-IV BPD psychopathology. Each of the nine criteria for BPD is rated on a five point rating scale of 0-4, yielding a total score of 0-36.

The ZAN-BPD examines four key areas:

- Affective disturbance (including inappropriate anger, marked reactivity in mood, chronic feelings of emptiness)
- Cognitive disturbance (including identity disturbance, transient paranoid ideation/ severe dissociation)
- Impulsivity (including binge eating, drinking heavily, drug taking, frivolous spending, sexual promiscuity, law breaking; also takes in self mutilation)
- Disturbed relationships (including frantic efforts to avoid real/imagined abandonment, unstable interpersonal relationships alternating between extremes of idealization and devaluation)

The scale has good psychometric qualities (Zanarini & Frankenburg, 2001). The convergent validity of the ZAN-BPD and relevant scales of the SCL-90 and the DIB-R was assessed and found to be highly significant. The discriminant validity of the various scores of the ZAN-BPD was also judged to be highly significant, easily discriminating the 139 patients who met the DSM-IV criteria for BPD from the 61 patients who did not. In addition, internal consistency of the ZAN-BPD was discovered to be high (Cronbach's  $\alpha=0.85$ ). The interrater reliability of the ZAN-BPD was assessed using 32 conjoint interviews and was found to be in the good to excellent range. When compared to the SCL-90 over time in a sample of 41 patients, ZAN-BPD measures change in a clinically meaningful manner.

*Rationale for using the ZAN-BPD in this study* –The ZAN-BPD was undoubtedly very useful to measure symptoms of BPD over time. In the present study this scale was administered three times, at baseline before starting the group, at mid point (6 months) and at the end of one year attending the full DBT programme. Change could be assessed across the four areas covered in the ZAN-BPD. The ZAN-BPD did not provide information on cut off points or interval levels to allow interpretation of clinical significance.

#### WHOQOL-BREF (WHO, 1996)

The WHOQOL-BREF is an abbreviated version of the WHQOL-100 and is used to assess self-reported quality of life, which is defined as an “individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (p.3). Hence, this definition reflects the view that quality of life refers to a subjective evaluation which is embedded in a cultural, social and environmental context. The scale refers to the last two weeks. A total of 26 items are covered in the scale with each item being rated on a 5 point scale from 1 (very dissatisfied/very poor/not at all) to 5 (very satisfied/very good/extremely). A total score of between 26 – 130 is possible.

The WHOQOL-BREF is subdivided into the following domains:

- Physical health (Items 3, 4, 10, 15, 16, 17, and 18)

Includes Activities of daily living, dependence on medicinal substances and medical aids, energy and fatigue, mobility, pain and discomfort, sleep and rest & work capacity

- Psychological (Items 5, 6, 7, 11, 19, and 26)

Includes bodily image and appearance, negative feelings, positive feelings, self-esteem, spirituality/religion/personal beliefs, and thinking, learning, memory and concentration

- Social relationships (Items 20, 21, and 22)

Includes personal relationships, social support, and sexual activity.

- Environment (Items 8, 9, 12, 13, 14, 23, 24, and 25).

Includes financial resources, freedom, physical safety and security, health and social care: accessibility and quality, home environment, opportunities for acquiring new information and skills, opportunities for recreation/leisure activities, physical environment (pollution /noise/traffic, etc), transport.

The WHOQOL is a well established and tested instrument. Many studies have been published documenting good-excellent psychometric quality of the WHOQOL-BREF (Berlim, Pavenollo, Caldieraro & Fleck, 2005; Tsutsumi *et al*, 2006). The WHOQOL-BREF has shown good convergent validity with the Beck Depression Inventory. The scale has shown good internal consistency and sensitivity to treatment effects.

*Rationale for use of the WHOQOL-BREF in the study* – Quality of life would appear to be an important variable in the considering change in the lives of clients with BPD. Involvement in the DBT programme would expect to impact on a client’s quality of life, particularly in areas such as psychological and social domains. However, this would expect to be a slower change than other variables, so this scale was only administered at baseline, six months and after one year of the skills group. WHOQOL-BREF did not provide information on cut off points or interval levels to allow interpretation of clinical significance

#### **4.7.4.1.2 Medical records**

In order to assess the impact of DBT on client’s lives through another source of evidence, medical records of the clients’ use of psychiatric inpatient services were gathered. Records were examined to calculate the frequency and length of psychiatric admissions for clients prior to their participation in the DBT programme and for the duration of the DBT programme.

*Rationale of use of medical records in this study* - It is widely recognised that behaviours surrounding BPD render it among the most costly of conditions, not only emotionally but financially (Lawlor, 2000). Examination of DBT clients’ use of

psychiatric services prior to and during treatment provided insight into whether this level of outside support decreases as the client passes through therapy.

#### **4.7.4.1.3 Attendance of DBT**

The level of attendance of skills group training and individual psychotherapy was recorded. Attendance record was scored as follows:

Excellent – 86% -100%

Very good – 70% - 85%

Moderate – 55% - 69%

Fair – 40% -54%

Dissatisfactory – 0% - 39%

*Rationale of use of attendance figures* - Attendance was a useful source of information to gauge the level of client commitment and engagement in the DBT programme. Poor attendance usually indicated some problem with client interpretation of a component of therapy, unsteady therapeutic alliance, fading motivation, or preoccupation with other issues.

#### **4.7.4.2 QUALITATIVE METHODS**

As shown in Table 11 a semi-structured interview took place with all research participants in Phase two of the research before starting in the skills group, and at the end of each skills module (every two months) until the end of one year in the full DBT programme. A copy of all the questions used is available in Appendix C. The main questions covered in each interview:

At baseline:

- Challenges experienced before treatment
- How these were coped with.
- Experiences of the Mental Health system
- Experiences of therapy to date
- Any expectations or hopes for skills group and therapy as a whole

At end of skills module (2, 4, 6, 8, and 10 months):

- Any changes occurring in previous 2 months
- Experiences about specific components of DBT – individual, telephone coaching, skills group.
- Understanding and application of skills of previous module

At end of one year in skills group (12 months):

- Views of instrumental elements of DBT for them
- General reflections of therapy both positive and negative
- Anything respondent would change about therapy

All interviews covered specific open questions, which included set areas but also gave the interviewee an opportunity to explore the question in whatever desired direction. Follow up questions were used afterwards to achieve greater clarity of understanding and to add focus to an interview. The semi-structured layout allowed easier data analysis at a later stage.

*Rationale for use of qualitative component in the study* - Examination of the experience of the client served only to enhance our knowledge about the application of DBT. Insight was gained into the clients' interpretations of changes that have occurred throughout the therapeutic process, as well as feelings and thoughts about therapy, which could be used to improve the effectiveness and user-friendliness of DBT in the future. It was useful to grasp what are the key components of DBT from a client's perspective. Regular interview assessments provided insight into the processes that a client experiences at distinct points and what stages the clients typically go through during DBT, providing a snapshot.

All interviews were carried out by the author, who was not involved in anyway with the DBT team. This precaution minimised the potential for interviewees asserting beliefs that they believe the investigator wants to hear, as the investigator explained fully that the research project was independent of the DBT team. Every opportunity was taken in interviewing to encourage clients to recall negative interpretations of therapy as well as positive.

#### **4.7.5 JUSTIFICATION OF THE SINGLE CASE STUDY DESIGN**

Yin (1984) defined the Single case study design as “an empirical inquiry that investigates a contemporary phenomenon within its real life context, when the boundaries between the phenomenon and the context are not clearly evident, and in which multiple sources of evidence are used” (p.23). Investigation of the impact of DBT in the treatment of BPD clients in a real world setting was valuable. Although randomisation was not possible due to small numbers involved, a baseline control facilitated comparison with measures for clients completed during therapy. The case study design allowed each client to serve as his/her own control.

Another feature in favour of the use of the case study design is that it provided much needed in depth and contextual information for individual clients. Yin (1994) stated that when process issues are involved, multiple sources of evidence and cases studies offer a holistic perspective allowing a fuller exploration of an issue. Case study design is also associated with capturing the uniqueness and wholeness of an individual and is extremely important (Stake, 1995). It has been suggested that collective Case study design is useful in theory building (Stake, 1995). It is common that group comparisons striving for external validity can in the process mask intriguing and telling individual differences, and produce an unrepresentative “average” result, which is applied to all research participants, revealing little about in which context the treatment has not worked or in contrast has worked particularly well. It was argued that generalizability can be achieved through replication (Hersen & Barlow, 1976). Such transferability to a wider group, in the form of analytical generalisation rather than statistical generalisation is possible (Jones & Lyons, 1996).

#### **4.7.6 DATA ANALYSES**

##### **4.7.6.1 QUANTITATIVE COMPONENT**

The following procedure for data analyses dealt with the quantitative data for each case study in Phase two:

- 1) All outcome measures were scored for each assessment point for each case study.
- 2) These figures were represented in tabular form
- 3) Percentage change from baseline figures for each outcome measure and this were graphed.
- 4) Statistical change for all case studies combined was analysed with use of effect size calculations (Cohen, 1992) and Wilcoxon Signed Rank Test.
- 5) Admission totals in psychiatric records and DBT attendances were computed for each individual case study.

#### **4.7.6.2 QUALITATIVE COMPONENT**

A thematic content analysis procedure similar to Burnard's (1991) method was applied to all interviews for each case study in Phase two. The method was adapted for use with longitudinal interview data. Please refer to Phase one for greater detail on this method.

#### **4.7.6.3 INTEGRATING FINDINGS**

A 'grounded inductive approach' (Morgan-Ellis, Alexander, Cronin, Dickinson, Fielding, Sleney & Thomas, 2006) was applied in order to integrate each set of findings. It was developed through a focused iterative process of data integration, which aims to interweave the findings that emerge from each dataset. The value of this integrative analytic approach lies in allowing an inductive lead to the analysis, preserving the value of the open, exploratory, qualitative inquiry but incorporating the focus and specificity of the quantitative data.

Findings for both qualitative and quantitative components were integrated at this point with equal importance and significance given to both. The following questions were asked of each case study. However, the data itself inspired further hypotheses and generated further questions.

- 1) Was there change in the outcome measures over therapeutic year? How does this relate or contrast with the findings of the parallel semi-structured interviews with each interviewee?
- 2) Did the level of psychiatric admissions change for the therapeutic year? Can this be related to what was reported by the interviewee?
- 3) Can the level of skills usage and application mentioned in the interviews be linked to performance in outcome measures etc?
- 4) How did the interviewee feel she/he changed if at all? When did this happen? What was this change attributed to?

Findings in both qualitative and quantitative analysis were assessed for the amount of corroboration and divergence. Each method was used to reflect, clarify, elaborate, illustrate, question, substantiate the findings of the other.

Following this integrative and inductive process a considerable amount of information needed to be condensed to produce a concise yet accurate and comprehensive picture of the impact of one year of DBT on each client. Once each case study was consolidated and a full picture of the impact of DBT for that particular client was deciphered, patterns and distinctiveness of findings across case studies were formulated. From this inductive process conclusions, clinical implications and recommendations could be drawn.

## **4.8 ETHICAL CONSIDERATIONS**

### **4.8.1 PHASE 1**

All interviewees gave their full consent to participate. An information sheet and consent form were given to each participant, and these were explained to them orally and in writing. All information sheets and the consent form can be viewed in Appendix D. All participants were made aware that their contribution was entirely voluntary, that they could exit interviewing at any point and that their participation did not impact on the future provision of any treatment. Interviewees were also told that any dissemination of the data would be anonymised as far as possible.

Interviewees were informed that they could feel free not to answer any question which made them feel uncomfortable, and that there were no right or wrong answers to questions.

The risk that the interview would evoke any negative reaction was strongly considered, and in order that this was managed, the interviewer frequently checked in with the participant about how they were feeling and also informed their key worker of their participation in the research (see Appendix E).

Ruof (2004) noted that in the WHO (2002) ‘International Ethical Guidelines for Biomedical Research involving Human subjects’ Guideline 13 declares that “Special justification is required for inviting vulnerable individuals to serve as research subjects and, if they are selected, the means of protecting their rights and welfare must be strictly applied”. This research was mindful that participants who have been diagnosed BPD could be particularly vulnerable to experiencing a negative response to recounting their past. Research investigation of sensitive issues, such as suicidal feelings, childhood abuse, poor treatment in Mental Health system, could precipitate intense emotions in informants. Participants need an opportunity to discuss their feelings, and a contact for additional help needs to be identified and provided following the interviews (Alty & Rodham, 1998; Murray, 2003). In this study, the consultant psychiatrist was contacted alerting them that their client had agreed to participate. In addition to this each individual therapist (if the client was still engaged in treatment) or key worker was asked to check in with the research participant in order that any subsequent distress or worry could be dealt with as effectively as possible. If a client no longer connected with Mental Health services was distressed by any of the interview content, contact details of a Psychotherapist were offered.

Dublin City University, St. Vincent’s Hospital, Fairview and St. Ita’s Hospital, Portrane, Co. Dublin Ethics committees approved the Phase one of this study. Copies of relevant letters of approval are in Appendices H, G and I respectively.

#### **4.8.2 PHASE 2**

As for Phase one, the above ethical considerations were taken also into account. The risk that the interview would evoke any negative reaction was strongly considered as in Phase one, and in order that this was managed, the interviewer frequently checked in with the participant about how they were feeling and also informed their consultant psychiatrist of their participation in the research. In addition each individual therapist was asked to check in with the research participant in order that any subsequent distress or worry could be dealt with as effectively as possible.

Dublin City University, St. Vincent's Hospital, Fairview and St. James' Hospital/Adelaide Meath National Children's Hospital research ethics committees approved the Phase two of this study. Copies of relevant letters of approval are in Appendices H, G, and J respectively.

# **CHAPTER FIVE**

## **FINDINGS 1**

### **CHAPTER FIVE**

#### **FINDINGS 1**

##### **5.1 SECTION 1: DBT COMPLETERS**

In order to gauge the impact of DBT on clients, 16 clients who completed the DBT programme and 6 who dropped out prematurely were interviewed. A semi-structured

format was implemented in each interview, and content analysis (Burnard, 1991) was applied to the data by two independent investigators. The structure of each interview was arranged to answer the following interview questions:

1. What was your life like before DBT?
2. What were your experiences like of DBT?
3. What kind of impact, if any, do you think DBT had on your life?

In accordance with the above interview questions, the following areas have emerged from the data:

Table 12: Division of overall themes in the “DBT completers group”.

<b>A. LIFE BEFORE DBT</b> <b>B. EXPERIENCES OF DBT</b> <b>C. IMPACT OF DBT</b>
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### 5.1.1 QUESTION AREA A: LIFE BEFORE DBT

The first question area was “What was life like for you before DBT?” and can be subdivided into the following themes:

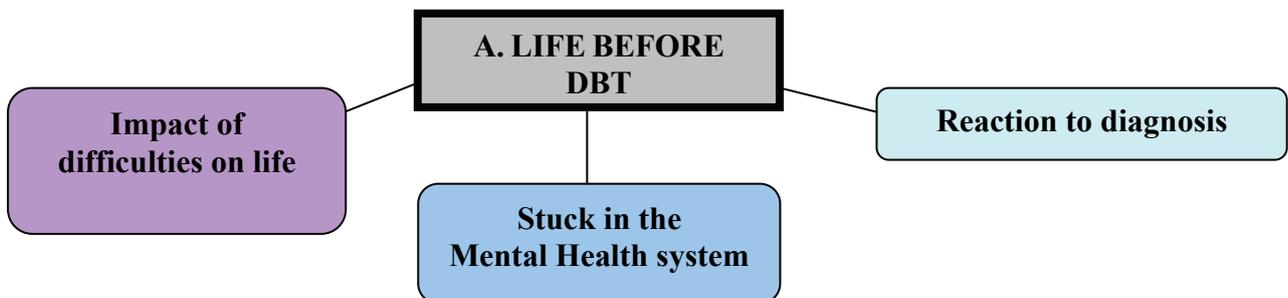


Figure 9: Subdivisions of Question Area A: “Life before DBT”.

Table 13: Theme & sub-theme breakdown for Question Area A.

Question Area	Themes found	Sub-themes found
		<i>DSH – Chronic, severe &amp; of multiple origin</i>

<b>AREA A</b>  <b>LIFE BEFORE DBT</b>	<b>Impact of difficulties on life</b>	<i>DSH &amp; Suicide attempts</i>
		<i>Tangled web of difficulties</i>
	<b>Stuck in the Mental Health system</b>	<i>Never ending hopelessness &amp; readmissions</i>
		<i>Veterans of the Mental Health system</i>
		<i>Failure of the psychiatric services</i>
		<i>Ineffective drug treatment</i>
		<i>Lack of continuity</i>
		<i>Disappointing Accident &amp; Emergency treatment</i>
		<i>Light at the end of the tunnel</i>
	<b>Reaction to diagnosis</b>	<i>Little understanding &amp; fraught with confusion</i>
<i>Changing perceptions of diagnosis</i>		
<i>Presentation of diagnosis is important</i>		

#### 5.1.1.1 IMPACT OF DIFFICULTIES ON LIFE

The following 3 sub-themes were found in response to the question “How was your life before being referred for DBT?”

**Impact of difficulties on life**

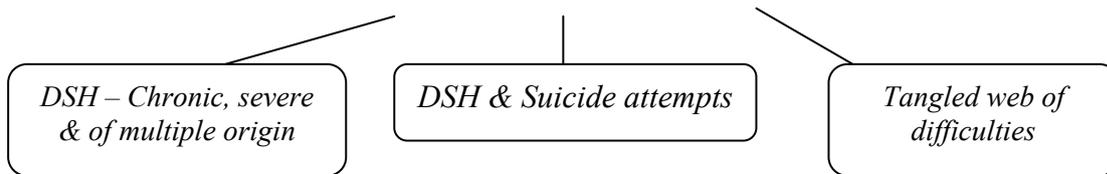


Figure 10: Sub-theme break-down of “Impact of difficulties on life”.

#### 5.1.1.1.1 DSH – Chronic, severe & of multiple origin

When DBT completers were asked to recount experiences, before coming in contact with the DBT programme, the following themes were encountered. Most interviewees gave rich descriptions of complex and often severe symptoms, including description and exploration of a huge range of self-harming acts. Deliberate self harm included slashing, cutting, overdosing, burning, binge-eating, hair pulling, and head banging. Amongst all interviewees, thoughts of and acts of self harm were chronic and relentless.

*“I cut every single day for about 10 years with a carving knife and I always had to get stitched” (Interviewee 16).*

Many DBT completers freely elucidated on reasons behind their self harming. The following descriptions were given to clarify motivating reasons for DSH.

A sense of not being listened to was often manifested in interviews. Many felt a palpable level of apathy from Mental Health professionals, which resulted in them going to great lengths to be taken seriously.

*“I do resent that I had to bang my head. I’d like you to say that to somebody, that’s what I had to do to be listened, to be heard” (Interviewee 1).*

Other interviewees recounted a feeling a relief as a motivating factor in self-harming. Some reported numbness and self-injury allowed feeling, whereas others described reprieve from being able to externalise invisible internal horror into a tangible and more manageable pain.

*“I was very numb as well, like I had no feelings. So I had to do something to make me feel something, which was the only relief I got. It was like a drug” (Interviewee 3).*

DSH was frequently equated with an effective coping strategy or means of tolerating distress. DSH was also judged to be a means of expression and a release of emotions for many participants.

*“I couldn’t express how I was feeling, and that was the only way I knew. It was just a release. It was the only way I knew how to express myself, I couldn’t talk to anyone about it. I couldn’t identify how I was feeling really. I did spend a lot of time in hospital, a lot of admissions before DBT” (Interviewee 9).*

Several respondents pointed to the addictive quality of DSH, which for some was parallel to alcoholism as a means of escape that steadily deteriorates into a vicious circle.

*“It’s like the other addiction I have. It was coping mechanism for me. It helped me, it was not a healthy way, but it helped me at the time. I don’t do it now, a day at a time, just like drinking. Once I don’t drink I don’t self-harm, because I’m able to communicate better to people, be more open to people. It’s an awful lot healthier and that’s the way I want to stay” (Interviewee 4).*

Many utilised self-harm as a way to escape or as one interviewee put it “anaesthetisation”, perhaps just a temporary detachment from a world of distress, yet a very valued escape.

*“I drank to anaesthetise myself from life, and that would have been the primary self-harm tactic...On occasion I had taken over doses but not necessarily enough to commit suicide, rather to make me sleep for maybe a day to get away from life” (Interviewee 5).*

A common theme running through this group of interviews, in relation to the reasons behind self harm, includes a legitimisation of self harm as a valid and often effective coping mechanism by self-harmers themselves. However, this attempt to deal with

their distress is often misunderstood and greeted with hostility by many Mental Health Professionals, which leaves them feeling invalidated. Attitudes of staff that categorised self harm as attention seeking and manipulative were vehemently denied by those who mentioned it.

#### **5.1.1.1.2 DSH & Suicide attempts**

Examination of the interviews revealed that self harm and suicide attempts are distinct behaviours for most respondents. Many interviewees saw their self harm as far from an attempt at taking their lives but opposed to this kept them alive, and provided a means of coping with their distress, whereas if this strategy was not available, their distress could have become unmanageable and resulted in a suicide attempt.

However, others felt that they wanted to definitively end their life and this was different from an act of self-injury.

*“There were suicidal feelings definitely there. A lot of the time when I self-harmed I wanted to die as well” (Interviewee 9).*

For many DBT graduates it was difficult to distinguish whether self harm existed alone as a distinct and functional entity or was accompanied by suicidal urges.

*“There was no let up, and I had made a promise ages ago that I wouldn’t commit suicide, but the thoughts of self-harm were forever, it just felt really bad. I presented myself at the Police station, saying ‘I’m sick of living like this, I can’t live like this anymore. As far as I was concerned I had nothing to live for, I’m bringing myself here because I intend on dying’” (Interviewee 7).*

#### **5.1.1.1.3 Tangled web of difficulties**

Common feelings accompanying this self destructive behaviour were a universal sense of emptiness, search for approval, not feeling understood, being self-critical, and frequent episodes of distress.

*“You see some people with my emptiness will reach out to alcohol or sex or gambling or crime or drugs. I reached out to people for love, for kindness, for approval. I seldom got it, I got rejected” (Interviewee 1).*

Many co-morbid problems accompanied BPD behaviours and complicated the presentations of most of the interviewees. Mood, anxiety, eating disorders were frequently referred to in interviews, causing significant impairment of functioning and well being. Problems with addiction problems were also recurrent, and featured in the majority of cases.

*“Inside I’d fallen apart altogether and this eating disorder was eating away at me. I was eating nothing, and lost a huge amount of weight. I just felt hurt. I had a breakdown completely. So I couldn’t hold down the job, and could never hold down another one for the years that followed” (Interviewee 2).*

All mentioned elements of a turbulent environment, which had multiple manifestations including family disharmony, abusive background, unemployment, little or no emotional support, and major stressors such as being bereaved, abandoned or abused by caregivers.

*“I had a very bad childhood; our whole family did because our father was an alcoholic. He used to beat my mother regularly every night without fail. She was so badly beaten; she lost five children from her beatings” (Interviewee 16).*

*“I would have had depression from the age of 13/14. Then I first started taking tablets, cutting myself, and trying to kill myself, not knowing what I was doing. I would have been sexually abused by my brother, a couple of other brothers were there, but didn’t stop anything” (Interviewee 15).*

Each case history is undoubtedly poignant with many participants recollecting poor communication with family and continual rejection having crushing effects on their psyche. Most family backgrounds of interviewees ranged from apathy of caregivers to horrific stories of physical, emotional and sexual abuse.

#### **5.1.1.2 STUCK IN THE SYSTEM**

The following 7 sub-themes were found in response to the question “What kind of interactions did you have with Mental Health professionals?”

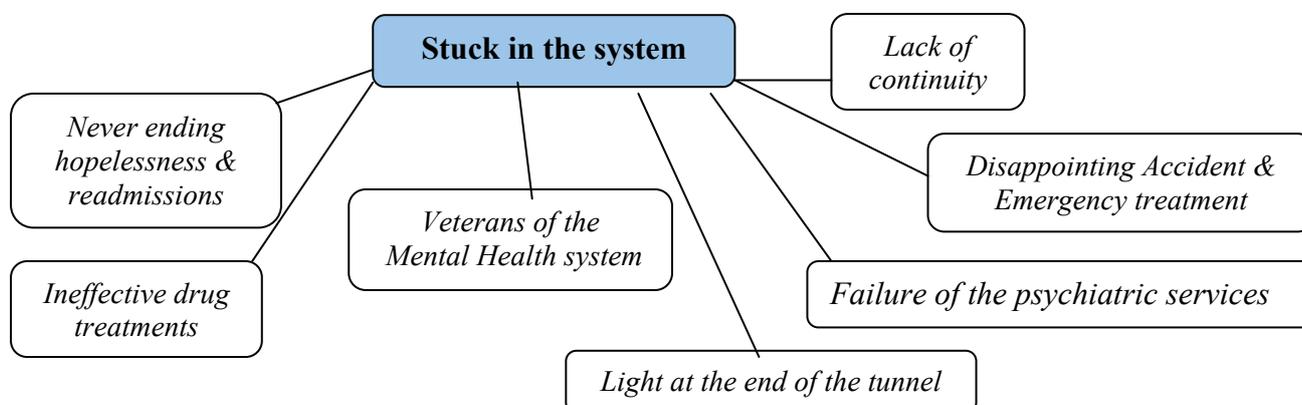


Figure 11: Sub-theme break-down of “Stuck in the system”.

#### 5.1.1.2.1 Never ending hopelessness and readmissions

For all interviewees suicidal attempts and self-injury were never-ending and contacts with both medical and psychiatric services were inevitable and long standing. All interviewees recalled a revolving door of repeated acts of self-injury that led to admissions in Accident and Emergency Departments.

*“Ending up in the psychiatrist’s chair on a lot of medication, in and out of the hospital, in and out, in and out” (Interviewee 2).*

*“I used to take a lot of overdoses, (which) I did for ten years as well as cutting. I dropped down to six stones, and I was in hospital for weeks trying to get my weight back up. It was all nerves, anxiety, and this hurt I was holding in, things I wanted to tell people but couldn’t get the words out... Without DBT I wouldn’t be here today. That terrible hurt I am able to bring it all out. Whereas before I wouldn’t talk about the hurt, nobody knew anything about what I went through at home...It’s like when I’m in DBT (sessions) words just flow out of me. I have a mind of my own now, I am my own person” (Interviewee 16).*

A sense of hopelessness and of being lost in the system was certainly easily identifiable in the accounts given.

*“I had no life, to put it as simple as that” (Interviewee 10).*

*“I put all of my recovery down to the DBT team... DBT works, if it works with me, it will work with anyone. Because I was very low, disillusioned, angry and nasty about the system, I had right to be, but not, not after DBT” (Interviewee 1).*

*“Before I started DBT nearly a year before that, I was a goner. Very depressed, suicidal, and a drug addict” (Interviewee 15).*

#### **5.1.1.2.2 Veterans of the Mental Health system**

Interviewees typically described coming to the DBT programme after much contact with a series of treatments and services and were largely cynical and not very hopeful for positive results from any intervention. Little had changed after many years of attending a variety of different Mental Health professionals. Many respondents felt rejected and let down by the Mental Health System.

*“After five admissions they still didn’t look at any alternative. I didn’t think I was being taken seriously at that point. I felt that I got no counselling and no therapy. Nobody seemed to want to know what went on in my past... I never heard of counsellors, it was something that was alien to me. It was just my life, and I had to deal with it. I really thought, before I went into hospital that the only way out was to kill myself, and I did make some serious attempts at that before I ended up in hospital” (Interviewee 6).*

*“I would have gone to my GP and he would have given me tablets, which I would have stocked them up (all), and I would have then taken them, which mostly happened when I was drinking...I would have been very disappointed with the services, because I was able to walk out of the ward onto the street, still feeling suicidal, feeling even worse because I’d experienced even more rejection” (Interviewee 15).*

Many interviewees recalled being subjected to maltreatment and apathy by Mental Health Professionals. Some alluded to an “us” and “them” attitude of many staff members.

*“You’re on a different level to people, you feel so different, these are normal people, I’m not” (Interviewee 10).*

#### **5.1.1.2.3 Failure of the psychiatric services**

Numerous interviewees alluded to being given little time in psychiatric care by consultant psychiatrists and some mentioned that they would regularly be treated in a condescending manner.

*“I had met condescension from doctors and sort of expected it” (Interviewee 12).*

Some recalled appointments being as short as five minutes on a regular basis. Psychiatric treatment was often judged to not offer answers or solutions, which contributed to heightened dismay, hopelessness and isolation.

*“The doctors, you see them for 5/10 minutes maybe, they’re prescribing drugs, they are just treating symptoms, which I don’t agree with. In my experience I don’t think the doctors were treating the underlying problem they were just treating the symptoms” (Interviewee 2).*

#### **5.1.1.2.4 Ineffective drug treatments**

Many took objection to the focus of psychiatric appointments being on pharmacological treatment, as they believed the underlying problems were not being addressed. Some found this regime to be a very rejecting and an apathetic experience, and would feel more disillusioned after attending a psychiatric appointment than beforehand.

*“That really annoyed me. I felt when you went to the consultant you had ten minutes of their time, and shoved out... I felt they weren’t listening. You’d be telling them like*

*I feel suicidal and I'm having these thoughts, I'm very irritable, I'm thinking of doing something really bad. But increase your medication, go home... It's like you're not there, you're a guinea pig" (Interviewee 3).*

Many believed that they knew little about and were not consulted enough on drug treatment, and often they were oblivious to other treatment options. Drug treatment was extensively referred to as ineffective and criticised strongly – especially in terms of the multitude of side-effects and increasing potential to overdose. Some participants asserted that doctors should be more open about the effects of and length of usage of medication.

*"Medication, I tried loads of things but nothing was working. It was just a cycle I was caught in...I just went along with what ever they did. I thought they (psychiatrists) were right" (Interviewee 9).*

*"Looking back on it, it's scary! At the time I was in a fog, I was confused. So I just thought they were going to make me better, they were going to make the situation better, somehow it was going to work. But yeah looking back on it now it was scary, because I don't think I would have recovered. Well all it was doctors and medication. There was no real talking to me. There was no therapy. It was just drug therapy, that was it, which is not what I needed. At the time I believed them that this was the solution... it was just increasing and increasing. You know I was ending up doing crazy things" (Interviewee 2).*

*"I've always seen a psychiatrist, but for some reason it was just walking in, getting a prescription, and walking out. There was no counselling. That's all I knew. There was no change, just uping dosing of tablets. Anytime there was something wrong, it meant more and more tablets. So it meant it was easier and easier to overdose. I never spoke to anyone about my problems... Basically nobody ever asked me what was wrong with me or about my problems. I just felt full of medication. I thought it would never end" (Interviewee 14).*

#### **5.1.1.2.5 Lack of continuity**

The psychiatric rotation system was censured, as it does not always offer a continuity of care and causes much frustration for clients who are under transient registrars' treatment.

*“I really didn't like re-explaining myself, when doctors were only there for six months, there was no consistency there. I wanted my usual doctor. I know services are busy, but I think patients need the best treatment possible” (Interviewee 15).*

In spite of all of these criticisms of psychiatric care, a minority of interviewees did speak favourably about their consultant psychiatrist, who in most cases was the professional who referred them to DBT. Interactions with these consultant psychiatrists differed as clients were offered an opportunity to collaboratively problem solve, were listened to, given time, taken seriously, and the consultant psychiatrist took genuine interest in the client. Such positive reports of psychiatric care were, however, the exception in this sample.

#### **5.1.1.2.6 Disappointing Accident & Emergency treatment**

Accident & Emergency staff members were universally castigated as offering minimal time and empathy for those who came in contact with the service after self-injury or a suicide attempt. A couple recalled instances of being ignored by staff, who they assumed disapproved of their behaviour. Little understanding or even attempt to understand the difficulties of these service users was reported.

*“Then there is if you go into casualty, you just get treated like crap. You can be as distressed as you like, they'll sit you in a corner, they'll put you somewhere they can't see you, they'll try and loose you... They say 'if you're really distressed go to A&E , well you'll just want to kill yourself more after being in A&E! Because you get the medical doctor coming up and saying 'there is nothing wrong with you'” (Interviewee 8).*

*“You see the doctors in A&E ...A lot of them haven't got a clue why you're in there. They just dope you up and hope for the best” (Interviewee 11).*

### 5.1.1.2.7 Light at the end of the tunnel

A sense of fortune was described to come in contact with the DBT team and sometimes the consultant psychiatrist who referred them to the therapy.

*“To get the right professional help it did take some time. I think I was extremely lucky because I saw and met so many people a long the way that weren’t as lucky as me, I know they’re still in that whole system, they’re still there. I thought they would have similar stories to me, they had similar attitudes, they were doing similar things. But they’re still there, so I felt I was extremely lucky” (Interviewee 2).*

Remarkably, many respondents referred to their DBT individual therapist as their only positive experience of the Mental Health system.

*“The only good experience I had with professional people was with Individual Therapist” (Interviewee 10).*

### 5.1.1.3 REACTION TO DIAGNOSIS

The following 3 sub-themes were found in relation to a diagnosis of BPD.

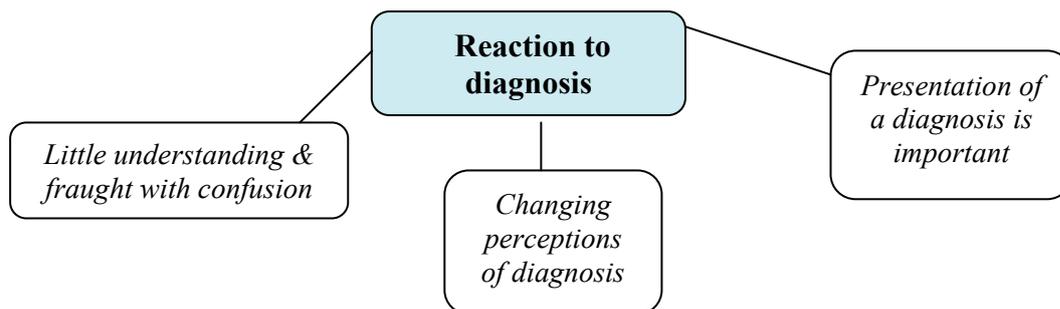


Figure 12: Sub-theme divisions of “Reaction to diagnosis” theme.

#### 5.1.1.3.1 Little understanding and fraught with confusion

A majority of respondents reported little understanding of their final diagnosis and also a lot of confusion caused by their multitude of diagnoses. One interviewee

pointed out that she felt a diagnosis could be swayed by the particular interests of the consultant psychiatrist.

*“They gave me several...Yeah there was never really a definitive...There was anorexia, Bipolar and then depression. And it was sort of yoyo between the three” (Interviewee 2).*

#### **5.1.1.3.2 Changing perceptions of diagnosis**

Interpretations of the impact of the diagnosis tended to change for many interviewees. Initially some found relief from finally having a description of their difficulties and that the diagnosis can be treated. The knowledge that they are not alone with it and there is hope was also comforting.

*“At first it was really useful that I had a label, something to say I was not just a completely crazy person. Then I was very angry being labelled” (Interviewee 6).*

*“I was given a diagnosis BPD, which I was very pleased with, because once you don’t have any symptoms of this disorder you are well” (Interviewee 7).*

However the labelling experience can seem unnecessary for some, and even become a source of discontent.

*“I was delighted at the time, I was glad that I was sick, there’s a name on me, a label on me. But when I did think of it now it’s ridiculous the way people put labels on things, it’s like more politics- I don’t believe in putting labels on people... if I’m labelled with this, I’m always going to have this with me. Just because of actions and behaviour people can label me? I don’t know why they label you” (Interviewee 11).*

#### **5.1.1.3.3 Presentation of a diagnosis is important**

Many found the BPD diagnosis a useful one to better understand themselves and it was also helpful that these criteria could be recovered from and it was not a life long

sentence. It also became clear that the way a diagnosis is presented and explained to a client is instrumental in the client's own understanding and acceptance of it.

*"It was very scary. Jesus mental illness, but when it was explained to me it didn't sound as bad" (Interviewee 9).*

It appears when a diagnosis is introduced in simple comprehensible terms and is normalised, it begins to fit better and feel more comfortable for the client.

*"The diagnosis, it was presented to me in a very positive way, BPD, and also who I was explained in a wonderful way. I remember my individual therapist sitting me down saying 'you are a square in a world full of roundies. You feel and perceive things in a completely different way', and I felt like kissing the ground. Thank God, I always thought it was me, yes it was me, but not in a bad way. My individual therapist also pointed out that my problem all my life was interpretation, that was magic! If I look back at any of the arguments, It was all about what I was doing in my mind" (Interviewee 7).*

### **5.1.2 QUESTION AREA B: VIEWS OF DBT**

The second interview question area was "What are your views of the DBT programme?" and can be subdivided into the following themes:

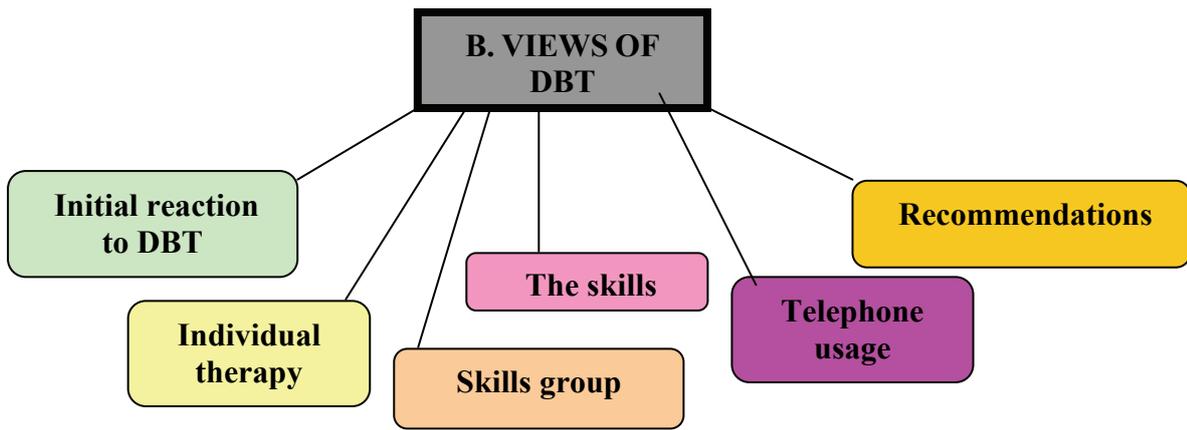


Figure 13: Subdivisions of interview question Area B - Views of DBT.

Table 14: Overall theme & sub-theme breakdown for Question Area B

Question area	Theme found	Sub-theme found
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<b>AREA B</b>  <b>VEIEWS</b> <b>OF DBT</b>	<b>Initial reaction to DBT</b>	<i>Effortful commitment &amp; orientation to therapy</i>
		<i>Unclear expectations</i>
		<i>User friendly explanation</i>
	<b>Individual therapy</b>	<i>Life changing</i>
		<i>Slow progress</i>
		<i>Gargantuan commitment</i>
		<i>Turbulent therapist-client relationship</i>
		<i>Elements of individual therapy are useful</i>
		<i>Insight</i>
		<i>Therapeutic contract</i>
	<b>Skills group</b>	<i>Encouragement to counter client resistance &amp; challenges</i>
		<i>Companionship of other group members</i>
		<i>Difficult to attend</i>
		<i>Devoted group trainers</i>
		<i>Helpful rules</i>
		<i>Diary cards – source of much discontent</i>
	<b>The skills</b>	<i>Mindfulness</i>
		<i>Distress tolerance</i>
		<i>Interpersonal effectiveness</i>
		<i>Emotional regulation</i>
		<i>Skill applicability</i>
<b>Telephone usage</b>	<i>Really helpful</i>	
	<i>Did not use</i>	
<b>Recommendations</b>	<i>Frustrations</i>	
	<i>Suggestions</i>	

### 5.1.2.1 INITIAL REACTION TO DBT

The following 3 sub-themes were found in response to the question “What was it like to begin the DBT programme?”

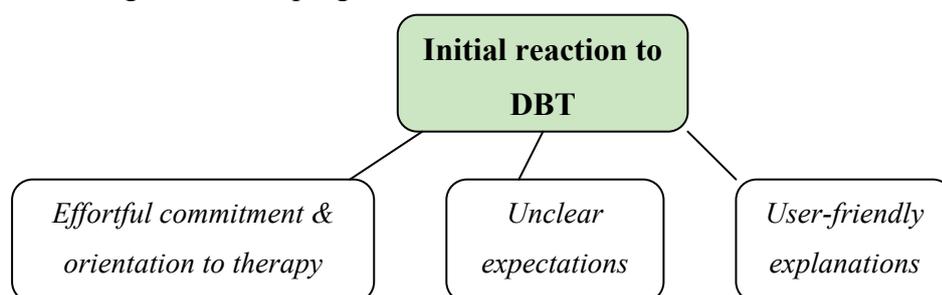


Figure 14: Sub-theme divisions of the theme “Initial reaction to DBT”.

#### **5.1.2.1.1 Effortful commitment & orientation to therapy**

Most DBT graduates had to be heavily encouraged by their Individual Therapist to stay in therapy, as this multiple mode therapy can appear to be a heavy burden to distressed clients who are unconvinced of its effectiveness. Huge effort, time and negotiation went into the commitment and orientation strategies before formal DBT commences, against an often reluctant and weary client who seemed unwilling to sign up to the full range of commitments. DBT graduates illustrated how they had few expectations of DBT and most wanted to leave treatment after the first couple months.

*“Another thing that I just have to do. I resisted it. At the beginning I wanted to leave, I wanted to get out, but thankfully she convinced me to stay” (Interviewee 1).*

#### **5.1.2.1.2 Unclear explanations**

Most clients didn’t have clear expectations before beginning in DBT, as often they were not fully sure what to expect by the therapy. Sometimes clients were going through so much, were dissociated, or disinterested that little explanation of DBT is absorbed.

*“I didn’t 100% understand even though it would have been fully explained to me” (Interviewee 5).*

#### **5.1.2.1.3 User friendly explanations**

Explanations of DBT equating it with common sense seemed helpful to some interviewees. Other explanations including increasing coping skills and enabling one to function in a much smoother way were both useful. DBT was elucidated as filling in the gaps for coping mechanisms that are missing. One other person saw it as a “skills pack”.

*“The first thing that jumps into my mind is common sense. DBT is about learning how to deal with basic issues, there is a basic premise, and learning how to cope with things... I wasn’t born with common sense, the way I see it I was born raw, and this helps put skin on you, that’s what it was described as” (Interviewee 7).*

### 5.1.2.2 INDIVIDUAL THERAPY

The following 7 sub-themes were sourced from the questions “What are your views of DBT?” & “Tell me what you think of the individual therapy?”

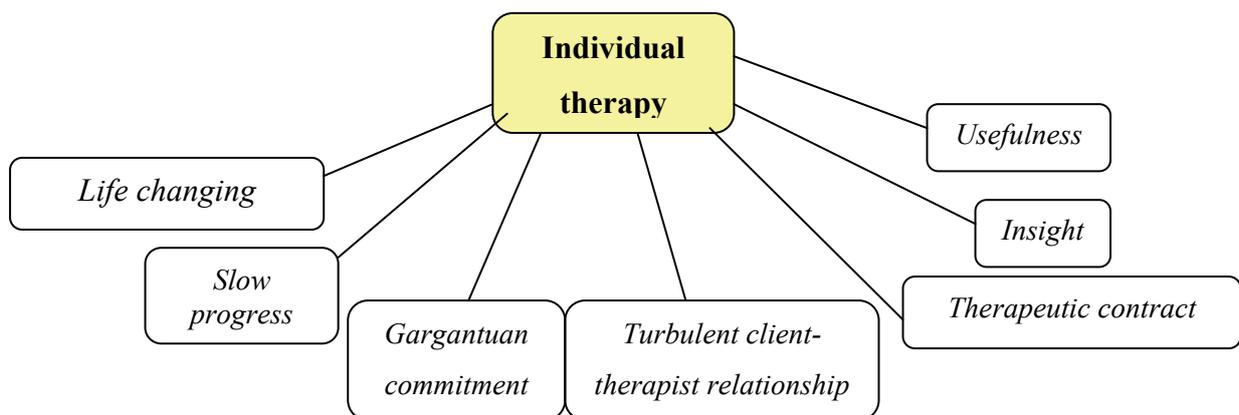


Figure 15: Sub-theme divisions for theme “Individual Therapy”.

#### 5.1.2.2.1 Life changing

All DBT completers viewed Individual therapy auspiciously and there was a definitive consensus that DBT does work. All clients mentioned life-changing events during and after therapy, and attributed this improvement to DBT.

*“For the first time in fifteen, twenty years, I have hope, I never had that hope, it comes and it goes, but it’s definitely there. So there’s a huge difference” (Interviewee 6).*

A desire to live a life worth living with potential of being finally free of the Mental Health Service existed for many participants. Many felt they now possess the skills to be able to cope with life, renewed confidence to deal with situations, no longer living in fear of relapse with a new sense of empowerment.

*“I feel extremely lucky to have gotten a therapist as good as my DBT individual therapist and then to have gotten the DBT for the year. I just think I’m extremely lucky. I’m completely out of it, I can live the rest of my life not even afraid that it’s going to happen again or afraid that I’ll get depressed again. I don’t have any fears like that because I know I will cope. I have the confidence, I have the skills through the DBT. It’s the confidence of knowing if anything happens I have the skills and have the resources, and have my head together” (Interviewee 2).*

*“All my defects aren’t gone, but what my DBT individual therapist has taught me is that ‘it’s not the end of the world’, not to beat yourself up stupid over it, pick yourself up tomorrow and be normal about everything... that’s one of the biggest things she’s taught me, because before when I messed up I would feel so bad that I’d end up taking all my tablets that night because the guilt was consuming me. It was completely out of proportion and was consuming me” (Interviewee 11).*

One interviewee described a dramatic change in how she is now enjoying life and no longer hoping to die.

*“I don’t feel like killing myself anymore” (Interviewee 6).*

*“What would you attribute that to?” (Researcher).*

*“The individual therapy. I feel like living, I want to live...I’m worried about damaging my health where as before I’d pray I’d get cancer or something” (Interviewee 6).*

#### **5.1.2.2.2 Slow process**

According to DBT completers, work done in DBT takes a long time before it manifests any kind of tangible effect. There were frequent comments of delay in assimilating skills by the interviewees.

*“Very slow to get on and see progress” (Interviewee 6).*

*“I used to write down 0 for the skills, because I didn’t know how to use them. It was very frustrating. I couldn’t understand how other people could do them and I couldn’t. I was thinking I was going back to square one, but I didn’t let that get to me, I kept my head focused on everything that was said in the group and by my individual therapist. Eventually I got to a stage where everyday was a good day, where I use the skills most days in different ways” (Interviewee 16).*

It takes a long period; sometimes well over a year is needed before a client is typically able to feel confident and adept enough at putting skills into action.

*“All of a sudden the DBT is gelling and it’s sitting into place. All the things I have been learning for the year, it’s only hitting me now” (Interviewee 15).*

#### **5.1.2.2.3 Gargantuan commitment**

Consistent with all interviewee reports, a huge level of commitment was needed to complete the therapy, despite ongoing and persistent crises. Early on in therapy was universally judged to be very challenging. Regardless of this level of demand, clients must show ample commitment and openness to change in order to progress in treatment. There were many bad days at the start, where commitment and belief in change was rock bottom, and it was decidedly difficult to attend. However clients admitted that once they attended they usually felt better when leaving. It can be surmised that a huge level of dedication and belief is needed for individual therapy to have a significant impact.

*“You need that commitment. It was very hard, but I was glad. Because after the first few months I would have walked away because I was so sick and not focusing on what was being done” (Interviewee 3).*

*“There is no way it’ll work. You have to be willing to come a little of the way, to give it a half chance. If you don’t believe you can better and this will do you no good, then there is no point in doing it” (Interviewee 14).*

*“It’s not magic and it won’t work like magic but if you’re willing, even a little bit, and you don’t have to be willing 100%, they’ll make you willing 100%. They’ll encourage the remaining percentage... you might be saying my life is shit, it’s not worth anything, I’m worthless, but you’re going somewhere to change that. You’re doing something positive” (Interviewee 6).*

#### **5.1.2.2.4 Turbulent therapist-client relationship**

The therapeutic alliance was tumultuous with many threatened and actual ruptures that needed to be acknowledged and speedily fixed. Participants oscillated from viewing their Individual Therapist as a life-saver to a demon.

*“One week I would hate my individual therapist, the next XX was my life-saver” (Interviewee 8).*

*“Initially we didn’t (work well together). I didn’t like X (DBT Individual Therapist). I told her, she knows, we laugh about it now. I was definitely determined I wasn’t going to her, I ended up going to her, and I’m still going to her and I certainly feel 90% of my recovery is down to her... There is a difficulty in giving myself praise. But I do think I did work hard, that’s a big thing, for me to say that now, if you met me last year, I would never said that” (Interviewee 13).*

The individual therapist was commonly observed as being long-standing and resilient, with a never-ending source of support for the clients. Within the DBT therapeutic stance, a client was regarded non-judgementally as an equal whereas seen as a “patient” elsewhere.

#### **5.1.2.2.5 Elements of Individual Therapy are useful**

Individual Therapy was seen as very needs based and dealing with present moment crises. DBT graduates reported being encouraged to accept themselves and validate their feelings, which took some time before this could be effectively completed – in which the proverb “it is not the end of the world” was assimilated and practiced by clients. Initially clients were encouraged to tackle their self-destructive behaviours and this was prioritised in treatment.

*“She did start working with my problems of taking so many pills, my compulsive shopping and my compulsive nature to deal with the problems” (Interviewee 6).*

Positive feedback from the Individual Therapist was understood as essential to building self-respect.

*“It really has helped. The feedback I got with my individual therapist that was really good. I’d say to my DBT individual therapist that I’m doing this and I’d just feel great. For me praise or doing things in a certain way, to know that I’m on the right track, that I’m not just imagining it, that was really good” (Interviewee 7).*

A new way of thinking that is more adaptive was offered with DBT – many interviewees remarked living with DBT is a more free life.

*“Thinking with DBT, doing that, processing that, it’s just such a freer life. It’s much more healthy, and you can really feel it, when I don’t do it I get very toxic very quickly” (Interviewee 7).*

Individual Therapy was universally seen as actually listening, being explicit, laying down rules when needed. This environment gave clients the opportunity to work on and revise skills and discuss multiple other issues that were relevant at that time.

*“I don’t think I would have coped without it...It just got better and better...no matter what I did she never walked away” (Interviewee 11).*

*“My individual therapist was very good at getting me to talk what really mattered. X was good at bringing it around to whatever X wanted to bring it around to and it opened up from there. X was never condescending, and the fact that somebody was*

*actually listening to you in a non-condescending way...It was different than going to XX where you are a patient, while counsellors regard you as clients” (Interviewee 12).*

#### **5.1.2.2.6 Insight**

Insight was gained about the diagnosis of BPD itself. DBT provided individuals with the ability to face difficulties that have plagued them for a lifetime through increasing insight and hope for change. Most clients mentioned the support as immeasurable from their Individual Therapy – putting a considerable amount of their recovery down to the Individual Therapy.

*“I found with the DBT that it gave a great insight into my illness and a great understanding. It also made me think about, it made me very aware of little things. I would know that I was becoming a little bit ill. It made me think about my illness. I’m aware of it and I just feel that, I’m not saying I’m in control of it 100%, but I feel with the support of my Individual Therapist I can manage ok. I’ve done remarkably well in the last few months” (Interviewee 5).*

#### **5.1.2.2.7 Therapeutic contract**

Some clients commented that being reminded of the contract was useful, as it “scared you into staying”, as dropping out would certainly result in discontinuation of therapy until that current contract elapsed. One client commented that DBT was the first thing she ever fully completed, and this pattern of completing things successfully has continued ever since.

*“You were reminded of the contract...I possibly could have walked if that agreement wasn’t put in place, so it was very good” (Interviewee 9).*

*“You need it, it sets the boundaries. I was nearly going to drop out. It made me go into the next session. It is a vital thing. You have to want it, otherwise you shouldn’t sign it. You’re wasting people’s time and taking up someone else’s place. If you have that mentality that nothing will work, it won’t work” (Interviewee 14).*

### 5.1.2.3 SKILLS GROUP

The following 6 sub-themes were found when interviewees were asked about their views of DBT and in particular the skills group.

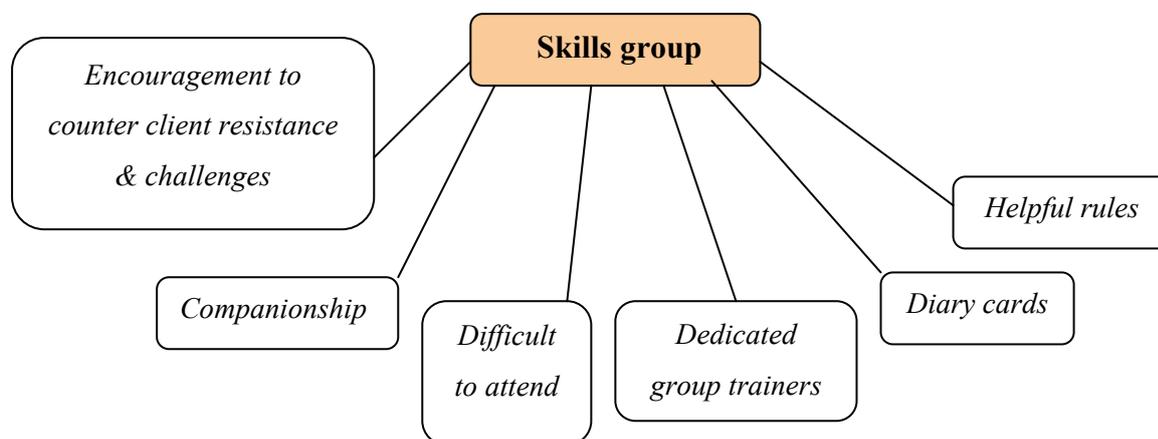


Figure 16: Sub-themes divisions of the theme “Skills group”.

#### 5.1.2.3.1 Encouragement to counter client resistance & challenges

According to the report of DBT graduates, the start of the DBT skills group was a difficult period. Participants found the whole group experience frustrating, even embarrassing.

*“My initial reaction of the group was that I’m one of these odd people! Here I’m in the odd group of odd people” (Interviewee 7).*

Interviewees were disinterested and quite resistant at the beginning of attending the group. Much encouragement and direction was given from the Individual Therapist to attend group sessions.

*“I just wasn’t interested. I didn’t really want to be there. I had a negative attitude to it...I wanted to chuck it in, I said to my individual therapist ‘I don’t want to do it’, so she got cross with me. So she said ‘try this, I want you to stay’. She convinced me then that I should stay. So I did. I don’t know I think it was probably three or four months into it, that I began to see that these skills work” (Interviewee 2).*

#### **5.1.2.3.2 Companionship of other group members**

Once clients settled in and realised that every member was going through similar experiences, attendance of the skills group usually improved and became less anxiety provoking.

Most interviewees referred to the support of the companionship of the other group members as being instrumental in knowing that they were not alone in the distress they were experiencing. It was distinctly helpful to be around people who experienced similar problems, as clients did not feel so isolated.

*“We weren’t supposed to, but we became quite friendly some of us, that was really important because it felt like having friends who knew what you were going through. You didn’t have to discuss what you were going through but at least they knew you weren’t completely insane” (Interviewee 8).*

*“There was a feeling I wasn’t on my own for starters. There was support there, and I really needed that support at the time...There were people who felt similar to me, possibly not altogether the same, but there was a similarity there. It did you make think, it was something good” (Interviewee 5).*

*“You feel at home when you’re with people like that, because they understand you” (Interviewee 4).*

Other DBT graduates felt that it was helpful to hear how other individuals were getting on with skills and also know that they have experienced similar events.

*“The group has similar problems, and you think that you are the only one that feels that inner hurt. Then when you hear that other people have felt that way all their life as well, you can help each other...before I was closed in, it was like the shutters were down and I couldn’t open up at all, now it’s like I’m blooming. DBT is marvellous” (Interviewee 16).*

#### **5.1.2.3.3 Difficult to attend**

Most interviewees found it a challenge to attend at the beginning, as they were experiencing so much distress and believed they could not handle it or take anything on board. The onset of the skills group was remembered as being a distinctly anxiety provoking experience. One former DBT client made the point that the longer one persists to attend, the easier attendance becomes.

*“It is hard, but the more you stick to it, the easier it gets. Some days are hard, but you will build yourself up, and those hard days won’t be as hard as they were. If you’re honest with yourself and do want to get help, then it’s a brilliant course” (Interviewee 14).*

The over-arching finding was that it takes time to see results, one client remarked *“I’d warn them (newcomers to DBT) that it might not seem very helpful for a while you have to give it time” (Interviewee 12).*

*“It would have been a few months (to take things in), because I was still very disturbed. Stressed out, it got to the stage where I wouldn’t turn up to the group because I was too distressed or I couldn’t handle it” (Interviewee 3).*

The “four consecutive session drop-out” rule was seen as scary, but also viewed as improving attendance and motivation. This rule also places responsibility for attendance firmly with the clients themselves.

*“There would be weeks where you didn’t feel like going and that was it. It did motivate you, because you knew the end result of not going. The only person who will lose out at the end of the day is you, if you didn’t go” (Interviewee 9).*

#### **5.1.2.3.4 Devoted group trainers**

Many clients commented that the group trainers were devoted, genuine, understanding and clued in. Group trainers were also remembered for their persistence,

encouragement and resolute efforts to get all clients to attend the group weekly. One person noted that *“I was going to beat this because they cared. I was going to succeed because they cared”* (Interviewee 6).

#### **5.1.2.3.5 Helpful rules**

The rule of not displaying self-harm was shown to have majority approval. Rules were perceived negatively at the beginning, but most appreciated that they were in place for the benefit of the group – especially individuals going through vulnerable times.

*“It’s run very well, it’s run very strictly, initially when you start the group you find that strictness a bit annoying but as you get into the group, you realise that it has to be like that and it actually works out beneficial to one and all the way it is run so strictly”* (Interviewee 5).

Appropriate distance from others’ problems avoided over-identification with being unwell.

*“If I self harmed I would come in a long t-shirt. ...(If I saw others’ self harm) I’d feel sick. I’d feel nauseous, because I knew I was doing it myself, I would have felt for them”* (Interviewee 13).

*“I found that you kept a certain distance between people, if they were having bad days”* (Interviewee 7).

The group outlook was viewed as “about looking forwards”, so it can be argued that this stringent rule about disclosure of self harm facilitates such an outlook.

*“I loved the way we couldn’t talk about past suicidal situations, I loved the way we weren’t to go in there and say ‘I took an overdose last night’, because I don’t want to hear other people’s stories like that, I was too vulnerable at the time, I can now. I loved the way it was all about looking forward and not looking back. It wasn’t about*

*the problem, it was about the solution and that's what I really liked about it"*  
(Interviewee 6).

#### **5.1.2.3.6 Diary cards – source of much discontent**

Clients largely named diary cards as a major source of frustration. All found them pretty laborious, especially when they only received five minutes of feedback within a group context, which did not equate to the work put into them.

*"Diary cards were the most frustrating, because there was so much work involved. You brought them into the group and it was like you got five minutes and you're after spending ages and ages doing these stupid cards out. That was frustrating"*  
(Interviewee 2).

Some clients found diary cards very difficult to fill in and fully understand. A few actually mentioned not attending the group to avoid the imminent feeling of embarrassment of not being able to complete the diary cards

*"I was filling them in wrong because I still didn't understand. I didn't understand what it was about, I just couldn't take it in... I felt stupid because I couldn't understand. Sometimes when I couldn't have it filled in, I wouldn't go to the group"*  
(Interviewee 3).

It was difficult for most clients to admit to having suicidal thoughts and having self harmed during the week, even though all found group trainers to provide positive feedback and reassurance.

*"Sometimes it was hard to fill it in, if you had suicidal thoughts and you had to fill it in, or if you were self-harming"* (Interviewee 5).

For some interviewees, although diary cards were clearly hard work, they acknowledged the benefits of keeping track of how the last week has gone for them.

*“As much as I hate filling out another diary card, it is essential to it. I could say the worst thing about this course is the diaries but realistically they are very important. If you didn’t do them, you really wouldn’t realise what you accomplished over the week, or how you felt” (Interviewee 15).*

#### **5.1.2.4 THE SKILLS**

The following 5 sub-themes were established when interviewees were asked their views of DBT and in particular of the skills themselves.

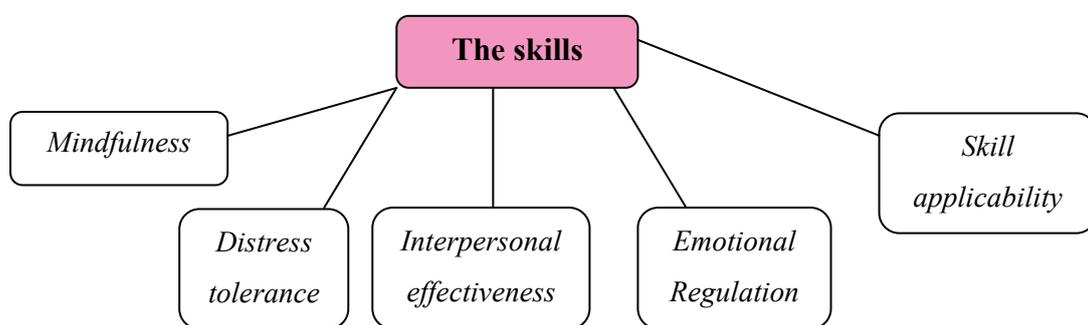


Figure 17: Sub-theme divisions of the theme “The skills”.

All former clients admitted to using some or most of the skills they learned in the DBT programme, although they acknowledged that many of these skills have become automatic and they do not usually purposefully execute them. Once skills are believed to be working, this appears to give clients a sense of mastery. DBT graduates recognised that through the use of skills they become in control of their lives.

*“I think they do get embedded, or even you sort of feel I can cope, that’s the big thing it gives you...That you are actually in control of your emotions and your mental state” (Interviewee 13).*

#### **5.1.2.4.1 Mindfulness**

Many DBT graduates mentioned that after a considerable amount of time they found mindfulness useful. Mindfulness appeared to take a long time to master and

participants found some early exercises difficult and pointless, with some even suggesting that they dreaded learning this skill. Numerous interviewees complained of poor concentration and attributed this as a major impediment in succeeding with mindfulness.

*“Mindfulness is best of all” (Interviewee 1).*

*“Today is today. Don’t think about tomorrow, tomorrow will come when it comes. The past is gone that’s all over with. I just live in every day as it comes” (Interviewee 16).*

Once clients moved onto tasks of being mindful of breathing or pain, this frequently struck a chord for them, as they realised the effectiveness of and rationale behind being able to slow things down in their bodies, and became more aware of thoughts and body positioning, in times of stress.

*“The mindfulness was hard to do, because it was hard to concentrate on what you were doing. I know when I started doing it, I was doing it wrong, I hated it. Some of the tasks were hard, and hard to remember” (Interviewee 3).*

*“Staring at something for three minutes was a load of crap! It didn’t work for me. I can understand the slowing down of your mind and everything so I probably needed it in other ways. The breathing is the one thing that I’ve come out with and still use. Even last night I was saying ten deep breaths in and ten deep breaths out. It does work for me” (Interviewee 8).*

#### **5.1.2.4.2 Distress Tolerance**

According to DBT graduates, self soothing techniques were easily applied and had a calming effect particularly at times of distress – instead of choosing a self destructive option e.g. bingeing or drinking excessively. Some distress tolerance skills were difficult as it was hard to substitute well-practiced self-harm as a means of coping

*“When you’re in times of distress, you self-soothe. Where as my self-soothing (previously) would have been a bottle of alcohol and cream cakes, so it was a suggestion that there was something else that wasn’t self-destructive” (Interviewee 2).* A couple of interviewees remarked that distraction was a temporary technique, but it is much more effective to be able to express how you are feeling. Numerous clients mentioned “turning the mind” as a comprehensive effective strategy. Many mentioned acting opposite as a distinctive skill, which is testing and takes much focus but was hugely effective.

*“A constant battle. Being judgemental of people, places and things, which I feel. I try to act opposite to the emotion. I’m really focused on that” (Interviewee 4).*

*“Distraction, which is ok temporarily, but distraction doesn’t get you anything, because your problem is bottled up. The one thing I do is I don’t bottle up anything...I express how I feel. I don’t go out of my way to hurt anybody deliberately but I do express what’s happening or how I feel. I make every effort not to hold the emotion” (Interviewee 5).*

*“Turning your mind, while it’s very difficult to do, it’s a real life saver, because your not thinking of the disturbing thought, you’re not entertaining it...The quickest impact has to be turning the mind, because it underlies everything else. It kicks starts everything else” (Interviewee 7).*

*“When you accept a hard thing in your life, it’s easier to go on. When I make mistakes, I just accept what happened and just pick myself from what happened and try better next time. All I can do is now. For me that’s one of the best skills” (Interviewee 14).*

#### **5.1.2.4.3 Interpersonal effectiveness**

Interpersonal effectiveness was judged as being useful. Techniques such as half smiling and good eye contact were mentioned. Many pointed to becoming

increasingly assertive and the ability to say no as important elements. Some interviewees described increased efficacy dealing with people, with empathy for others being a central part of this. Others focused on developing an ability not to personalise what people do in their lives, so that they are less fragile and susceptible to criticism from others.

*“Got to the stage, and even now I’m standing up for myself, because of the group, before I wouldn’t... it’s all down to the group being taught the skills.... I’m more aware of what’s going on around me, other people’s feelings, how to help them, because I am a good listener, being able to talk back to people” (Interviewee 3).*

*“So I’d be able to have a conversation with you and not take it personally and be able to look at things, why am I taking it personally, and being able to identify what is my stuff and what is your stuff. It was about communication” (Interviewee 7).*

#### **5.1.2.4.4 Emotional Regulation**

A noteworthy number of clients found emotional regulation skills particularly relevant, taking value out of the ability to recognise and label emotions correctly. The ability to take control over your emotions was certainly empowering for those who talked about this skill.

One person noted that it was hard to utilise skills when mood was so low and distress is so high – where no skills actually work because you are not thinking rationally.

*“The thing about those skills is that, I think you practice those skills when you’re just beginning to feel down, but when you go very quickly down through the floor, down through the ground into the hole it’s very hard to think about practising anything. But at the same time it’s very good to have those skills, because those skills do make you very aware of what’s happening or your environment, of where you’re at, if you look into them” (Interviewee 5).*

#### **5.1.2.4.5 Skill applicability**

Each skill or module appeared to be of varying degrees of applicability to clients, while some clients found valuable bits out of one module, others mentioned tasks and techniques from another module as being more impactful and pertinent for them. No module seemed to be a dominant trigger in change, but each participant found certain modules lend themselves to recovery better than others. Perhaps participants were less able in particular areas, and the skills targeting this “gap” will be noted as more effective. From a review of all data, all clients have acknowledged using skills together not in isolation, so that the multitude of skills form part of their repertoire of coping or “skills pack”. Many clients thought of examples where an inventory of skills were applied to tackle an urge to self harm or other distressing situations.

*“When it comes to helping yourself, you’re not so much picking up one, but the whole thing gels together” (Interviewee 12).*

#### **5.1.2.5 USE AND VIEWS OF THE TELEPHONE CONTACT**

The following 2 sub-themes were sourced when interviewees were asked their views of DBT and in particular the out of hours telephone skills coaching.

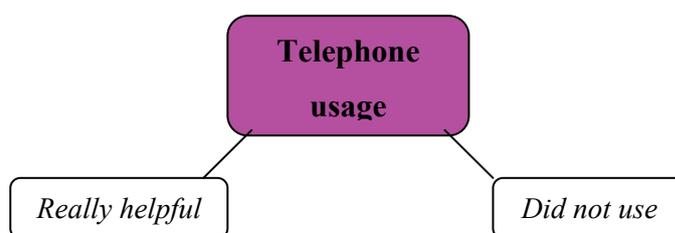


Figure 18 Sub-theme divisions of the theme “Telephone usage”.

A clear split was evident between those who used this facility and found it very beneficial and those who did not use it.

##### **5.1.2.5.1 Really helpful facility**

For those who used the facility, they applauded it as extremely helpful. Having someone to talk sense over the phone or even having the possible access to it was

viewed as a means of safety. Many interviewees saw it as an essential component in times of distress, where support and reassurance were available.

*“Great. I really valued having that telephone contact with my DBT Individual Therapist. I valued it very strongly. I think it is really important. I think seeing a person once a week for an hour when your life is in a mess isn’t enough. You need to make that phone call to say ‘look, I’m really stuck, I’m in a jam’. You just need to do that” (Interviewee 6).*

*“I found them extremely helpful...it was knowing that was somebody that was going to talk sense to you on the other end of the phone, that there was access to it. It did help” (Interviewee 2).*

*“When it just got so unbearable that I was going to act on it, then I would call her. As I say it’s someone who knows you...It kept sense at a time when your head is all over the place. It was there to give advice to get you through it and to the other side” (Interviewee 13).*

This contact often resulted in a termination of an escalation in distress that could have manifested in self-harm. For some interviewees using the telephone coaching was a challenge in itself, but when used, they found it beneficial.

*“It’s just the contact, sometimes I’d get off the phone and I’d completely forget what she said, especially if I was anxious, I wouldn’t remember what was said. But I knew I voiced what was going on in my mind, and I just felt better for doing that...Even though I telephoned I still went out (did something impulsive), but you have to want to listen and want to change. If you’ve got something in your head, the other person is not magic. But if you’re going half way with them, then you telephone, then it will work. Definitely there has to be hard work on your part. Because a phone call alone won’t change it. It won’t make any difference. If you want to take six or seven tablets a telephone won’t change that. You must meet them half way, then they help you come the other half way” (Interviewee 4).*

It was commented that this contact only worked in alleviating such distress, when the client came half way and carried through what the therapist had advised. Several interviewees noted that contact could not be allowed following a self-harm act, and it was only used as preventative measure when they were in the midst of strong self destructive urges.

*“It was great that it was there, because X could unwind you with the skills and suggest what you could do, and give it a shot does it get any easier...Once I took the time to listen and actually do it! It’s nice to know that it was there if you needed it if things got to such a desperate point. So it was good to know it was there” (Interviewee 9).*

#### **5.1.2.5.2 Did not use the facility**

For those who did not use the facility, these interviewees often cited the Samaritans as the alternative resource for them. This group said that they did not want to overburden or annoy their therapist, and also wished to avoid infringing on their therapist’s private time. This group addressed any issues between sessions at the next session. Some believed that they would not learn if they created a dependence of the reassurance provided in a phone call.

*“That for me would create some form of dependence of needing reassurance, I won’t learn that way. If I was feeling down I would ring the Samaritans, because I know I just need to let off steam and say what it is what is annoying me” (Interviewee 7).*

*“I never did use it, because I couldn’t bring myself to use it, because I feel I was imposing on somebody’s private time” (Interviewee 5).*

#### **5.1.2.6 RECOMMENDATIONS**

The following 2 sub-themes were discovered when interviewees were requested to give their views of DBT and in particular what frustrated them about it and what recommendations if any they would make to improve the treatment.



Figure 19: Sub-theme divisions of the theme “Recommendations”.

#### 5.1.2.6.1 Frustrations

From an inspection of the most frustrating components of therapy a majority of interviewees referred to diary cards as the most frustrating component. Diary cards were viewed by many to be overly tedious, an annoying reminder of mental illness, time consuming, difficult to fill in and anxiety provoking when recalling suicidal or self harm thoughts. Questions about filling in diary cards at the beginning of the skills group were also remarked as being laborious.

*“Actually filling in a diary card is too much of a reminder that you have a mental illness and you actually have to keep track of it. I wouldn’t say overall that they’re really helpful” (Interviewee 12).*

The next most common frustrating component was the tension caused by one individual who was found to be aggravating in the skills group.

*“That one person in the group that was very distracting and made me really annoyed...there was nothing else I didn’t like about it” (Interviewee 6).*

One person pointed to the frustration caused when the skills did not come easily and when they didn’t practice them.

*“When I didn’t practice it, or when it didn’t come immediately to hand. When you think you’re ok, and then something happens, and you don’t feel so ok...That would*

*be the most frustrating thing is knowing what to do and not doing it. That is actually the Mr. Ugly...The bottom line of knowing it, and not doing it, that used to annoy me. Other people when they said I know what to do, but I can't do it, I used to think you can do it, you just won't do it" (Interviewee 7).*

The level of commitment and attendance needed for the therapy was a source of frustration.

*"I hated having to come every week to both" (Interviewee 8).*

Mindfulness was also judged to be a frustrating component and a source of considerable challenge.

*"Mindfulness is very difficult, I still have difficulty working on it" (Interviewee 5).*

Other themes under challenges included attending therapy, stopping self harming, trying to change oneself to a new way, and putting the skills into action.

#### **5.1.2.6.2 Suggestions**

All interviewees were able to highlight several recommendations for DBT service delivery and the model itself that could have improved their experience of the treatment. According to DBT graduates the following areas could be altered including diary cards, preparation for the skills group training, time alterations and expanded application of DBT.

On reflection of the place of diary cards as source of both frustration and challenge, they were featured among the suggestion therapeutic changes. Many claimed that the length of the diary cards were unjustified considering how little time was given to feedback on diary cards and that diary cards were examined in both skills group and once more in individual therapy. Diary cards were judged to be somewhat patronising for some.

*“Probably just make it briefer. The diary cards were huge big blocks of things. Probably just make it simpler, and make it briefer. I think we all had a problem with it” (Interviewee 2).*

*“I would get rid of them (diary cards). I found them frustrating actually. It was too much of a reminder. It was a check-up, did you do your homework, where everyone there is adult. Everyone was well over 18. You didn’t need to be checked when you went back in, did you do your homework, that was the bit I disliked the most” (Interviewee 12).*

A suggestion was made with regard to the orientation period to DBT. This interviewee believed that if she could have met some previous DBT participants or watched a video, it may have helped her stay committed and form expectations of treatment more easily.

Others suggested improvements pertaining to time allocation in the different therapeutic modalities of DBT such as more time given to either skills group or individual sessions to enable learning of skills. Follow-up monthly sessions with group trainers on an individual client basis was suggested as a possible means of strengthening and facilitating skills learning. Another suggestion with regard to timing is to slowly increase the length of the skills group for new members so that attendance does not become prematurely overwhelming.

Another theme was that the therapy should be extended to more men and to other non-psychiatric groups, in which the therapy has general applicability and utility.

*“I think it should be open to a lot more people. I know they class you as an extreme case and that’s why you get to do it. I think I’m very lucky. I know that there are parts of that course that my friends would benefit hugely from, anybody would not just people who are mentally ill. It would be great if it were spread around, if that course was available to people” (Interviewee 10).*

### 5.1.3 QUESTION AREA C IMPACT OF DBT

The third section related to the question “What kind of impact, if any, do you think DBT has had on your life?”. The responses to the question can be divided into the following themes:

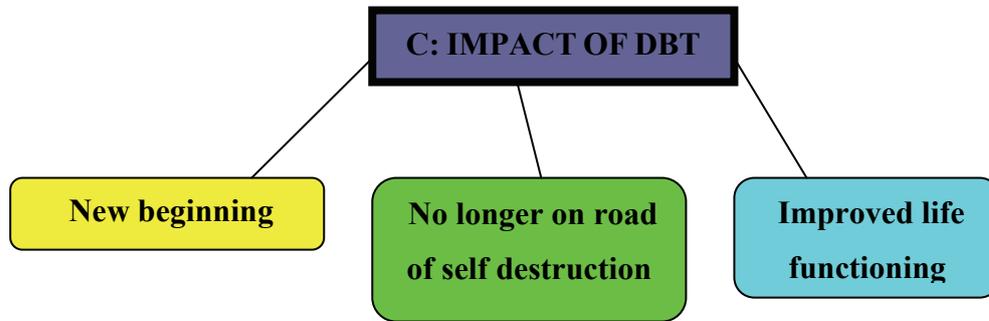


Figure 20: Subdivisions of Question Area C “Impact of DBT”.

Table 15: Overall theme & sub-theme breakdown for Interview Question Area C.

Question Area	Themes found	Sub-themes found
<b>AREA C</b> <b>IMPACT OF DBT</b>	<b>New beginning</b>	<i>A new person</i>
		<i>Self acceptance</i>
		<i>Clients must want &amp; commit to change</i>
	<b>No longer on road of self destruction</b>	<i>Deliberate self harm</i>
		<i>Suicide attempts</i>
	<b>Improved life functioning</b>	<i>Coping</i>
		<i>Emotion regulation</i>
		<i>Thinking</i>
		<i>Getting on with others</i>

### 5.1.3.1 NEW BEGINNING

The following overall theme a “New beginning” was recorded in relation to exploring the impact of DBT on graduates and can be divided into 3 sub-themes.

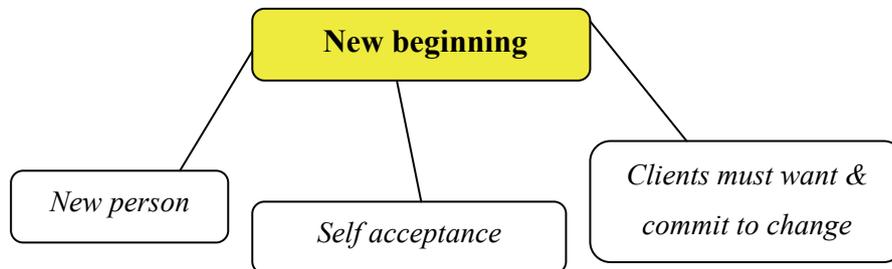


Figure 21: Sub-theme divisions of the theme “New beginning”.

For interviewees, life has changed dramatically. For each client it was their own personal journey, with some aspects of their life changing hugely, while perhaps other parts were slower to change. Clients were asked in general what things have changed about their life since DBT and each remembered things that were more salient to themselves at that time.

#### 5.1.3.1.1 A new person

Some clients pointed to returning to a time before all the distress was apparent, yet most clients refer to the alterations due to DBT as a new pathway, one in which they have been offered a new start.

*“I’m a changed person, if you’d known me ten years ago, or even a year ago, you’d say I was a different person” (Interviewee 16).*

For many their transformation was remarkable and they are without any contact with the Mental Health services – describing themselves as a different person, while others have witnessed more steady but moderate changes.

*“I’m a completely different person now, very different. I’d still be very vulnerable and my emotions can be knocked for six very easily. But I recognise that now where as before I didn’t” (Interviewee 5).*

*“I’m completely drug-free, therapy-free, doctor-free. I never have any reason to even phone to say I’m going through a tough time here. No I’m coping really well... So there’s a lot of sort of stress and hassle with that situation but I cope with it fine. It doesn’t get to me, I’m not losing sleep over it, I can manage it fine. As well as the work situation, getting back to work after all those years of not working, trying different things out. Remaining in control and remaining happy. I’m a very happy person”.*

*“Do you think your life is back the way it was back in X?” (Interviewer).*

*“It’s better! I feel with the therapy and the DBT it got rid of any skeletons that I would ever had in my closet completely and I feel it’s given me a new start. I didn’t go back to the person I was because I used to suffer a lot of tension, angst- that’s not me now at all, I cope with things very well. I have my bad days but I do generally cope with things very well. I feel I’ve no problems, I’ve nothing lurking in the background, I’ve no hang-ups about things. I just have a very clear head after the whole experience” (Interviewee 2).*

### **5.1.3.1.2 Self acceptance**

Most clients mentioned an ability to self-validate, a hugely transformed self-image, where self-love is now possible. Improvements in self esteem took a lot of time according to the clients, and after some time they eventually noticed improved well-being.

*“I’m not belittling my own feeling...Only since XX (DBT Individual Therapist) and the DBT I feel I’m important for the first time in my life...I put all of my recovery down to the DBT team” (Interviewee 1).*

*“Gradually I have developed a small amount of self-esteem, I have developed a liking for myself...So there’s a very big difference” (Interviewee 5).*

Clients became more accepting of themselves, and were less judgemental of themselves and self respect began to grow. Ultimately participants reported a feeling capacity for joy.

*“The DBT dictum, of you are worthy because you are a human being, that made a lot of sense. I did feel good about myself...Embarking on a new way of thinking, and one where I don't judge myself” (Interviewee 7).*

*“You do learn a lot about yourself, you begin to learn that you are a special person, you are a person worthy of love and happiness. I'm not a bad person. I have self worth, these are developing more or I'm seeing them more (Interviewee 15).*

#### **5.1.3.1.3 Clients must want to change & commit to it**

Many interviewees qualified the improvements that were indicative of their involvement in the DBT programme by commenting that such progress could only have occurred if the clients want to change and are fully committed to their part in treatment.

*“Absolutely recommend it to other people. But how I would recommend it would be by saying what you put in is what you get out of it. You have to be willing to try, otherwise it's not going to work” (Interviewee 15).*

#### **5.1.3.2 NO LONGER ON ROAD TO SELF DESTRUCTION**

The following theme “No longer on road to self destruction” was documented in relation to exploring the impact of DBT on DBT graduates and can be broken down into 2 sub-themes.

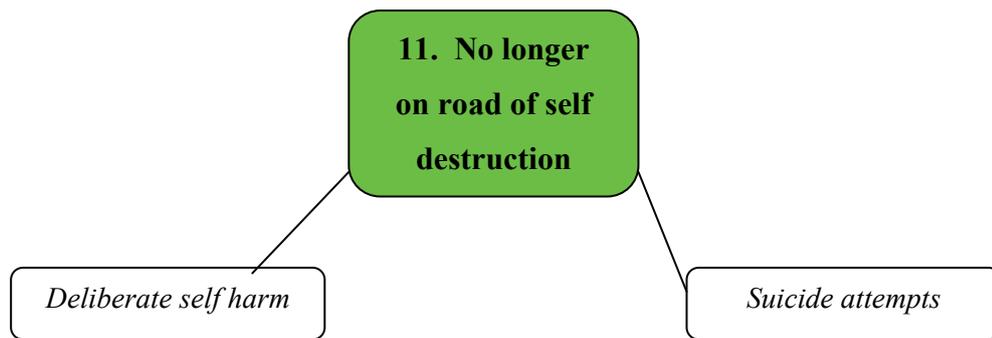


Figure 22: Sub-divisions of the theme “No longer on road of self destruction”.

#### 5.1.3.2.1 Deliberate self harm

For many former clients DSH is a past memory, as many interviewees have realised that there are alternatives and have been able to successfully implement these.

*“I also will never bang my head again, because that’s only hurting myself. I don’t grovel for approval” (Interviewee 1).*

*“Since I started the course I haven’t cut myself or taken an overdose. There have been times where I did want to do, but it’s a case of having those options. I even find that if I pick up my notes and read through them, just to keep my mind occupied. It distracts me from the other thoughts, and I’m also learning at same time” (Interviewee 14).*

Other self-destructive patterns of binge eating, binge drinking, substance misuse, promiscuity have largely dissipated for most interviewees. In addition for many the shackles of co-morbid addictions have been released, allowing the client a much freer life.

#### 5.1.3.2.2 Suicide attempts

Suicide attempts have now become dormant for many, as most interviewees now firmly believe they have a life worth living. Most DBT graduates were full of hope for the future and wanted to maximise their life.

*“Now when I hit a crisis I know now my suicidal thoughts are just an escape, whereas before I really did want to die. Before I used to think what will I do, tablets, cut, now*

*when I hit a crisis I don't do that... I don't think of suicide in the same way. I know I will let it go in time. But it is escapism, as I know if things ever get too bad I can kill myself. I try not to even think that" (Interviewee 15).*

For a small remainder of interviewees suicidal thoughts are occasionally present, but rarely escalate to attempting to take their own life.

*"I do not want to go back down that road, I do not want to take Paracetamol, I do not want marks on my arms, I don't want people saying oh what happened to you?...I can think now, my natural reaction is I just want to kill myself, but I'm not going to act on it, because I know from my past. Accept what I think, but not go ahead and do it. Maybe I have to accept that sometimes I will feel like that, let it pass, because it also has passed in the past. Then I have to accept that's probably just part of me, but sure I'm still here!" (Interviewee 8).*

Hospital admissions due to suicide attempts have become less and less, and for a number of clients they were non-existent.

*"I did notice the hospital admissions lessened and lessened. I wasn't going in as much" (Interviewee 9).*

### **5.1.3.3 IMPROVED FUNCTIONING**

The following theme "Improved functioning" was found in relation to exploring the impact of DBT on DBT graduates, and breaks down into 4 sub-themes.

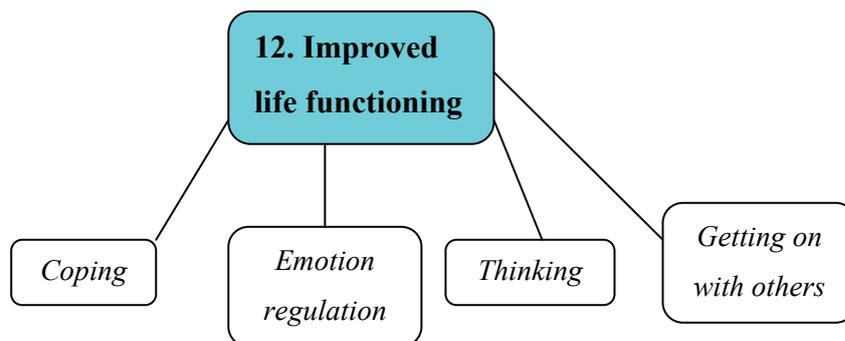


Figure 23: Sub-divisions of the theme "Improved functioning".

#### **5.1.3.3.1 Coping**

All former clients referred to using some level of adaptive coping strategies. Most interviewees appeared to no longer be fearful of presenting difficulties. Problem solving skills have given DBT graduates a sense of mastery and empowerment.

*“I was better able to deal with them (problems). I began to take a step back and just think about it, which worked. I still have set backs. But everyone does in life. I’m able to cope with them a hell of lot better than I was” (Interviewee 9).*

Many interviewees revealed dramatically improved functioning, such as returning to work and college, family interactions.

*“I approach things differently, they encourage you do the opposite of what you normally do. I had a lot of problems with access to my son, so I acted differently and spoke differently using a different tone, and it worked. So when you first hear you think it’s stupid, but when you try it, it really does work” (Interviewee 14).*

#### **5.1.3.3.2 Emotion regulation**

The vast majority of DBT graduates admitted to no longer suffering the same level of emotional fluctuations as before. Participants were typically more adept at identifying felt emotions and managing stress, although the vulnerability to be more sensitive to stimuli than the average person may well remain and have to be accepted.

*“The way I feel now is that I know I have options. I know I am going to feel bad, and will get upset at times, but I’ll always have the skills to look for, it might work or it mightn’t, but I have a chance, I have options. It is a sense of security” (Interviewee 14).*

#### **5.1.3.3.3 Thinking**

Interviewees seemed very aware of the old way of thinking, and were very determined not to slip into old patterns. A commitment to maintain change was also evident

throughout the interviews. Many former clients were mindful that they are still susceptible to relapse and the battle to stay well by using the skills learnt in DBT. Style of thinking and increased level of awareness appeared to be heavily related to level of functioning.

*“I began to stand back from things, I began to view them from all different angles, that I would never have seen before everything was black and white...DBT probably made me confront a lot of things, which I had never thought of before. It opened my eyes to new things that I never would have before” (Interviewee 8).*

*“It’s like I want positive routine, it’s healthier. I don’t want to be negative...it is working but the old way of thinking is still sneaking in but I’m not going let that happen” (Interviewee 4).*

*“Things have just changed tremendously. With the skills because you’re more aware of what you’re doing, that you are using the skills, you are helping yourself, building your strength, you are doing something...my mind used to be a jumble, but now it’s clearer” (Interviewee 15).*

#### **5.1.3.3.4 Getting on with others**

Interpersonal relations were far improved for most, as DBT graduates were able to get on better with family and friends. Interviewees commented that they were no longer as distressed by social encounters and handle them confidently, assertively and appropriately.

*“I’m more aware of what’s going on around me, other people’s feelings, how to help them” (Interviewee 12).*

Many former clients described increments in assertion and empathy for others. DBT completers described an increased self-awareness that certainly aids interpersonal effectiveness and contributes significantly to overall functioning.

*“You’ve the right to ask for things, you’ve the right to say no. I’m a person and I can say no. I still remember them. I remember I started asking for help from people and support, and I never did that. Helping myself, and opening doors in life, connecting with people and feeling small bits of joy. I knew at the very end that I was changed from it...Now I am assertive, I’m able to deal with people, and my daily-life. I am confident. I am strong” (Interviewee 10).*

## 5.2 SECTION 2: DBT DROP OUTS

The following themes emerged from the data and are arranged to answer the research questions:

1. What was your life like before DBT?
2. What were your experiences like of DBT?
3. For which reasons did you leave DBT?

Question areas can be divided into the following areas:

Table 16: Division of question areas for interviews with the “DBT drop-out group”.

<b>D. LIFE BEFORE DBT</b> <b>E. EXPERIENCES OF DBT</b> <b>F. REASONS FOR LEAVING</b>
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### 5.2.1 QUESTION AREA D: LIFE BEFORE DBT

The first question area for the drop-out group was “What was life like for you before DBT?” and can be subdivided into the following themes:

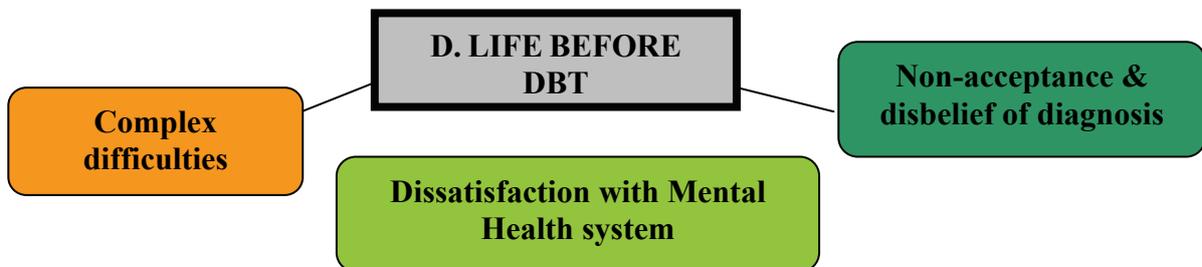


Figure 24: Subdivisions of Question Area D “Life before DBT”.

Table 17: Overall theme & sub-theme breakdown for Interview Question Area D.

Question Area	Themes found	Sub-themes found
<b>AREA D</b> <b>LIFE</b> <b>BEFORE</b> <b>DBT</b>	<b>Complex difficulties</b>	<i>Chronic self harm &amp; suicidal ideation</i>
		<i>Chaotic family background</i>
	<b>Dissatisfaction with Mental Health system</b>	<i>Psychiatry – a mixed bag</i>
		<i>A&amp;E staff</i>
		<i>Discontent with therapy received prior to DBT</i>
	<b>Non-acceptance &amp; disbelief of diagnosis</b>	<i>Confusion about &amp; dislike of diagnoses</i>
<i>Non-acceptance about BPD diagnosis</i>		

### 5.2.1.1 COMPLEX DIFFICULTIES

The following 2 sub-themes were found in response to the question “How was your life before being referred for DBT?”

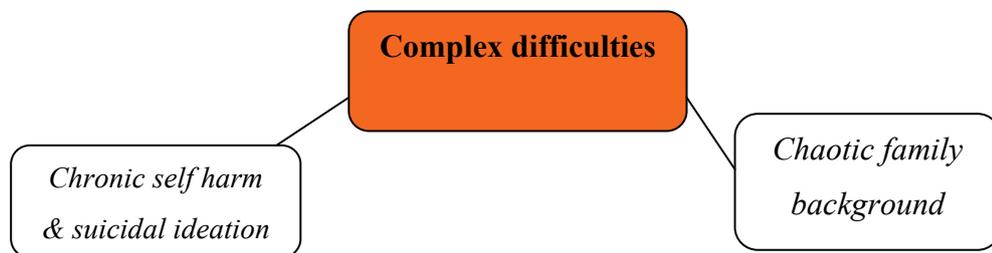


Figure 25: Sub-theme breakdown of “Complex difficulties”.

#### 5.2.1.1.1 Chronic self harm & suicidal ideation

A similar spectrum of self harm and suicidal urges were verbalised by the drop-out group. Exploration of the function of these behaviours did not deviate hugely from the DBT completers.

*“I had to, it was my own only way. It was like a pressure cooker, I had to release it”*  
(Interviewee D.O. 3).

### 5.2.1.1.2 Chaotic family background

All the “DBT drop-out group” voiced that their self-injury and related difficulties were unrelenting and they consistently maintained contact with the Health services as a result. Once more this group concurred with the variety of additional difficulties already put forward by the DBT completers. Chaotic family background continued to be a feature of reports of difficulties that led to contact with Mental Health Services.

*“My family were, you know the Waltons, the ideal family, and the Simpsons, the dysfunctional family...well my family make the Simpsons look like the Waltons” (Interviewee D.O. 3).*

The impact of the combination of traumatic history with little support and huge range of aforementioned difficulties had tremendous negative impact on functioning and well-being of the group.

### 5.2.1.2 DISSATISFACTION WITH THE MENTAL HEALTH SYSTEM

The following 3 sub-themes were found in response to the question “What were interactions with Mental health professionals like?”.

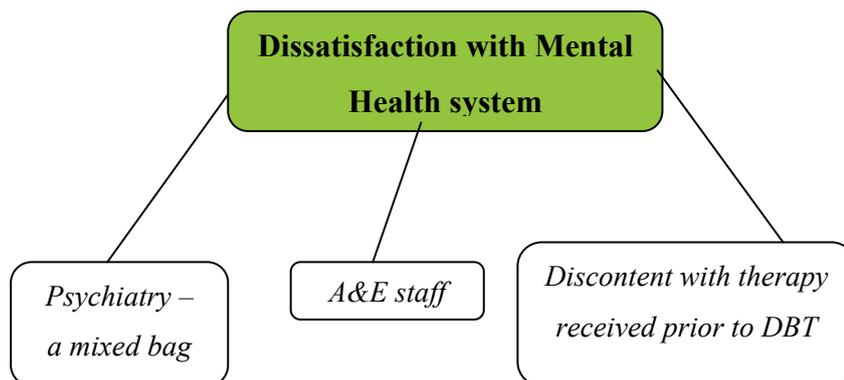


Figure 26: Sub-theme breakdown of “Dissatisfaction with Mental Health system”.

Similar patterns as the DBT completer group of frequently negative experiences and ineffective poor treatments from the Mental Health services were also revealed by this group. Most interviewees had engaged in numerous interventions both

psychotherapeutic and pharmacological before coming in contact with the DBT programme, and had distinctly destructive reports of them.

#### **5.2.1.2.1 Psychiatry – a mixed bag**

In relation to psychiatrists, one interviewee recalled a feeling of betrayal when she believed her psychiatrist was more concerned with her VHI subscription than in her.

The theme of only dealing with symptoms not the cause was also covered.

*“They miss out, they always treat the symptom, but they avoid the cause, because they don’t want to get into something messy. “Leave that mess aside”, we’ll just stitch her up, bandaged her up and she’ll be grand, now give her a cup of tea and talk nice to her! So the cause of that scar is never dealt with. The cause is going to come back as a symptom. It’s a vicious circle that keeps going around” (Interviewee D.O. 3).*

Similarly to the DBT completer group, overmedication was viewed as a significant problem.

*“Likes of him (former psychiatrist) did nothing, but wrote out scripts (prescriptions). I haven’t taken them because he doesn’t monitor them... I begged him to change my medication for three years. I cried and cried. He wouldn’t just saying you’re going through a bad time... I feel particularly abused because I have a mental health problem” (Interviewee D.O. 6).*

*“Six years have been wasted on me because of tablets... as far as I can see psychiatrists only give you tablets. I spent so much of my life on medication, and it seemed as far as I could see, nobody was even interested. When I was an inpatient, I stopped eating, it was then retaliated against with more drugs. It was so frustrating, I was locked up behind two doors, so I cut myself. Then I would buy tablets in the chemist, and I would overdose, and I would be locked up again. One day I stripped the bed and threw it all over the place, then they gave me more tablets! I was so groggy, I was on forty valium a day! (Interviewee D.O. 5).*

One interviewee gave a vivid description of her disappointment when her psychiatrist failed to ask her about her difficulties. She complained her psychiatrist was forceful and did not consult her on many decisions made about her care; she felt this demolished trust she had in her. Since that bad experience this interviewee has linked in with another consultant psychiatrist who she feels does not make assumptions and actually listens. Another interviewee suggested that there perhaps is a distinction between “old style” and doctors who are more au fait with psychotherapy and take a more open-minded view of BPD behaviours.

*“X actually talks to me, listen to, and won’t make assumptions; whereas my previous doctor made assumptions...Dr. X has given me time to get to understand me. X is the first doctor that’s ever apologised for not getting me well quick enough, X will actually tell me what’s going on. Not keeping this closed book. It’s very much a 50-50 doctor-patient relationship” (Interviewee D.O. 6).*

#### **5.2.1.2.2 A&E staff**

Similarly bad experiences were reported of Accident & Emergency Departments

*“A nurse told me to ‘pull myself together’ and I lashed out at her, she roared at me. I hit her” (Interviewee D.O. 1).*

*“One guy (in A&E) and he was just very condescending. It was said to me that “we all have free will”, that was his way of saying what I did was wrong. That point I was so low, I started picking that up as I’m going to hell” (Interviewee D.O. 2).*

#### **5.2.1.2.3 Discontent with therapy received prior to DBT**

Some interviewees commented that they had experienced poor therapeutic interventions before being referred to DBT. One interviewee recalled an unsavoury psychoanalytic therapy, in which she partook.

### 5.2.1.3 NON-ACCEPTANCE & DISBELIEF OF DIAGNOSIS

The following 2 sub-themes were found in response to the question “How was your life before being referred for DBT?” – particularly with a focus on views of diagnoses.

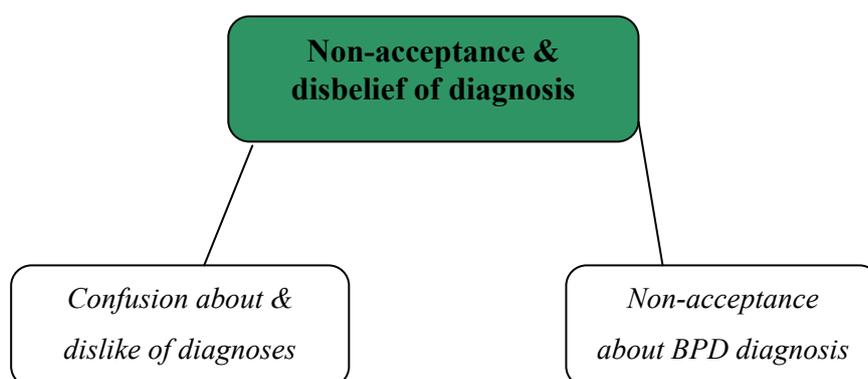


Figure 27: Sub-theme breakdown of “Non-acceptance & disbelief of diagnosis”.

#### 5.2.1.3.1 Confusion about & dislike of diagnoses

Again a level of complication of diagnoses and confusion was reiterated. This interviewee group received serial diagnoses and different diagnosis from different practitioners. Definitive confusion about such diagnoses existed, as they were not explained to the client well enough or comprehended by the client at that time.

*“The right diagnosis is bipolar II, the one that hospital gave me was anorexia and the one Dr. X gave me was borderline personality disorder” (Interviewee D.O. 3).*

*“I didn’t like it at all, it troubled me. What kind of person am I? Am I a monster? I didn’t know whether I’d be able to cope with it” (Interviewee D.O. 1).*

#### 5.2.1.3.2 Non-acceptance about BPD diagnosis

In addition there appeared to be firm disbelief and non-acceptance of the established BPD label, much more overt resistance was evident among the DBT drop-out group. Many interviewees were at the time deeply offended about being diagnosed with a Personality Disorder, strong emotional reactions of anger and fear were caused by it.

“I remember hearing that it was targeted for people who have BPD. I had a great difficulty with going along with that, I don’t think I have a personality disorder. I suffer with depression, and have a bipolar condition. But I most certainly won’t be put under a category of having a personality disorder. I think it’s a horrible term to give anybody” (Interviewee D.O. 2).

**5.2.2 QUESTION AREA E: VIEWS OF DBT**

The second question area for the drop-out group was “What were your experiences like of DBT?” and can be subdivided into the following 2 themes:

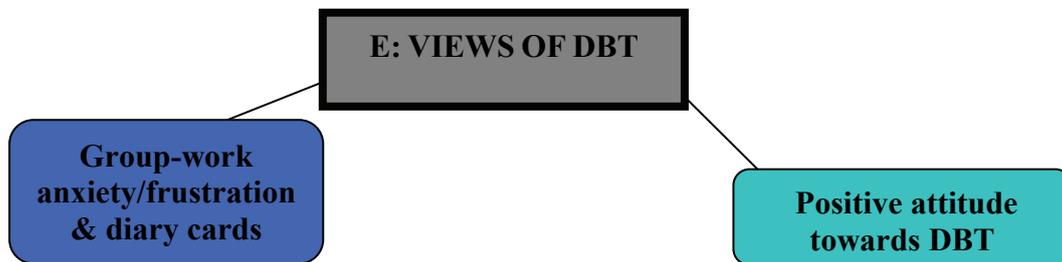


Figure 28: Subdivisions of Question Area E “Views of DBT”.

Table 18: Overall theme & sub-theme breakdown for Interview Question Area E.

Question Area	Themes found	Sub-themes found
<b>AREA E VIEWS OF DBT</b>	<b>Group-work anxiety/frustration &amp; diary cards</b>	<i>Group work anxiety</i>
		<i>Skills group frustrations</i>
		<i>Diary cards – source of pervasive criticism</i>
	<b>Positive attitude towards DBT</b>	<i>Longer in therapy the more positive the picture</i>
		<i>Individual therapy – active listening</i>
		<i>Telephone contact - a positive point</i>

### 5.2.2.1 GROUP-WORK ANXIETY/FRUSTRATION & DIARY CARDS

The following 3 sub-themes were found in response to the question “What were your experiences of DBT?” – particularly with focus on views of the skills group and the diary cards.

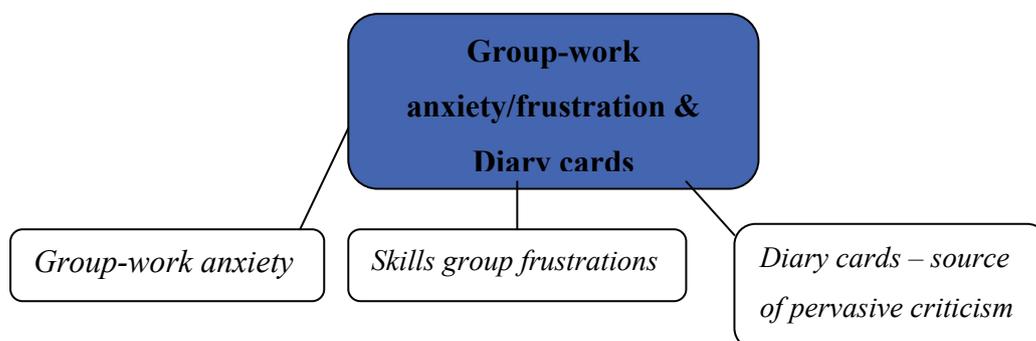


Figure 29: Sub-theme breakdown of “Group work anxiety/frustration & diary cards”.

#### 5.2.2.1.1 Group-work anxiety

A majority of the ‘DBT drop-out group’ mentioned that they had anxiety specifically about working in a group. Although they hoped to move on and cope within a group, yet this proved too distressing for many interviewees.

*“I would have hoped would have been able to work in a group without the need to self-harm. But I wasn’t able to do that. We had a break half way through, and I used to self-harm during that break” (Interviewee D.O. 3).*

#### 5.2.2.1.2 Skills group frustrations

Some interviewees who were distinctly opposed to the diagnosis of BPD, not surprisingly found the group very frustrating. Other interviewees complained that the speed at which the skills group progressed was far too slow, and found this aggravating.

*“I thought everything was so slow, dragged out, it was like sitting in Junior infants listening to the stuff. They covered stuff in an hour, that could have been said in fifteen minutes, that’s the way I felt, which was too slow. Each time I went I’d be listening to them for an hour, but before that you’d be listening to all the problems. So*

*each week I felt frustrated because you didn't feel you were moving on. It wasn't helping me, because I was just doing the same things” (Interviewee D.O. 5).*

Many of the ‘drop-out group’ acknowledged that they did not have clear expectations entering therapy and this was found to be directly related to reasons for dropping out, as they later found therapy entailed a commitment beyond their capabilities at that time.

#### **5.2.2.1.3 Diary cards – source of pervasive criticism**

Correspondingly, the ‘drop-out group’ were critical of the diary card component of treatment. Diary cards used in both skills group and individual therapy appeared double jointed and were judged as wasting time. Diary cards reminded clients of their suicidal thoughts even when they were feeling ok. However, sometimes it was noted as useful to write it down when you were feeling that way.

*“Filling out the diary cards when you weren't feeling suicidal or anything like that. Especially if you were feeling grand, and then late at night you started filling them out, it sort of brought back things” (Interviewee D.O. 4).*

The length of time allocated to diary cards in the skills group session was viewed as a negative experience. One drop-out participant asserted that she was not honest in her diary cards, as she found it too embarrassing to be open about self harming.

*“I found it easier to lie. The reading of it in public, no way was I going to tell the truth ... they're (skills group facilitators) reading it out, it's like the worst time ever” (Interviewee D.O. 3).*

#### **5.2.2.2 POSITIVE ATTITUDE TOWARDS DBT**

The following 3 sub-themes were found in response to the question “What were your experiences of DBT?” – particularly with focus on views of individual therapy and the telephone contact out of hours.

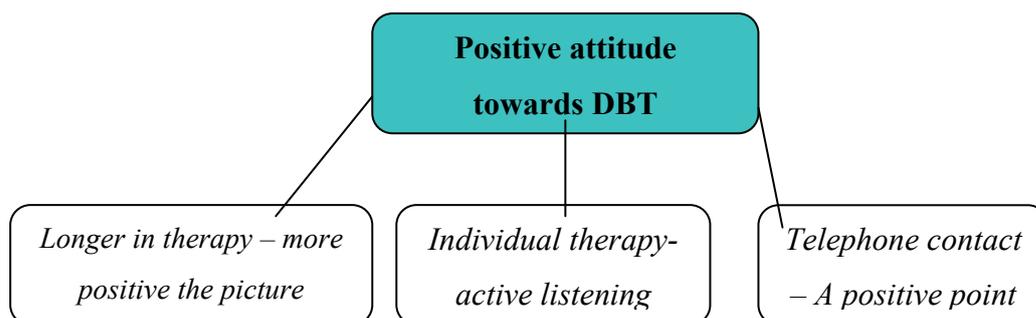


Figure 30: Subdivisions of the theme “Positive attitude towards DBT”.

#### 5.2.2.2.1 Longer in therapy – more positive the picture

It was found that those who managed to stay in therapy longer, viewed all aspects of therapy more positively, and dropped-out of treatment for reasons other than therapy-related factors. Therapy was seen as a constructive experience.

*“I found it enlightening. You always went out in better form than you came in... They wanted to help you, that wanted to show you a new way of doing things. They were very open and approachable” (Interviewee D.O. 4).*

Some interviewees had poor memories of the therapy and did not stay long enough in treatment to have comprehensive views of all therapeutic components.

#### 5.2.2.2.2 Individual therapy – Active listening

For those interviewees in the drop-out group who mentioned their individual therapist, although therapeutic alliance often is turbulent at the beginning, they were largely pleased with their relationship with their DBT one-to-one therapist.

*“In the beginning I hated X, she was the wicked witch from the west. But X did help me more than Dr. XX. My talk was camouflaged. I know if they can understand the talk, they’ve actually been listening. That is one thing about X, X does listen... when you have X, you get X 100%, X never works on half power” (Interviewee D.O. 3).*

### 5.2.2.2.3 Telephone contact – A positive point

The telephone contact facility was certainly viewed by several interviewees as a hugely valuable component, even having the possibility of contact their individual therapist was helpful.

*“I would say ‘because I have you on the phone it’s like holding you in my hand’. It helped big time. But at the same time I didn’t want to abuse it either. If I was always ringing her, what if something mega came up” (Interviewee D.O. 3).*

### 5.2.3 QUESTION AREA F: REASONS FOR LEAVING DBT

The third question area of the drop-out group was “For what reason did you discontinue your participation in DBT?” and can be subdivided into the following themes:



Figure 31: Subdivisions of Question Area F: Reasons for leaving DBT”.

Reasons for leaving therapy tended to be multiple reasons rather than just one sole reason for each person interviewed.

Table 19: Overall theme & sub-theme breakdown for Interview Question Area F.

Question Area	Themes found	Sub-themes found
<p style="text-align: center;"><b>AREA F</b></p> <p style="text-align: center;"><b>REASONS FOR LEAVING</b></p>	<b>Therapeutic reasons</b>	<i>Difficulty attending skills group &amp; completing diary cards</i>
		<i>Turbulent relationship with individual therapist</i>
		<i>Non-identification with rationale behind &amp; effectiveness of therapy</i>
	<b>Non-therapeutic reasons</b>	<i>Additional inhibiting problems</i>
		<i>Other commitments</i>

### 5.2.3.1 THERAPEUTIC REASONS

The following two sub-themes were found in response to the question “For what reason did you discontinue your participation in DBT? - focusing on the therapeutic related explanations.

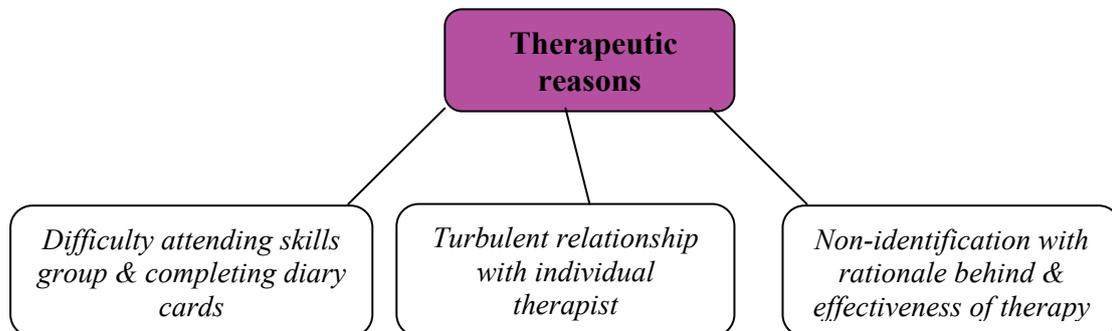


Figure 32: Sub-theme breakdown of “Therapeutic reasons”.

#### 5.2.3.1.1 Difficulty attending skills group

For most participants the whole group therapy experience was definitely an impediment to progression in treatment, as they found the skills group too restrictive, while others preferred individual therapy and could not identify with the purpose of the skills group. Some found the experience invasive, and did not like being around people with similar difficulties.

*“A group situation, it’s uncomfortable. I couldn’t really talk about what I wanted to talk about” (Interviewee D.O. 1).*

*“I do find it very hard to work in groups. I’m a very private person, reading out of these diary cards was tough” (Interviewee D.O. 3).*

*“At the start it was comforting to be around others with similar difficulties, I didn’t feel as odd. But that changed with the diary cards. I kept saying to my husband that I have to leave, and I got to dread Thursdays (group day)” (Interviewee D.O. 5).*

*“I remember being very frustrated being there in general, I just didn’t think it suited me. I prefer one-on-one... it just didn’t feel right” (Interviewee D.O. 2).*

#### **5.2.3.1.2 Non-identification with rationale behind and effectiveness of therapy**

Some interviewees objected to being referred for treatment that adhered to the BPD diagnosis, as they did not believe in such a diagnosis. Such individuals reacted to the treatment negatively, and complained of poor orientation to treatment and an inability to identify with the treatment. One person felt other treatments (e.g. ECT for depressive symptoms) worked more effectively and believed in a biological imbalance as a reason for problematic behaviour not a psychological problem. Hence, she remained resolutely unconvinced about DBT as a result and even deemed it a waste of time talking..

*“I wasn’t really sure why I was there and what it was for. I couldn’t identify with the exercises we were being given. I remember being really bored, and feeling that it was undermining my intelligence in a way...I just felt I couldn’t really identify with what was happening in the group” (Interviewee D.O. 2).*

#### **5.2.3.1.3 Turbulent relationship with Individual Therapist**

Another interviewee found that he had a problematic relationship with his individual therapist and wanted to change therapists. This was not facilitated, however, and he

felt in combination with other factors (addiction) he could no longer attend, a decision he made with much regret.

*“I wanted to see if I could change therapists. Not problems, just that we’d difference of opinion. She was brilliant at her job, and I’d no problem with her.... I was waiting for it for years and years” (Interviewee D.O. 4).*

### 6.2.3.2 NON-THERAPEUTIC REASONS

The following 2 sub-themes were found in response to the question “For what reason did you discontinue your participation in DBT? - focusing on the non-therapeutic related explanations.



Figure 33: Subdivisions of the theme “Non-therapeutic reasons”.

#### 5.2.3.2.1 Additional inhibiting problems

External factors played a role in attendance also. Many interviewees felt they wanted to continue therapy but were experiencing so many additional problems that impinged upon attendance of treatment. Alcohol and gambling addiction were among the obstacles to showing full commitment to therapy.

“As far as I can recall, this was a major problem on the second time (attempt at completing the DBT programme)...I hadn’t much hope. I was still gambling, so I think I was on a loser straight away” (Interviewee D.O. 4).

#### **5.2.3.2.2 Other commitments**

For another interviewee, she could no longer attend skills group, as she had just begun a course, and both commitments collided. The group skills could not be facilitated in another format at that time, resulting in this interviewee discontinuing attending the service with a certain level of indignity.

*“I got angry at the way it finished... It’s almost they want you to succeed in their thing, but not in things for anybody else or anything for yourself. They wanted another statistic for treatment success, they want that, but they don’t want or don’t care or they haven’t got time for personal success” (Interviewee D.O. 3).*

## **5.3 SUMMARY TO FINDINGS I**

### **QUALITATIVE INVESTIGATION INTO THE CLIENT IMPACT OF DBT ON THOSE WHO COMPLETE AND DROP OUT OF TREATMENT**

A total of 22 former DBT clients were interviewed. The findings for each group can be divided into the following conclusions.

#### **SECTION 1: DBT GRADUATE GROUP**

##### **Area A – Life before DBT**

All interviewees were able to narrate a vivid and bleak picture of “Life before DBT”. All former DBT clients described being caught in a revolving door Mental Health system, not receiving appropriate or effective treatment when coming into repeated contact with health services especially A&E. From such accounts there was a distinct feeling of hopelessness, being misunderstood, injustice, being extremely self critical, empty, and suffering relentless distress. DSH behaviours were also freely recalled by interviewees.

Most interviewees experienced multiple interventions and different pharmacological treatments with little or no success. Some professions (psychiatry, nursing, general and emergency medicine) have been perceived to be examples of poor treatment, apathy and inappropriate attitudes directed at this client group.

Most interviewees in the DBT graduate group recounted experiences of not being listened to or understood by staff. In some cases the needs and wishes from the client’s perspective was ignored or not attended to. Pharmacotherapy was viewed negatively by the vast majority of former clients interviewed. A statement of “treating the symptoms not the cause” was frequent, with no talking or working on constructive solutions. Interviewees often recalled not knowing of, or being directed to, alternatives to psychiatric treatment. Psychiatrists were often regarded as spending little time and just writing out prescriptions in sessions. Many of the side-effects of

medications were uncomfortable and inhibiting. Psychiatric care was often seen as inconsistent, due to psychiatric rotation system.

Accident & Emergency staff, according to DBT client reports, typically gave very little time and empathy to people who deliberately self harm. Many described their Accident & Emergency experience as one of apathy and of being ignored. Many clients commented that the staff did not understand and accept self harm.

Some DBT clients showed surprisingly little knowledge about their diagnosis. Most had received several diagnoses, before receiving the BPD diagnosis. A few interviewees believed they had been misdiagnosed several times. Others found labelling a very mixed experience. Some stated that labels were unjustified and one strongly objected to it. A few clients were pretty positive about the diagnosis, as it had been explained as something that could be recovered from and framed in a way that can be understood by them. When the diagnosis was shaped in this way it provided a sense of hope.

### **Area B – Views of DBT**

Detailed accounts of views of DBT were given by the DBT graduate group. DBT was named as the road to recovery for many and life changing, although this was far from easy. Getting referred for DBT took time and many thought they were just lucky to have accessed DBT. Global effects of the programme were discussed, with a few clients tackling other difficulties such as alcohol dependency. Most DBT graduates had to be heavily encouraged by their Individual Therapist to stay in therapy, as this multiple mode therapy can appear to be a heavy burden to distressed clients who are unconvinced of its effectiveness.

Most interviewees did not have clear expectations, as often they were not fully sure of what to expect of the therapy. Explanations of DBT equating it with common sense seemed helpful to some. Other explanations including increasing coping skills and enabling one to function in a much smoother way were both useful. DBT was elucidated as filling in the gaps of missing coping mechanisms.

There appeared to be a consensus that DBT works. All DBT graduates mentioned life-changing events, and attributed this improvement to DBT. Interviewees documented that they had been given skills to be able to cope with life, renewed confidence to deal with situations, no longer living in fear of relapse with a new sense of empowerment. Work done in Individual Therapy took a long time before it had any kind of effect, with frequent comments of delay in assimilating skills. Early on therapy was universally judged to be very challenging. There were many bad days at the start, in which it was very difficult to attend.

The therapeutic alliance was tumultuous with many threatened ruptures that need to be fixed. Clients oscillated from viewing their Individual Therapist as a “life saver” to a demon. The Individual Therapist was observed as being long-standing and resilient, with a never-ending source of support for the clients. In Individual Therapy, the client was regarded non-judgementally as an equal whereas seen as a “patient” elsewhere.

Individual therapy was seen as very needs based and dealt with present moment crises. Clients were encouraged to accept themselves and validate their feelings, and it took time before this was achieved – the proverb “it’s not the end of the world” was practised. Positive feedback from the Individual Therapist was judged as essential to building this self-respect. A new way of thinking that is more adaptive is offered with DBT. Most clients mentioned the support as immeasurable from their Individual Therapist, putting a considerable amount of their recovery down to the Individual Therapy. One-to-one sessions consisted of active listening, being explicit, and laying down rules when needed. This environment gave clients the opportunity to work on and revise skills and discuss multiple other issues that were relevant at that time. Some interviewees commented that being reminded of the contract was useful, as it “scared you into staying”.

In the early days of the skills group, some interviewees found the whole group experience frustrating, even embarrassing. Clients were disinterested and quite resistant at the beginning of attending the group. Much encouragement was given from the Individual Therapist to attend group sessions. It was distinctly helpful to be around people who experienced similar problems, as interviewees did not feel so isolated and felt really understood. Other former clients felt that it was helpful to hear

how other individuals were getting on with skills. Most interviewees found it a challenge to attend at the beginning.

Many interviewees observed that the group trainers were devoted, genuine, understanding and clued in. Group trainers were remembered for their persistence, encouragement and resolute efforts to get all clients to attend the group weekly. The ethos of the skills group appeared to be “looking forward rather than back”. The rule of not displaying self-harm was shown to have majority approval. Rules were often perceived negatively at the beginning, but most appreciated that they are in place for the benefit of the group.

Once skills were perceived to be working, this gave clients a sense of mastery. All interviewees admitted to using some or most of the skills they learned, although they have become automatic and they do not usually purposefully execute them. Examples of each of the different skills were given by each of the interviewees. Each skill or module appears to be of varying degrees of applicability to former clients, so that while some clients found valuable bits out of one module, others mentioned tasks and techniques from another module as being more impactful and pertinent for them. No module seemed to be a dominant trigger in change, but each client found certain modules lend themselves to recovery better than others. All clients acknowledged using skills together not in isolation, so that the multitude of skills form part of their repertoire of coping or “skills pack”.

Diary cards were unanimously labelled as a major source of frustration by DBT graduates. All found them pretty laborious, especially when they only received five minutes of feedback, which did not equate to the work put into them. Some interviewees found diary cards very difficult to fill in and fully understand. It was also difficult for most former clients to admit to having suicidal thoughts and having self harmed during the week.

A clear split was evident between those who used the telephone coaching and found it very beneficial and those who did not use it. For those who used the facility, they applauded it as extremely helpful. Having someone there to talk sense over the phone or even have access to it was viewed as a means of safety. Many interviewees saw it

as an essential component in times of distress, where support and reassurance were available. For those who did not use the facility, they often cited the Samaritans as the alternative resource for them. This group said that they did not want to overburden or annoy their therapist, and also wished to avoid infringing on their therapist's private time. This group addressed any issues between sessions at the next session. Some believed they would not learn if they created a dependence of the reassurance provided in a phone call.

Interviewees also described some recommendations to improve DBT. There was a discussion of the most challenging elements of treatment, which included components such as mindfulness and the diary cards.

### **Area C – Impact of DBT**

For all DBT graduates interviewed, life has changed dramatically. For each former client it was their own personal journey, with sections of their life changing hugely, while perhaps other parts were slower to change. For many their transformation was remarkable and they are without any contact with the Mental Health system, while others have witnessed more steady but moderate changes. Most interviewees mentioned an ability to self-validate, a hugely transformed self-image, where self-love is now possible. All interviewees referred to using different adaptive coping strategies and no longer being fearful of presenting difficulties. Hence, such problem solving skills have given the clients a sense of mastery and empowerment.

For some interviewees self harm is a past memory, as they have successfully implement alternatives coping strategies. Most clients were full of hope for the future. Hospital admissions have decreased and for most clients they no longer exist.

Interpersonal relations were far improved for most, as clients are able to got on better with family and friends. Many clients revealed improved functioning, such as returning to work and college. Most interviewees described not suffering the same level of emotional fluctuations as before. Interviewees seemed very aware of the old way of thinking, and were very determined not to slip into old patterns. Many DBT

graduates were mindful that they are still susceptible to relapse and the battle to stay well.

## **SECTION 2: DBT DROP-OUT GROUP**

### **Area D – Life before DBT**

A similar picture was created by the ‘DBT drop-out group’ with regard to their experiences prior to being referred to DBT. Chronic and pervasive self destructive behaviours were common and for many still are in this group.

Another parallel with the DBT graduate group was the frequent poor reports of treatment by the Mental Health system. Treatment by staff (nurses, registrars, consultant psychiatrists) was viewed as dismissive & condescending. DSH was not fully explored. Moreover the common trend was similarly of treating the symptoms not the cause, mainly by means of drug treatment. Some psychiatrists were criticised as not giving time, not listening and not following through with client wishes.

Multiple diagnoses received or high complexity of difficulties did not instil faith in doctor’s judgement. For some in the ‘DBT drop-out group’ the BPD diagnosis was strongly objected to as a derogatory term. Typical reactions to being given a diagnosis included fear of being labelled, anger, suspicion, and helplessness.

### **Area E: Experiences of DBT**

The relationship with their individual therapist was turbulent and brittle at beginning, but there was recognition that the individual therapist gave 100% and listened well. Therapy was viewed as enlightening, open, and encouraged a new way of doing things. Telephone contact was essential at difficult and distressing times. Even the thought of being able to phone the individual therapist helped. Interviewees were also careful not to abuse this facility.

Diary cards were judged to be time consuming and cumbersome. Diary cards were frequently seen as frustrating and a reminder when not suicidal.

## **Area F: Reasons for leaving**

Reasons for leaving the DBT programme appeared to fall into either therapeutic or non-therapeutic reasons. For many interviewees the skills group was very difficult, as they found the structure restrictive, preferring flexibility of one-to-one sessions. Some interviewees disliked the skills group adherence to the BPD label and could not identify with exercises and were not convinced by it. Such DBT drop-outs felt bored and undermined and believed that they had not received a very satisfactory explanation about the diagnosis.

The main non-therapeutic explanations for discontinuing treatment early included finding it difficult to focus on therapy, when there were so many things going on for a client. Other interviewees could not carry on with therapy because of other commitments. Another interviewee acknowledged personal difficulties with an individual therapist, even though acknowledging she was good at her job.

### **5.4 LINKING FINDINGS I WITH FINDINGS II**

Findings I (Section I & II) based on Phase I of the overall study was completed prior to the initiation of Phase II for numerous reasons.

- 1) It was expected that Findings I would clearly highlight the main areas that should be focused on with regard to qualitative interviewing of case studies.

Question areas A & D “Life before DBT” emphasised the typical picture that an individual being referred to DBT presents with – complex presentation, multiple unsuccessful, interventions, poor view of mental health system, long term patients with high service usage. For this reason it appeared particularly pertinent to include a section on “Life before DBT” as part of the baseline interview of those individuals beginning in Phase II, in order to fully illustrate the pre-DBT life and enable maximum comparison with post-DBT presentation.

Question areas B & E “Views of DBT” provided much data on typical experiences of participation in the DBT programme. It was proposed that further probing of

perceptions of those currently participating in treatment would augment and clarify this substantial collection of data to date, and subsequently accumulate into a convincing documentation of the perspectives of all who have participated in DBT within this sample, and perhaps to a limited extent to those involved in DBT elsewhere. Numerous suggestions for improved implementation of the DBT programme were reported within question area B, and it would be worthwhile to be particularly mindful of such recommendations in the analysis of Findings II.

- 2) Findings I, particularly Area C “Impact of DBT”, would prompt the usage of certain outcome measures in order to most accurately and appropriately map any change across time, which may be attributable to participation in the DBT programme and also decipher the active ingredients involved in producing positive outcomes.
- 3) Findings I would also be expected to increase understanding of the relationship between any change in outcome measurement and a variety of contextual factors, which may typically be in play.

# CHAPTER SIX

## **FINDINGS II**

## **CHAPTER 6**

### **FINDINGS II**

#### **6.1 CASE STUDY EVALUATION OF DBT**

A total of ten case studies were collected from Site A (n=6) and Site C (n=4). Outcome measurements and qualitative interview data were collected on each research subject.

Out of the sample total, six clients discontinued prematurely and four clients completed all the comprehensive DBT sessions offered to them at this point. From the six clients who dropped out prematurely, two clients dropped out before six months and four clients dropped out after six months of attendance. From those who completed all expected and offered components of DBT, two clients finished at 12 months and two clients finished at 10 months and 6 months. In the latter cases, limited DBT was provided due to limited staff resources and falling client numbers. Each case study has been given a pseudonym to ensure confidentiality and also to maintain connection with the individual's personal story. Each case study in the Findings II section is divided into the following five sections:

**A brief history** – A brief history of the BPD condition and contact with services is given. There is also a description of any co-morbid conditions or relevant demographic or antecedent details, which may be useful for overall interpretation of the case study. Such information facilitates forming a perspective in terms of chronicity and severity of overall difficulties at baseline.

**Quantitative analysis** – Details the scores of each instrument from baseline until the end of participation in the DBT programme. A commentary section exists below each instrument to gauge overall level of change from baseline in the direction of deterioration or improvement. It allows the opportunity to comment on intricate changes in the components of a measure, as well as indicating whether any change from baseline is clinically significant. Clinical significance is defined in this study as any change in the severity of symptoms that allows movement from one range (e.g. moderate) of an instrument to a less severe range (e.g. minimal), which can be calculated in outcome measures with norms and intervals ranges (e.g. BHS).

Qualitative analysis – Consists of content analysis of the main and important themes found at each interview assessment and hypothesis-creation based on the overall themes found.

Integration of data – Provides the opportunity to incorporate the main findings of each paradigm. The main goals of this section include analysing whether or not change has occurred for each client, what obstacles to recovery may have existed, which components of therapy can be viewed as the ones producing change, and what was the overall impact, if any, of their participation in the DBT programme. This integration is achieved through systematic assimilation of both similar and conflicting findings from both sets of data. Conclusions are drawn based on the accumulation of data with a test of significance of change using Wilcoxon Signed Rank Test, accompanied by a test of effect size (Cohen, 1992).

## **6.2 OVERVIEW FOR ALL CASE STUDIES**

### **6.2.1 BACKGROUND HISTORY – HIGH LEVEL OF VICTIMISATION**

There was a high prevalence of victimisation in the history of almost all of the case studies described. This oppression often occurred in childhood and in some cases in their present situation. Six participants reported childhood sexual abuse and some sexual abuse at a later age. Four interviewees mentioned some domestic violence within the home from a partner or a family member. One participant mentioned bullying within a work environment as a significant cause to present psychological problems.

### **6.2.2 COMPLICATED PRESENTATION - PREVALENCE AND RANGE OF OTHER CONDITIONS**

In the initial interview, a picture of the range of co-morbid difficulties was provided by each participant. Affective disorder, particularly low mood/depressive disorder, was extremely common in this sample with a total of 8 reporting they suffered from the disorder. Alcohol misuse and dependency was next most common with six

participants disclosing that they had a problem in this area. Of these six participants, two interviewees mentioned that they had recently abused illegal substances. Eating disorder, in the form of either Bulimia Nervosa or Anorexia Nervosa, was moderately common with 40% commenting that issues with eating and diet were still problematic for them. Six participants mentioned that they had continual and severe body dissatisfaction. All participants reported low self esteem at the baseline interview. Problematic relationships were also very common among this sample, four participants mentioned that they had a turbulent relationship with their partner and five participants verbalised that they had become disconnection with many family members. Other less common difficulties mentioned included anger and violent outburst issues, attentional problems, anxiety and dissociative disorder.

### **6.2.3 DELIBERATE SELF HARM**

A range of different self-injurious behaviours was discussed across the case studies. Most individuals related their self-injurious behaviour to a form of stress management. Some interviewees described relationship tension, which could become too much to bear and they would adopt long-used and effective self-cutting, bingeing or abusing medication behaviours. For other participants they detailed self-harm as a means of managing abuse flashbacks. Another participant described it as a means of clearing her head. Case study seven explained her self-harm with thoughts of deserving it, which she related to her sexual abuse.

### **6.2.4 SUICIDAL THOUGHT AND ACTS**

Most participants could trace their suicidal thoughts and acts back to their early teens. A long and severe history of attempting to take their life included overdosing, cutting their throat, jumping off tall buildings and attempted hanging. For some participants these attempts were often reactions to the rejection or confusion they felt following an interpersonal conflict with a family member, staff member or partner. Many participants recognised that such attempts were often emotionally driven, out of anger and impulsive. For many interviewees, a suicide attempt represented an attractive means of escape from the present feelings of hopelessness, isolation, negativity and emptiness, and from past horrors inflicted against them. Case studies two and seven,

who during their participation of DBT were long-term inpatients, were particularly actively suicidal and hence resided in a acute psychiatric ward for their own safety. Many other participants clearly and vividly described acute suicide thoughts during the initial months of DBT, which for some became more controllable through skill application.

### **6.2.5 NUMEROUS FAILED INTERVENTIONS**

All case studies revealed that they had been involved in numerous different services, often from an early age. Dissatisfaction with elements of these services was voiced. Pharmacotherapy was definitively seen as insufficient in managing their difficulties and only having an impact on a superficial level. Medication was viewed as a hollow and temporary solution to life long difficulties. Many participants commented that the prescriptions were frequently altered and they had suffered uncomfortable side-effects. Medication was occasionally badly managed by those prescribing it, as many participants admitted abusing this medication and using it as a means of overdosing.

Another area of discontent was the response from staff, mainly nurses and consultant psychiatrists, to their self-destructive behaviours. Many participants commented that they met with dismissive and derogatory comments and actions following either a suicide attempt or self-injurious behaviour. This staff behaviour was perceived as further rejection enhancing their level of hopelessness and despair.

### **6.2.6 REACTION TO BPD DIAGNOSIS**

Some interviewees brought up their reaction to being diagnosed as having BPD. It was a difficult process of acceptance, as the name itself appeared unwieldy and frightening. Many fears arose about the chronicity and treatment of BPD. At first, many participants mentioned that they felt ill equipped to assimilate the diagnosis and needed support and questions answered. There were also simultaneously feelings of relief. Participants believed that they finally had a description of their difficulties after a long period of blaming themselves and confusion. Case study six described the experience as a “light being switched on”.

### **6.2.7 AIMS FROM COMPLETING DBT**

In the initial interview, numerous participants reflected on their expectations of and hopes for the year ahead. All interviewees identified that the programme would inevitably take a lot of work and there would be a lot of commitment involved. Among the most common hopes of the benefits of attending the programme included increased ability to control emotions, in particular anger, and a significant reduction in self-harming and suicidal thoughts. Many participants hoped that they could learn better coping strategies, instead of longstanding maladaptive ones such as alcohol misuse. Other interviewees outlined functional motivations for partaking in the programme, including discharge from hospital and returning to employment. Another common theme was an increase in overall well-being, in particular an increased ability to think positively and be able to relax. A noteworthy goal from the DBT programme included decreased self-hatred, which was a ubiquitous difficulty among participants. Other aims of increased well-being included not being as dependent on medication and being more assertive and independent.

### **6.2.8 INDIVIDUAL THERAPY – VIEWS AND IMPACT**

Individual therapy appeared to be a pivotal component of the overall DBT programme. The vast majority of participants identified many positive attributes about the individual therapist themselves and their relationship. Positive feedback was reported as early as the month two interview, which indicates the early onset of the foundations of the therapeutic relationship. Among the positive values attached to the therapists themselves included being easy to talk to, supportive, interested, motivational, open, a good listener, positive, diligent, reassuring, pragmatic, validating, unshockable, compassionate, and respectful. Within the relationship itself, many commented about a building trust and confidence, connection and strength of the relationship. The session itself for many was seen as providing a boost for the week, helping with the skills, positive feedback, gave focus, creation of a safe place to discuss feelings, an opportunity to problem solve and to stay grounded.

The individual therapy relationship is a challenge for both parties. The interviewees mentioned occasional times of finding their individual therapists pushy and

challenging. Three case studies identified that there were intermittent disagreements, misunderstandings and heated discussions with their individual therapists. Many of these critical ruptures were rectified through the appropriate use of the telephone consultation. Areas of disagreement included maintaining commitment and attendance.

All interviewees acknowledged the intrinsic value of the relationship with their individual therapist and the content of these weekly sessions. Many viewed this component of therapy as central in keeping on track to attain their goals and in staying alive.

### **6.2.9 SKILLS – VIEWS AND IMPACT**

Skill acquisition was a source of frustration. Some interviewees identified initial difficulties understanding certain skills, while many participants mentioned problems applying skills. Situations of high distress were found to be particularly difficult in which to use skills.

The repetition of the skills in the second six months and the rehearsal of skills in the individual sessions appeared to be important in maintaining learning and increasing level of assimilation. Interviewees appeared to go through stages in skill acquisition – listening, questioning, understanding, absorbing, applying, assimilating, generalising and internalising. Listening denotes ability to attend to the information in the skills group. Questioning is the process of probing the meaning and purpose of a skill with a skills trainer or individual therapist. Understanding is the stage where a client fully comprehends the skill procedure and rationale. Absorbing is the memorising of the essential stages of a skill. Applying is putting a particular skill to the test. Assimilating denotes the cementing of a skill, further mastering of its application, and using a skill when it is most necessary. Generalising means applying a skill in numerous different and relevant settings. Internalising is the knowing instinctively and automatically when a skill should be used. There is an extensive amount of material to cover in the first six months, so many interviewees mentioned only applying a small number of skills initially and this slowly increased as their confidence and ability grew. Some participants mentioned particular problems of

attention in the skills group, which meant that they were left stuck at the early stages of skill acquisition.

Mindfulness was particularly viewed as useful in calming emotions, returning to wise mind, stepping back from impulsivity and staying in the moment. Many interviewees mentioned early use of mindfulness, in particular observing, describing and techniques involving the body such as breathing. The major benefits of well-practiced mindfulness included being able to relax, sooth and focus. Mindfulness has been mentioned as more abstract than some other more concrete skills.

Pragmatic distress tolerance skills such as distraction were useful in situations of suicidal intent and self-harm urges. Accepting, improving the moment and self soothing were useful, but viewed as more difficult. Radical acceptance was seen as more abstract and difficult to master. Emotional regulation was also relatively common in reports of skill usage. Many interviewees mastered a greater understanding of emotional experience, its causes, and adaptive expression. The main learning piece is the understanding that we as individuals are separate to the emotion.

Interpersonal effectiveness was a frequently mentioned skill set, especially in maintaining relationships and dealing with conflict. Many interviewees noticed improvements in managing misunderstandings, interpersonal setbacks and asserting needs in a productive way. Some participants identified examples of using interpersonal skills such as pros and cons, balancing wants and shoulds, saying no and making requests. Since there was less interpersonal conflict and anger outbursts noticed and more opportunity for sustained positive relationships, there was a reduced source of distress.

#### **6.2.10 SKILLS GROUP TRAINING – VIEWS AND IMPACT**

Among the most important elements of the skills group training was the cohesion between the skills group members. If a group is not cohesive, it could be source for conflict, learning is minimised and the group could fall asunder. In one case study, a negative experience with one group member was detrimental to attendance. The benefits of group training compared to skills taught on an individual basis are vast,

including comradeship, connectedness, reduced isolation, supplementary support and encouragement. The skills group offers an opportunity to hear others' experiences and usage of skills. All interviewees repeatedly referred to these benefits and also described a strengthening bond and relationship with their fellow group members.

New members entering mid-way had a disruptive influence on an established group. However, it was an opportunity for established members to be flexible and it can accelerate learning of new members. Premature discontinuation of established members within the skills group was disappointing and disheartening for fellow group members, especially when there was a strong connection. One interviewee mentioned feeling abandoned and isolated when such a situation occurred.

Another common theme running through the interviewees was around the rules of self disclosure and non-discussion of self harm. Many interviewees desired a 'process group', whereby they could talk about their difficulties, rather than learn how to deal with or manage them. Most interviewees understood the rationale behind such rules, but still would prefer a more open format and a forum to discuss their issues. Many participants believed it would be helpful to discuss diary cards more openly and minimise irritating political correctness.

Two case studies mentioned significant issues around attention within the skills group and that they could miss large chunks of information. Some referred to the motivational nature of the skills group trainers, which could sometimes be pushy. One case study particularly did not like one skills trainer.

For those who mentioned diary cards, they were viewed as difficult to fill in and a reminder of their pathology. One interviewee admitted not being truthful in them, while conversely another found them a positive source of feedback.

On balance, most interviewees were moderately positive about the benefits of the skills group. Many participants mentioned feeling better having attended and enjoying the experience of it. The skills group training was an opportunity to receive some support from skills trainers and fellow group members, learn some skills, talk about how they were feeling, receive positive feedback and give focus to their week.

### **6.2.11 TELEPHONE COACHING – VIEWS AND IMPACT**

Six out of ten case studies availed of this facility. Two interviewees chose not to use the telephone coaching because they preferred contacting their own friends, found it intrusive on the therapist's free time and had a distinct difficulty requesting help when suicidal. Two interviewees were not provided with telephone coaching due to limited staff resources.

From those who used the telephone coaching, all interviewees found that facility helpful and even essential. The benefits from telephone coaching were relationship repair with their individual therapist, skill learning and application, and management of distress, crisis and self-harm urges. The telephone contact itself was useful to prevent emotional escalation, allowing the interviewee to become rational, calm things down and make sense of things. The frequency of calls tended to decrease over time.

The focus of the telephone coaching was skills coaching and not validation. Some interviewees found this probing for their own solutions and skills usage irritating and awkward, preferring to talk about the issue itself.

### **6.2.12 CHANGES NOTED**

Out of the nine case studies that completed more than one research assessment, five participants showed clinical improvements in several areas, three participants demonstrated little or no change and one participant clinically deteriorated due a worsening alcohol dependency, ongoing stressors and lack of social support. Out of the three participants that showed little or no change, one discontinued prematurely and two finished the scheduled comprehensive DBT. Out of the five participants showing extensive improvements, three demonstrated improvement on all outcome measures administered at pre and post intervals (two discontinued prior to the full completion of DBT and one completed the scheduled comprehensive DBT) and two displayed positive changes in global functioning, hopelessness, and BPD symptoms (one participant discontinued prematurely and one completed the full programme of DBT). It was found that for the most part perceived stress and quality of life were

slow to change, while the other outcome measures including hopelessness, borderline symptoms, global psychological functioning normally demonstrated change earlier (by six months).

When all case study data was accrued and tested for statistical significance using Wilcoxon Signed Rank test, it was found that the borderline symptoms (measured by ZAN-BPD;  $z=26.5$ ;  $p=0.0234$ ) and hopelessness (measured by BHS;  $z=32.0$ ;  $p=0.0273$ ) showed statistically significant improvement between 0-6 months. Between the same period, mindfulness (measured by KIMS;  $z=5.5$ ;  $p=0.547$ ) and perceived stress (measured by PSS;  $z=29.0$ ;  $p=0.742$ ) approached clinical significance. No statistical significant change occurred in global functioning or reported quality of life within this period. Effect size calculations (Cohen, 1992), effect vs. standard deviation (sd.) ratio, reflected these results. ZAN-BPD and BHS demonstrated a huge and very large effect size (1.74 and 1.42 respectively) between baseline and six months. PSS and KIMS showed large effect size (0.8 and 0.82 respectively) within this period. Table 20 illustrates the direction of change in mean scores at pre-treatment and six month intervals.

Table 20: Mean scores pre-treatment and six months for 8 case studies

Outcome measure	Mean Pre-treatment score	Mean six-month score
CORE <Max score – 139>	83	77
KIMS <Max score – 195>	89	103
PSS <Max score – 40>	30	26
BHS <Max score – 20>	16	10
WHOQOL <Max score – 125>	55	58
ZAN-BPD <Max score – 36>	20	14

Qualitative data provided further insight into the nature and range of these improvements. Qualitative data strongly correlated with the results in outcome measurements and outcome measurements clearly reflected what was reported in qualitative interview. Improvements in functioning included interpersonal effectiveness, community reintegration, and drinking less. Positive change in interpersonal effectiveness was reported by many interviewees, in which there were reconnections with and improved relations with family members, less conflict, easier expression of needs and assertiveness. One case study was discharged from hospital and two others returned to employment.

Level of risk, that is self-injurious behaviour, suicidal ideation and acts, showed marked improvement for many interviewees. Six participants mentioned that they had better control of their emotions, in particular anger and anxiety. Impulsivity had shown dramatic improvement for some participants. By the second half of the year, many participants were more in control of their suicidal urges and claimed they had not partaken in any self destructive behaviour in an extended period. Length of and number of psychiatric admissions tended to show positive change in some cases.

Improvements in well-being were less dramatic than the other areas. By the end of their participation in DBT, numerous interviewees admitted being more hopeful and positive. Increments in self confidence and esteem and self acceptance were slower to be realised, as all participants had longstanding and deep-rooted difficulties in these areas.

### **6.2.13 OBSTACLES TO PROGRESS**

Another finding of this research is that improvement was greatly moderated and complicated by co-morbid difficulties, especially alcohol misuse/dependency and hopelessness/depressive outlook. The majority of participants had either difficulty in alcohol misuse/dependency or hopelessness/depressive outlook, many interviewees possessed both. Another common difficulty was a reported disengagement or disharmony with a close social network, which could otherwise have been a source of support and encouragement. Almost all participants at baseline had poor coping

abilities and heightened stressors, including invalidating inpatient and home environments, abuse flashbacks and health issues.

A manifest finding was the high level of early discontinuation of DBT in the study. Only four out of ten can be argued to have completed all scheduled components of DBT. Two participants finished a full year of the DBT programme. One participant completed at ten months, while a second finished at six months. Both participants continued in individual sessions, however their participation in the research ended, as the intervention was longer 'comprehensive' DBT.

Of the six participants who discontinued prematurely, two interviewees left in order to begin employment, one participant dropped out to begin an inpatient alcohol-detoxification programme, while the other three participants discontinued through poor attendance, mainly due to alcohol misuse/dependency.

## 6.3 CASE STUDY 1 - MARGARET

Margaret (50) presented with serious alcohol dependency and depression, resulting in loss of friends and disconnection from certain family members. Margaret has a long history of self destructive behaviour in the form of both suicide attempts (overdosing) and self harming (burning). Margaret first appeared in the Mental Health services after cutting her wrists at age 13. Margaret suffered child sexual abuse within the family. She began drinking at 18 years. She attended multiple alcohol rehabilitation programmes with occasional short-term success.

After a year of abstaining from alcohol, Margaret began the comprehensive DBT programme. However, due to multiple stressors and low mood, she began drinking again and eventually through poor attendance she discontinued her participation of DBT after six months.

### **6.3.1 QUANTITATIVE ANALYSIS**

#### **6.3.1.1 ATTENDANCE OF INDIVIDUAL THERAPY**

**OVERALL AVERAGE INDIVIDUAL SESSIONS ATTENDED → 63%**

##### **Commentary**

Margaret's attendance of her individual therapy was at a moderate level. In the last two months of her participation in the DBT programme, her attendance became very poor.

#### **6.3.1.2 ATTENDANCE OF THE SKILLS GROUP**

**OVERALL AVERAGE SKILLS GROUP SESSIONS ATTENDED → 81%**

##### **Commentary**

Margaret's attendance in the skills group was very good. However, around six months, her attendance became poor, and she eventually dropped out of treatment.

### 6.3.1.3 PSYCHIATRIC ADMISSIONS

Table 21: Psychiatric admissions for Case study 1.

	Within two years prior to DBT	During the DBT programme (6 months)
Number of appearances/admissions	10 (Average of 2.5 admissions per 6 month period)	5
Length of admissions within this period (days)	364 days (Average of 91 days per 6 month period) 50% of time hospitalised Mean length of admission – 36 days	89 days 49% of time hospitalised (during DBT attendance) Mean length of admission – 18 days

#### Commentary

Margaret has an extensive and very frequent pattern of day hospital and inpatient admissions, following A&E visits, alcohol detoxification, and ongoing difficulties around her BPD symptoms. The percentage of time hospitalised showed little change during DBT. The mean length of the admission showed some improvement. It also appears that the number of admissions increased from 10 over 2 years to five in a six month period.

### 6.3.1.4 OUTCOME MEASUREMENTS

#### 6.3.1.4.1 Clinical Outcome for Routine Evaluation (CORE)

Table 22: CORE figures for Case study 1.

	0 month	2 months	4 months	6 months
Well Being (Max – 16)*	8	4	11	16
Problems (Max – 48)	15	17	25	43
Functioning (Max – 48) –	21	16	18	36
Risk (Max – 24)	3	0	7	16
<b>Total CORE scores</b>	<b>47</b>	<b>37</b>	<b>61</b>	<b>101</b>
Change from baseline	-	21%	-30%	-115%

Note - Increases in scores indicate decreased global functioning.

\* Scores for “Well being” are counter-intuitive, so a higher score denotes lack of well being according to the client.

– Scores for “Functioning” are counter-intuitive, so a higher score denotes lack of functioning according to the client.

### **Commentary**

Although the CORE figures demonstrated some initial improvement at two months, a pattern of deterioration began at four months, with clinical significant deterioration recorded at six months. All measures increased dramatically in a negative direction, with risk among the most alarming changes.

#### **6.3.1.4.2 Kentucky Inventory of Mindfulness Skills (KIMS)**

Table 23: KIMS figures for Case study 1.

	0 month	2 months	4 months	6 months
Observing (Max – 60)	34	40	39	40
Describing (Max – 40)	19	23	29	25
Acting with Awareness (Max – 50)	31	25	25	17
Accepting (Max - 45)	28	21	20	22
<b>Total KIMS score</b>	<b>112</b>	<b>109</b>	<b>113</b>	<b>104</b>
Change from baseline	-	-3%	-	-7%

Note – Increases in scores indicate improvement in reported level of mindfulness.

### **Commentary**

Very little, if any, change was observed in the level of mindfulness, although interestingly the level of acting with awareness halved by six months.

### 6.3.1.4.3 Perceived Stress Scale (PSS)

Table 24: PSS figures for Case study 1.

	0 month	2 months	4 months	6 months
<b>Total PSS score (Max – 40)</b>	<b>23</b>	<b>30</b>	<b>29</b>	<b>31</b>
Change from baseline	-	-30%	-26%	-35%

Note – Increases in scores indicate greater perceived stress.

#### **Commentary**

The level of perceived stress increased by two months and this pattern was maintained at four and six months.

### 6.3.1.4.4 Beck Hopelessness Scale (BHS)

Table 24: BHS figures for Case study 1.

	0 month	2 months	4 months	6 months
<b>BHS score (Max – 20)</b>	<b>15</b>	<b>3</b>	<b>2</b>	<b>18</b>
Change from baseline	-	80%	87%	-20%

Note – Increases in scores indicate greater reported hopelessness.

#### **Commentary**

The BHS demonstrated a dramatic U-turn between baseline and six months into treatment. Margaret reported a severe level of hopelessness at baseline and six months. However, at two and four months assessment, Margaret conveyed clinically significant improvement dropping to the minimal range of hopelessness.

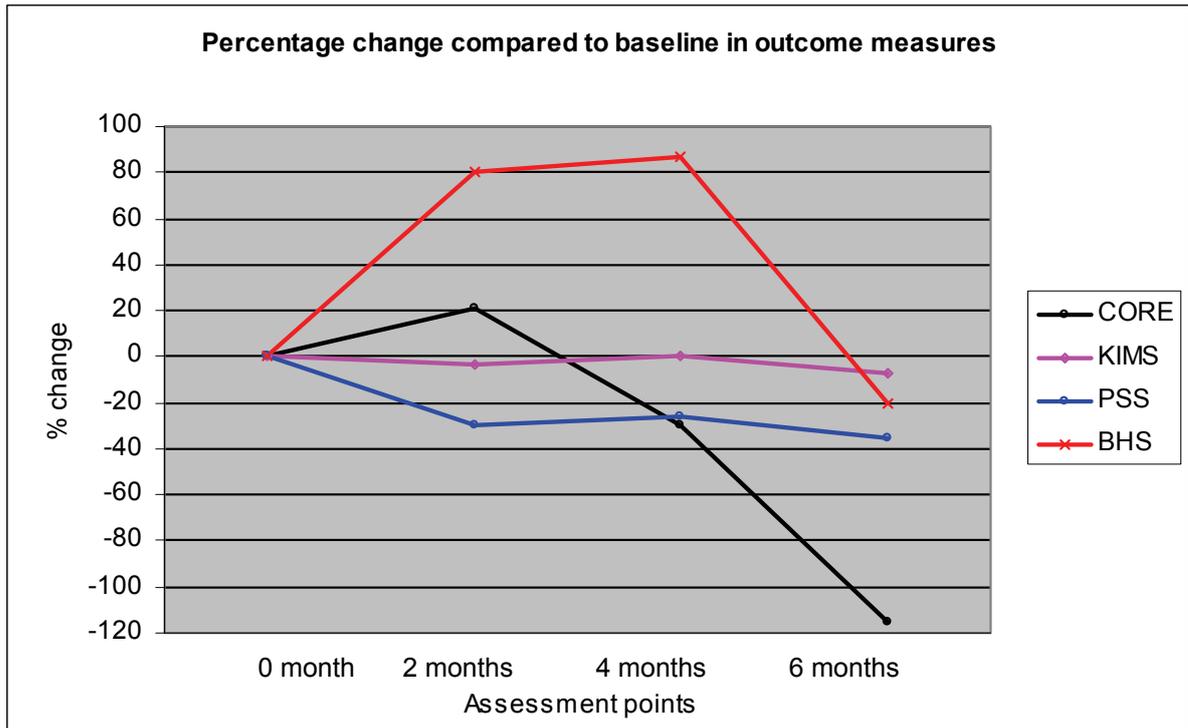


Figure 34: Percentage change compared to baseline in outcome measurement in Case study 1.

**Commentary on Figure 34:**

0 months signified the commencement of comprehensive DBT, i.e. all components of DBT, and at each bimonthly assessment point, a new skills group modules began. A decrease in percentage change denoted deterioration compared to baseline, whereas conversely increases in percentage change demonstrated improvement compared to baseline measurement.

**6.3.1.4.5 ZAN-BPD**

Table 26: ZAN-BPD figures for Case study 1.

	0 month	6 months
Affective disturbance score (Max – 12)	5	6
Cognitive disturbance score (Max – 8)	1	0
Impulsivity disturbance score (Max – 8)	0	2
Disturbed Relationships score (Max – 8)	2	4
<b>Total ZAN-BPD score</b>	<b>8</b>	<b>12</b>
Change from baseline	-	-50%

Note – Increases in scores indicate higher BPD symptoms.

### **Commentary**

By six months, Margaret reported 50% deterioration in her BPD symptoms, especially in impulsivity and disturbed relationship components.

#### **6.3.1.4.6 WHOQOL-BREF**

Table 27: WHOQOL figures for Case study 1.

	0 month	6 months
Physical Health (Max – 35)	26	13
Psychological Health (Max – 30)	8	9
Social Relationships (Max – 20)	5	3
Environment (Max – 40)	11	16
<b>Total WHOQOL score **</b>	<b>60</b>	<b>41</b>
Change from baseline	-	-32%

\*\* Lower the WHOQOL-BREF scores, the less satisfactory quality of life reported by the client

### **Commentary**

In the WHOQOL, a deterioration of around a 1/3 of baseline total figures was calculated, especially centred around environment and physical health areas.

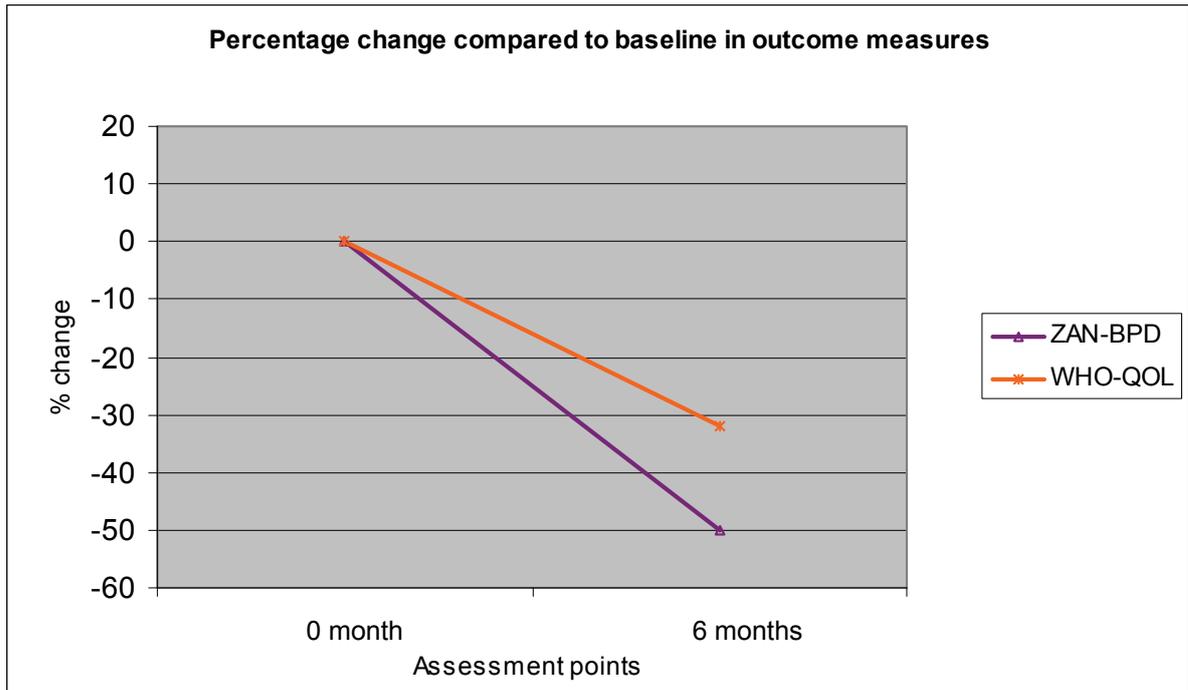


Figure 35: Percentage change compared to baseline in outcome measurement in Case study 1.

### **6.3.2 QUALITATIVE ANALYSIS**

#### **0 MONTHS**

Margaret presented with severe and disabling alcohol dependency and depression. She identified that her alcohol issues had jeopardised many of her close relationships.

*“I haven’t got a job or I’m not in a relationship. I’ve lost a lot of my friends because of my circumstances in life...AA was the starting point. But I kept relapsing time and time again. It seemed I couldn’t beat it at all. I was overdosing and was suicidal. I ended up in hospital more times than not there. It was a terrible pressure, I self harmed a lot and still do. I burn myself... Everybody started pulling away from me, and my family eventually. I lost everything in the end, my friends, my job and as I say my family”*

Margaret expressed dissatisfaction with her living arrangements. She was frustrated with her psychiatric care, which she believed did not deal with underlying problems and mainly focused on altering her medication.

*“Well you’d get to see a psychiatrist one or twice a month, but X just ends up writing out another script off you go. And that’s not getting to the tail end of the problem”.*

Margaret expressed doubt that she would be able to successfully complete the year.

*“Oh it won’t be easy. It’s going to take an awful lot of work. I’m stubborn, and that could go against them...I’m a negative person. So you view things pessimistically, so if it’s not working quickly. I’ll fall off the wagon”*

From the therapeutic year, she said she would like to learn better coping strategies and perhaps return to employment.

## **2 MONTHS**

Margaret recalled that she recently impulsively took an overdose. She mentioned that many of the nurses and her individual therapist were frustrated by her actions. Despite this setback, Margaret was able to name many of the mindfulness and emotion regulation skills. She has been practising skills (e.g. observe, describe, participate, acting against emotions), but has difficulty being non-judgemental. Margaret described herself as an emotional person and has difficulty staying in ‘wise-mind’. There is a slowly building trust between her and her individual therapist. She has availed of and applauded the out-of-hours telephone coaching on several occasions, which has prevented her attempting to take her life. She remarked that it is less emotionally validating and more focused on skills coaching.

Margaret declared two new changes in her life, a reconnection with a supportive brother and a planned moving to less supported accommodation. She noticed improved focus and better interpersonal effectiveness. She has been able to more constructively manage conflict in her accommodation.

## **4 MONTHS**

Margaret reported that she had made several attempts to take her life in recent time. She rationalised each episode as purely impulsive coping strategy, where she felt she

could not manage her accommodation situation, so she wanted to escape from it. She identified her thinking as dichotomous and extreme, and is working towards more balanced thinking. Margaret has availed of telephone contact to help cope with her strong suicidal urges, and has particularly utilised distraction. Margaret mentioned attempting to be more gentle with herself, yet she is finding herself getting frustrated at not fully understanding and applying the skills. Margaret remained hopeful that through repetition, she will be able to master the skills. Margaret alleged that one other group member has broken confidentiality, which has certainly been aggravating for her. She commented that she has been relatively pleased with progress to date, although this has been limited by her frequent setbacks.

## **6 MONTHS**

Margaret presented as very depressed, suicidal and hopeless. She has been suffering numerous incapacitating physical problems. Margaret has begun drinking again due to her feelings of loneliness and isolation in her new accommodation. She has consequently lost contact with her brother. She reiterated the continued tension with one group member, and also declared that relations with her individual therapist were recently turbulent.

*“Stormy. Very challenging. When I’m suicidal and very depressed, She’d tell me that I don’t want you to do this and the other. It’s just a block. It’s like that I just can’t cope”.*

Skill acquisition and application was still very difficult, and she would prefer if therapy were more validating and less skills-focused. She has found skill application and diary cards particularly challenging.

### 6.3.3 INTEGRATION OF ALL DATA

Margaret attended for six months. Despite some initial moderate progress reported in global functioning at two months and some considerable improvement in hopelessness at two and four month assessments, Margaret returned to or sank below baseline figures on both measures by six months. Little change was reported in mindfulness.

BPD symptoms considerably deteriorated by six months compared to baseline, particularly in the areas of impulsivity and relationships, which is congruent with Margaret's reports of impulsive self destructive behaviours, difficulty abstaining from alcohol and arguments with her brother. Margaret's quality of life showed a considerable decrement at six months compared to baseline figures, especially in the areas of physical health, which again matches with her interview report of ill health at six months. Margaret's perceived stress level showed deterioration by two months and this downward trend was maintained. This pattern of heightened stress could be explained by her references to her disharmony with her fellow group member, disagreements with her brother and individual therapist, difficulty abstaining from alcohol, problems assimilating skills, and also her moving to less supported accommodation.

Margaret's sense of hopelessness may have been augmented through her struggle with understanding and applying key skills. Telephone coaching was a helpful crisis prevention facility. However, Margaret denied that telephone skill coaching helped with the next onslaught of suicidal feelings. Margaret did not become comfortable with any skill, apart from distraction. The skills group possessed a source of distraction through Margaret's personal difficulties with another group member, which cannot have aided Margaret's retention of each skills module.

The greatest obstacle to Margaret's attendance and success in the DBT programme was her chronic and severe alcohol abuse, which was utilised as a coping strategy to feelings of loneliness, hopelessness, self harm and suicide. This alcohol dependency resulted in Margaret dropping out of treatment through missing four consecutive sessions. It appears that Margaret's alcohol abuse was detrimental in her progress, yet

her perceived lack of early progress was managed through alcohol. Margaret's life threatening behaviours were unrestrained and clearly accentuated through alcohol. The DBT programme was unfortunately insufficient in isolation in managing Margaret's dual diagnosis. This difficulty is clearly reflected by reference to the lack of change in the rate and length of psychiatric inpatient admissions. Ideally, Margaret should have attended or been attending an outpatient/inpatient substance misuse facility alongside participation in DBT.

## 6.4 CASE STUDY 2 - SARAH

Sarah (35) is a mother and is currently separated from her partner. Sarah was originally admitted to hospital after overdosing. Sarah has a diagnosis of BPD, bulimia nervosa, polysubstance misuse and depression. She was sexually abused in her early childhood. Many of the hospital reports describe her as demanding and difficult to manage. Self-harm behaviours include hair pulling, picking herself, purging and cutting, but despite frequent suicidal threats, ward reports have said her suicide risk is low. Her consultant has more recently requested her to be transferred to a personality disorder specialist unit, alerting them to her risk to others and herself and her inability of independent living. Sarah attended DBT for six months, discontinuing her participation through non-attendance of sessions.

### **6.4.1 QUANTITATIVE ANALYSIS**

#### **6.4.1.1 ATTENDANCE OF INDIVIDUAL THERAPY**

OVERALL AVERAGE INDIVIDUAL SESSIONS ATTENDED → 73%

##### **Commentary**

Sarah's attendance of her individual sessions was very good. Sarah on average attended three out of every four scheduled appointments per month.

#### **6.4.1.2 ATTENDANCE OF THE SKILLS GROUP**

OVERALL AVERAGE SKILLS GROUP SESSIONS ATTENDED → 79%

##### **Commentary**

Her attendance record of the skills group was very good.

### 6.4.1.3 PSYCHIATRIC ADMISSIONS

Table 28: Psychiatric admissions for Case study 2.

	Within two years prior to DBT	During the DBT programme (6 months)
Number of appearances/admissions	1 (Continued long-term admission)	1 (Continued long-term admission)
Length of admissions within this period (days)	175 days 24% of time hospitalised	168 days 100% of time hospitalised

#### Commentary

Sarah was admitted into an inpatient ward, six months prior to beginning her participation in DBT of the same year. She continued to be an inpatient for the full length of time she attended DBT. No change in use of inpatient services occurred.

### 6.4.1.4 OUTCOME MEASUREMENTS

#### 6.4.1.4.1 Clinical Outcome for Routine Evaluation (CORE)

Table 29: CORE figures for Case study 2.

	0 month	2 months	4 months	6 months
Well Being (Max – 16)*	13	15	15	15
Problems (Max – 48)	36	40	46	44
Functioning (Max – 48) ↖	45	42	46	44
Risk (Max – 24)	12	12	15	18
<b>Total CORE scores</b>	<b>108</b>	<b>109</b>	<b>122</b>	<b>121</b>
% Change from baseline	-	-	-13%	-12%

\* Scores for “Well being” are counter-intuitive, so a higher score denotes lack of well being according to the client.

– Scores for “Functioning” are counter-intuitive, so a higher score denotes lack of functioning according to the client.

### Commentary

Sarah demonstrated little change in the first two assessments in global psychological functioning. Slight deterioration was observed in four and six month assessments, especially noticeable in risk, with a 50% increase in this measure recorded between 0 and 6 months. Problems, functioning and well being are almost all at the highest possible clinical levels at six months.

#### 6.4.1.4.2 Kentucky Inventory of Mindfulness Skills (KIMS)

Table 30: KIMS figures for Case study 2.

	0 month	2 months	4 months	6 months
Observing (Max – 60)	42	29	24	33
Describing (Max – 40)	25	25	11	14
Acting with Awareness (Max – 50)	15	20	23	25
Accepting (Max – 45)	14	13	19	11
<b>Total KIMS score</b>	<b>86</b>	<b>87</b>	<b>77</b>	<b>83</b>
% Change from baseline	-	-	-13%	-3%

### Commentary

Little change was recorded in the mindfulness scale. Accepting remained low throughout each assessment. Observing and describing showed a decrease between 0 and 6 month assessments.

#### 6.4.1.4.3 Perceived Stress Scale (PSS)

Table 31: PSS figures for Case study 2.

	0 month	2 months	4 months	6 months
<b>Total PSS score (Max – 40)</b>	<b>35</b>	<b>30</b>	<b>30</b>	<b>31</b>
% Change from baseline	-	14%	14%	11%

### **Commentary**

Slight improvement was observed at two months in the perceived level of stress compared to baseline. However, the reported level of stress remained within the top 25% of the clinical range in each assessment.

#### **6.4.1.4.4 Beck Hopelessness Scale (BHS)**

Table 32: BHS figures for Case study 2.

	0 month	2 months	4 months	6 months
<b>BHS score (Max – 20)</b>	<b>18</b>	<b>18</b>	<b>19</b>	<b>19</b>
% Change from baseline	-	-	-6%	-6%

### **Commentary**

No change was noted between baseline and six-month assessment points in hopelessness. Sarah remained within the top end of the severe range of hopelessness, answering almost exclusively in the direction of hopelessness.

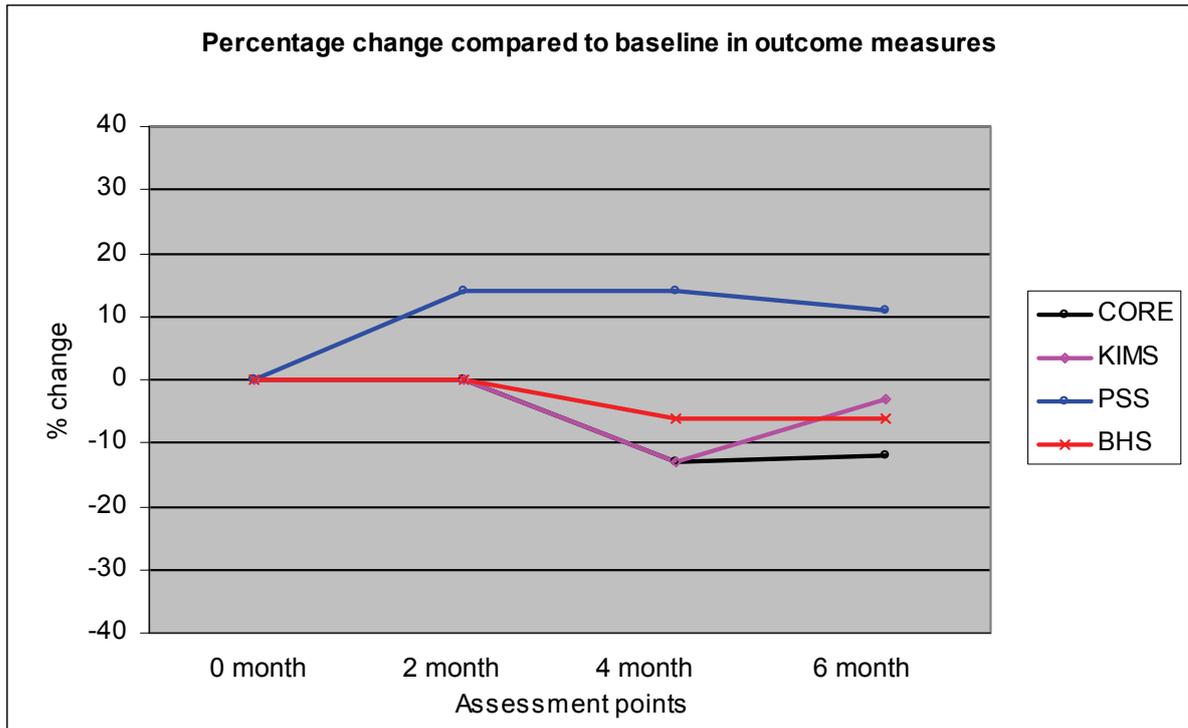


Figure 36: Percentage change compared to baseline in outcome measurement in Case study 2

#### 6.4.1.4.5 ZAN-BPD

Table 33: ZAN-BPD figures for Case study 2.

	0 month	6 months
Affective disturbance score (Max – 12)	10	10
Cognitive disturbance score (Max – 8)	8	8
Impulsivity disturbance score (Max – 8)	3	4
Disturbed Relationships score (Max – 8)	8	7
<b>Total ZAN-BPD score</b>	<b>29</b>	<b>29</b>
% Change from baseline	-	-

#### Commentary

No change was calculated in BPD symptoms across Sarah’s attendance in the DBT programme.

#### 6.4.1.4.6 WHOQOL-BREF

Table 34: WHOQOL figures for Case study 2.

	0 month	6 months
Physical Health (Max – 35)	15	14
Psychological Health (Max – 30)	8	6
Social Relationships (Max – 20)	3	3
Environment (Max – 40)	10	11
<b>Total WHOQOL score **</b>	<b>36</b>	<b>34</b>
% Change from baseline	-	-6%

\*\* Lower the WHOQOL-BREF scores, the less satisfactory quality of life reported by the client

#### Commentary

No notable change was recorded in level of reported quality of life between baseline and six months.

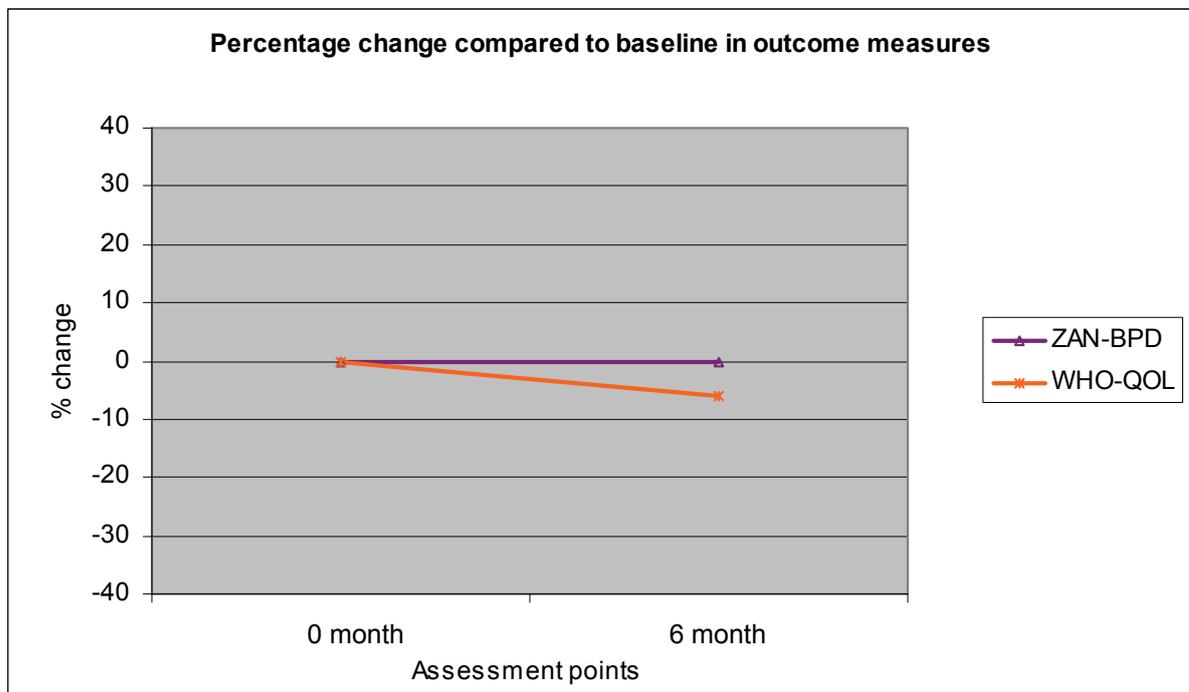


Figure 37: Percentage change compared to baseline in outcome measurement in Case study 2.

## **6.4.2 QUALITATIVE ANALYSIS**

### **0 MONTHS**

Sarah discussed her immense dissatisfaction with her appearance and her suicidal thoughts and plans. She described disagreements with her consultant psychiatrist about visiting her family and increasing medication. She portrayed her consultant psychiatrist as cold and dismissive, while she said her individual therapist is easy to talk to. She mentioned that she really dislikes the close monitoring of being an inpatient, and would like to become well enough to go home. Sarah confessed that she did not understand her diagnosis. The skills group may be helpful, as she will know she is not alone and there are further people with similar difficulties.

### **2 MONTHS**

Sarah commented that she did not want to be discharged from hospital, as even attending DBT makes her feel panicky because of others' expectations. Sarah mentioned that she is having difficulty comprehending the skills and is more of a passive observer in the skills group.

*“Complicated. It’s the way they are worded. If it were in simple English it would be ok. The big words, these highfaluting words...They (skills trainers) make everything sound so easy, but when you put it into practice it’s not easy, it’s hard... I haven’t been able to put any of those (skills) into practice. I haven’t bothered...I did not get mindfulness at all”.*

She reiterated the helpfulness of knowing she is not isolated in her condition, but complained that group members are not able to talk about self harming and collaboratively discuss coping strategies.

*“If people want to talk about self harming, I think you should be able to talk about i., because you’re actually looking for the bit of help of them. You could share with other people in the group, and see how they cope with it and how they feel”.*

Her relationship with her individual therapist has become more challenging, especially as her individual therapist has attempted to explain reasons behind inpatient restrictions. Sarah claimed her only self-harming behaviour is purging, but she is on the edge of “cracking up”.

#### **4 MONTHS**

Sarah was particularly low and despondent about her slow progress in DBT. She claimed that she has been committed to learning the skills, but is disappointed that she is still plagued by chronic suicidal thoughts. She told me that the skills are easier to comprehend when rehearsed with her individual therapist, yet are still difficult to apply. She confessed that her family are blaming her for her mother being admitted into a psychiatric ward. She said she felt stuck in the inpatient setting. She reiterated her dislike for her consultant psychiatrist, who is particularly unresponsive to her requests for anti-anxiety medication. She commented that she trusts her individual therapist more. DSH urges were managed through distracting activities available on the ward.

#### **6 MONTHS**

Sarah appeared extremely disillusioned, mentioning that her family had refused to see her. She felt miserable, low and alone. Sarah exclaimed that she would like to hang herself if she got the opportunity and she has been picking at her skin. She confessed that she is not very committed or motivated to attend the DBT and that she feels forced into going. In the skills group, instead of listening, she imagined how she could convince her parents to allow her to return home. Sarah confessed that she was not truthful in her diary cards. She commented that most of the skills she does not understand or apply. She complained that individual therapy now amounts to “ear bashing”.

### **6.4.3 INTEGRATION OF ALL DATA**

Sarah attended DBT for six months. The outcome measurement collected on Sarah unanimously indicated no change across the six months compared to baseline. CORE, measuring global psychological functioning, revealed little change across four assessments, although risk worsened by 50% between baseline and six months. The level of hopelessness remained almost at maximum level in the severe range at every assessment. This finding was not surprising, given that Sarah mentioned strong suicidal thoughts, threats and plans at every interview. Sarah became steadily more despondent, as she was not witnessing any changes and was still an inpatient. The perceived level of stress showed slight improvement, although stayed very high at every assessment. Sarah may have been supported to manage some of her stressors through the support and advice provided by her individual therapist such as the dissatisfaction of being an inpatient, disconnection with her family, disagreements with her consultant psychiatrist and ward staff and her suicidal feelings.

BPD symptoms, as indicated by the ZAN-BPD, did not change. Sarah remained in the same frame of mind at baseline and six months. Impulsivity, self destructive urges, relationship disharmony, anger outbursts, mood fluctuations, chronic emptiness and identity disturbance symptoms appeared to be as strong at her discharge as at baseline. Her quality of life did not appear to be improving across the six months of DBT treatment, possibly clarified through her continued status of inpatient and disconnection with her family.

As indicated in her qualitative interview, mindfulness showed no change across the six months. This stagnancy can be attributed to Sarah's continued references to having difficulty understanding and applying mindfulness and other skills modules. Sarah confessed that she had particular difficulties concentrating in the skills group and did not become actively involved in the new learning. Sarah preferred to stay quiet rather than vocalise her lack of understanding of the new concepts. Despite ample rehearsal of skills in the individual sessions, Sarah did not appear to assimilate any new skills within six months. Sarah mentioned that she appreciated that she was not alone in her difficulties. However, she did not comment on whether a sense of group companionship existed for her. According to hospital reports, Sarah had

particular difficulties in interpersonal relationships, and this interpersonal approach may have inhibited the formation of bonds with fellow group members, which could have contributed to added motivation, understanding of skills, and commitment. Telephone coaching was not provided for Sarah, as it was believed by her individual therapist that Sarah had adequate support on the ward during times of distress. Hence, Sarah did not receive comprehensive DBT.

Although initially Sarah provided a good report of the approachable nature of her individual therapist, Sarah tended to complain about her individual therapist being more challenging and demanding in the following interviews. Her individual therapist appeared to reason with Sarah with regard to home visits and access to materials that could be used for attempting suicide. Sarah was focused on achieving one of two goals: escaping her inpatient setting by returning home or through some self-destructive method of overdosing, disconnection through medication, or completed suicide through proposed hanging. Sarah demonstrated many self-destructive tendencies through purging, self picking and hair pulling.

Sarah mentioned that she was unmotivated to continue in DBT from the four month interview. Sarah's attendance was facilitated through her close supervision by her individual therapist and the ward staff. It appears that instead of DBT being viewed as a 'treatment of choice', in which motivation and commitment by the client is necessary to produce results, DBT became an irritating compulsory requirement made by external individuals rather than being formulated and accomplished by Sarah herself. Hence, Sarah came to interpret DBT as forced on her and unlikely to result in change.

Sarah was acutely unflattering about her consultant psychiatrist. Much of this discontent centred around the consultant psychiatrist not allowing home visits for Sarah, as she feared for her safety, and not allowing increased medication for Sarah's alleged panic attacks, as she believed Sarah would abuse this facility. Sarah viewed the solution of many of her difficulties in medication. Sarah did not seem to view herself as instrumental in producing many of the necessary changes. Hence, Sarah criticised her consultant psychiatrist as she was seen as an obstacle to her receiving some relief from her symptoms.

In conclusion, Sarah, a long-term inpatient, was not an easy case for the DBT programme. It is unlikely that many changes could have occurred for such a serious case within the short period of six months, especially due to the lack of full comprehensive DBT available (no telephone consultation) and difficult inpatient issues with ward reports that indicated ongoing tension and crises. It is noteworthy that Sarah perceived her individual therapist to take the side of the nursing staff, which created a strained relationship and ultimately jeopardised progress within therapy. Therefore, lack of the 'active ingredient' of telephone coaching (particularly to practice skills in crisis and times of reported acute suicide ideation, clarify therapeutic alliance and boundary difficulties and maintain motivation and hope for change), in combination with an overwrought therapeutic alliance and continued invalidating environment contributed heavily to the lack of progress and resulting attrition in this case. It may also have been the case that Sarah's approach to dealing with her difficulties (e.g. becoming confrontational or giving up) and level of insight (e.g. tendency to externalise and not adopt a more balanced view point) may have needed extended collaborative work. This aforementioned approach may have been the result of long periods of interpersonal conflict, invalidation, mistrust, and lack of opportunity to think more positively.

## 6.5 CASE STUDY 3 - ANNA

Anna (39) is married with four children. She first presented to the adult mental health services nine years previously. She had taken an overdose intending to kill herself and was diagnosed with severe postnatal depression and presented with severe thoughts of self harm. Anna was a victim of child sexual abuse. Anna continued to be in contact with both emergency medical and psychiatric services. She was diagnosed as having depression, bulimia nervosa, and emotional unstable personality disorder (BPD).

Anna attended comprehensive DBT for ten months and continued with individual DBT sessions thereafter. She was admitted during the DBT programme, for one month and diagnosed as having dissociative disorder.

### **6.5.1 QUANTITATIVE ANALYSIS**

#### **6.5.1.1 ATTENDANCE OF INDIVIDUAL THERAPY**

OVERALL AVERAGE INDIVIDUAL SESSIONS ATTENDED → 100%

##### **Commentary**

Anna demonstrated excellent attendance of her individual therapy sessions.

#### **6.5.1.2 ATTENDANCE OF THE SKILLS GROUP**

OVERALL AVERAGE SKILLS GROUP SESSIONS ATTENDED → 98%

##### **Commentary**

Anna displayed excellent attendance in her skills group. She missed just one scheduled appointment in the first two months.

### 6.5.1.3 PSYCHIATRIC ADMISSIONS

Table 35: Psychiatric admissions for Case study 3.

	Within two years prior to commencing DBT	During the DBT programme (10 months)
Number of appearances/admissions	7	1
Length of admissions within this period (days)	160 days (Average of 40 days per 6 months) 22% of time hospitalised Mean admission – 22.8 days	21 days (Average of 11 days per 6 months) 7% of time hospitalised (during DBT attendance)

#### Commentary

Anna was admitted seven times prior to attending DBT, in both inpatient and day hospital settings. This figure excludes 17 home visits during this period. These admissions were due to continuing low mood and thoughts of self harm. Considerable reduction in the number of admissions can be observed with one 21 days length admission during her participation for DBT due to recurring depressive episode and dissociative disorder. However, the mean length of each admission did not changed.

## **6.5.1.4 OUTCOME MEASUREMENTS**

### **6.5.1.4.1 Clinical Outcome for Routine Evaluation (CORE)**

Table 36: CORE figures for Case study 3.

	0 month	2 months	4 months	6 months
Well Being (Max – 16)*	13	13	12	15
Problems (Max – 48)	40	45	43	43
Functioning (Max – 48) –	40	36	33	39
Risk (Max – 24)	15	19	16	15
<b>Total CORE scores</b>	<b>108</b>	<b>113</b>	<b>106</b>	<b>112</b>
<b>(% Change from baseline)</b>	-	(-5%)	(+2%)	(-4%)
	8 months	10 months	12 months	
Well Being (Max – 16)*	12	15	DBT	
Problems (Max – 48)	39	41	ended	
Functioning (Max – 48) –	33	33	-	
Risk (Max – 24)	16	16	DBT	
<b>Total CORE scores</b>	<b>100</b>	<b>105</b>	ended	
<b>(% Change from baseline)</b>	(+7%)	(+3%)		

\* Scores for “Well being” are counter-intuitive, so a higher score denotes lack of well being according to the client.

– Scores for “Functioning” are counter-intuitive, so a higher score denotes lack of functioning according to the client.

#### **Commentary**

Little change was reported across the six assessments points in reported global functioning. Risk remained at a very high level at every assessment. Other measures displayed little changed and remained high.

### 6.5.1.4.2 Kentucky Inventory of Mindfulness Skills (KIMS)

Table 37: KIMS figures for Case study 3.

	0 month	2 months	4 months	6 months
Observing (Max – 60)	35	29	27	24
Describing (Max – 40)	19	22	21	27
Acting with Awareness (Max – 50)	16	17	18	22
Accepting (Max - 45)	21	18	17	21
<b>Total KIMS score</b>	<b>91</b>	<b>86</b>	<b>83</b>	<b>94</b>
<b>(% Change from baseline)</b>	<b>-</b>	<b>(-5%)</b>	<b>(-9%)</b>	<b>(+3%)</b>
	8 months	10 months	12 months	
Observing (Max – 60)	19	21	DBT	
Describing (Max – 40)	20	24	ended	
Acting with Awareness (Max – 50)	20	12	-	
Accepting (Max - 45)	23	14	DBT	
<b>Total KIMS score</b>	<b>82</b>	<b>71</b>	ended	
<b>(% Change from baseline)</b>	<b>(-10%)</b>	<b>(-22%)</b>		

### Commentary

The reported level of mindfulness did not appear to show any noteworthy change between baseline and six months. Deterioration was recorded between 0 months and the final assessment at 10 months.

### 6.5.1.4.3 Perceived Stress Scale (PSS)

Table 38: PSS figures for Case study 3.

	0 month	2 months	4 months	6 months
<b>Total PSS score (Max – 40)</b>	<b>34</b>	<b>30</b>	<b>33</b>	<b>31</b>
<b>(% Change from baseline)</b>	<b>-</b>	<b>(+13%)</b>	<b>(+3%)</b>	<b>(+9%)</b>
	8 months	10 months	12 months	
<b>Total PSS score (Max – 40)</b>	<b>36</b>	<b>32</b>	-	
<b>(% Change from baseline)</b>	<b>(-6%)</b>	<b>(+6%)</b>		

### Commentary

Anna reported little change in her level of perceived stress throughout the therapeutic year. The level of stress stayed within the top 25% in all assessments.

#### 6.5.1.4.4 Beck Hopelessness Scale (BHS)

Table 39: BHS figures for Case study 3.

	0 month	2 months	4 months	6 months
<b>BHS score (Max – 20)</b>	<b>17</b>	<b>14</b>	<b>16</b>	<b>14</b>
<b>(% Change from baseline)</b>	-	(+18%)	(+6%)	(+18%)
	8 months	10 months	12 months	
<b>BHS score (Max – 20)</b>	<b>14</b>	<b>15</b>	-	
<b>(% Change from baseline)</b>	(+18%)	(+12%)		

### Commentary

Minimal improvement was observed in the level of hopelessness stated. Anna remained within the severe range of hopelessness in every assessment between 0-10 months.

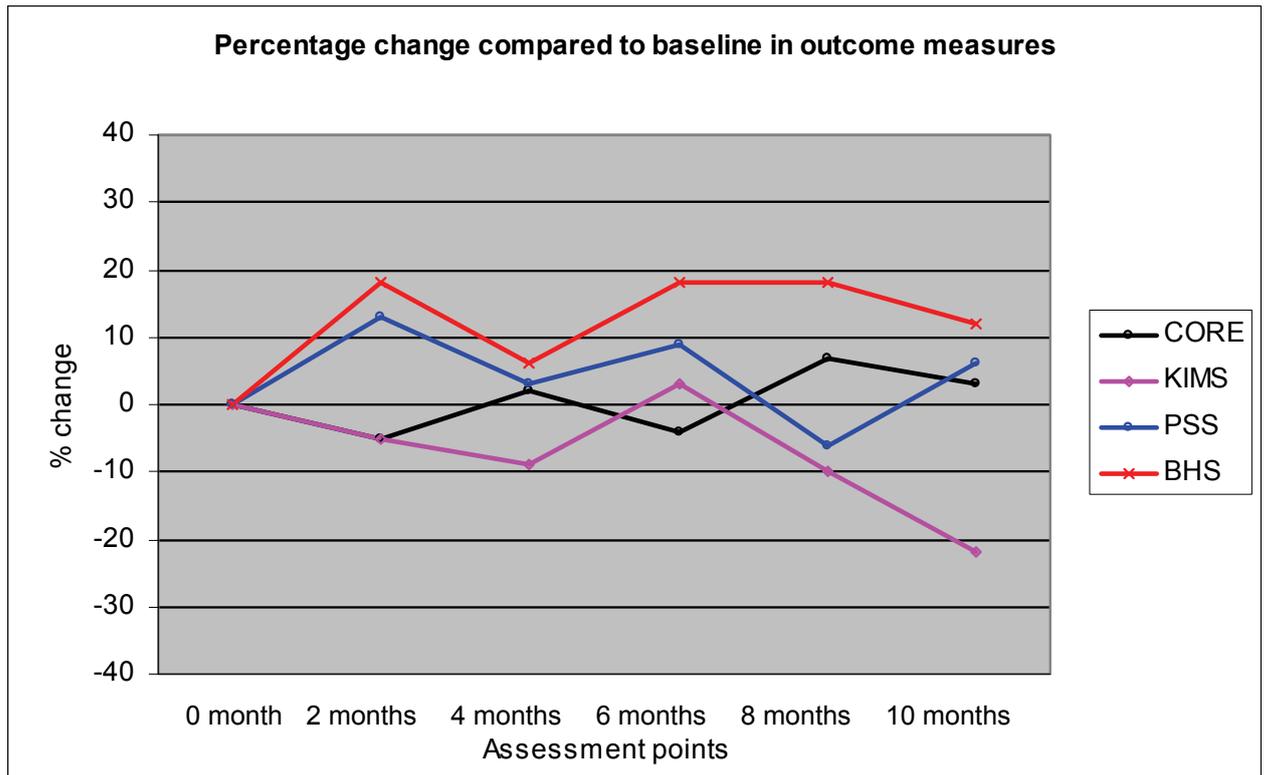


Figure 38: Percentage change compared to baseline in outcome measurement in Case study 3.

#### 6.5.1.4.5 ZAN-BPD

Table 40: ZAN-BPD figures for Case study 3.

	0 month	6 months
Affective disturbance score (Max – 12)	10	5
Cognitive disturbance score (Max – 8)	5	8
Impulsivity disturbance score (Max – 8)	3	1
Disturbed Relationships score (Max – 8)	3	3
<b>Total ZAN-BPD score</b>	<b>21</b>	<b>17</b>
<b>(% Change from baseline)</b>	-	(+19%)

#### Commentary

Small improvement was reported between baseline and six month assessment in terms of BPD symptoms. Although cognitive disturbance increased within this period, impulsivity and affective disturbance both displayed a downward direction.

### 6.5.1.4.6 WHOQOL-BREF

Table 41: WHOQOL figures for Case study 3.

	0 month	6 months
Physical Health (Max – 35)	21	15
Psychological Health (Max – 30)	10	9
Social Relationships (Max – 20)	5	6
Environment (Max – 40)	25	27
<b>Total WHOQOL score **</b>	<b>61</b>	<b>57</b>
<b>(% Change from baseline)</b>	<b>-</b>	<b>(-7%)</b>

\*\* Lower the WHOQOL-BREF scores, the less satisfactory quality of life reported by the client

#### Commentary

No change was recorded in level of quality of life between pre-therapy and six months.

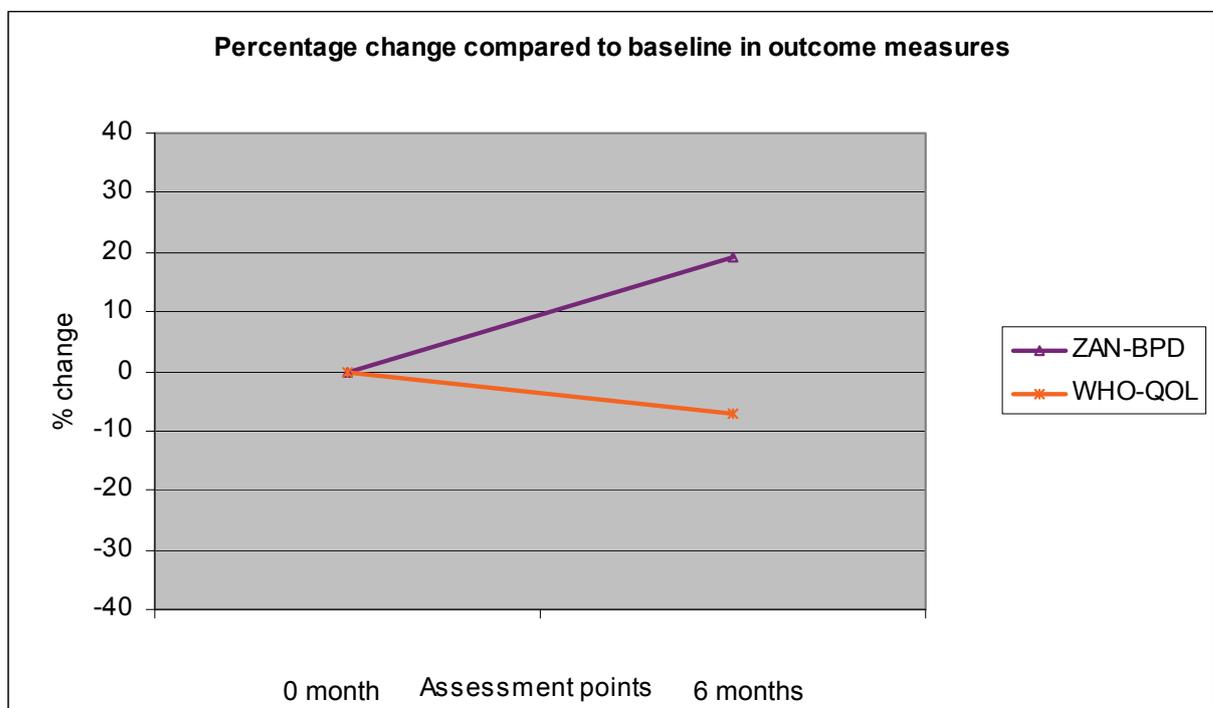


Figure 39: Percentage change compared to baseline in outcome measurement in Case study 3.

## **6.5.2 QUALITATIVE ANALYSIS**

### **0 MONTHS**

Anna described the horrendous sexual abuse she had experienced in her childhood and her teenage years. Anna connected these experiences with her diagnoses of depression and anorexia. Anna informed me that she took numerous overdoses in order to escape from the daily torturous feelings. Anna recalled many dismissive experiences with mental health professionals, who attempted to treat her anorexia. Anna mentioned that she was adverse to medication, more often abusing it rather than taking it appropriately. She claimed she would like to be the cause of change rather than the medication. Anna talked about past disappointments with a counsellor and how she found it difficult to begin with her present individual therapist. It appeared her faith in and trust with her individual therapist has built up firmly. She has found it difficult to seek help through telephone coaching, as she feels her problems are “too pathetic” to talk about. Seeking advice, when she is suicidal is the last thing she wants. Anna described her time in hospital as difficult. Anna felt many of the nurses disliked her and found it challenging to ask for help. With regard to the skills group, Anna had many fears around feeling patronised and awkward, and possibly becoming confrontational. She blamed herself for her present situation. It will be difficult to attend, but once she has committed, she will follow through on this.

### **2 MONTHS**

Anna reiterated that although she has committed to the DBT programme, she did not feel she had a choice. Anna has had difficulty attending in skills group sessions and her mind tended to drift. The skills that she rehearsed at home were basic, however she has found it aggravating that she has not managed to apply them. Certain skills were particularly difficult as they were connected to memories of abuse, such as self soothing and half smiling. Radical acceptance was particularly problematic. The skills group trainers have been a bit forceful at times and she has disliked the sense of political correctness. Anna thought that the individual sessions did not always match the skills group. She was still reluctant to avail of the telephone coaching, as she

believed it to be intrusive to her individual therapist and did not want advice when she felt suicidal.

#### **4 MONTHS**

Within the skills group, Anna has still had the problem of dissociation in a large of proportion of it. Anna admitted that she missed out on a lot of important material.

*“I’ve been dissociating most of the time. I’ve found it very tough to stay there, it’s going back to mindfulness again. I blanked out through so much of it, as it sometimes brings back bad memories for me. As for what I do get, it’s very patchy and I don’t always understand it”*

Anna has found the format of the group too restrictive and some terms such as “good-enough family” can be disturbing and commence a torrent of negative questioning. Anna felt ‘stuck’ with the skills and she did not always have the opportunity in individual sessions to discuss skills. Anna admitted that she misapplied many of the skills. Anna has recognised several opportunities, in which she could have used the telephone coaching, but she was firmly resistant to seeking help. Anna remained committed to finishing her year in DBT.

#### **6 MONTHS**

Anna acknowledged that the interpersonal effectiveness module has been especially useful. She has become more assertive and has been more willing to express herself. Anna has found the restrictive format of the skills group frustrating. She would prefer to be able to discuss diary cards and DSH. Anna commented that closer links between the content of the skills group and individual sessions would be more effective. Anna applauded the investment, support, acceptance and direction of her individual therapist.

*“I see her as a very supportive person. Extremely interested in what’s going on with my life, far more than any other therapist I’ve ever come across... I think she accepts me for who I am and what I am. She also has great expectations, and she pushes me*

*along, and she doesn't except any dithering. You just have to pull yourself together, but she's not condescending, and is encouraging the whole time.*

However, on occasion she has found the continued focus overwhelming and has thought of giving up. Anna has at times questioned where the therapy was heading, but recently finds the relationship with her individual therapist is beyond reproach, as her therapist never gives up. Anna has recently been admitted to hospital due to her dissociation.

## **8 MONTHS**

Anna has been discharged from hospital, but following an increase in her medication has had an uncharacteristic high feeling. In this period, she felt everything was coming easier to her including DBT skills. Anna expressed a great fear that she will slip down to dismal levels that she has previously experienced. Anna maintained that individual therapy has been consistently good, although the results largely depend on her mood. Anna confessed that she has formed a close bond with one of the group members, which is a distinct motivating force to continue attending.

*"I get the impression that we understand each other a bit. I would have an insight into his problems, he would have an idea of mine... It does help and motivate me. During the session we can rebound off each other there is a bond there".*

Anna has managed to stay patient when other group members have been at a slower pace. Anna reiterated that she would like closer coordination between the material covered in the skills group and the individual sessions. Anna has been able to apply more assertion in her interpersonal relations. However, she has still been reluctant to use certain skills, such as self soothing. Anna also cautioned that it is very difficult to adopt skills when feeling dismal and motivation levels are minimal.

## **10 MONTHS**

Anna has found time alone difficult as she has begun negative rumination. She admitted that she has commenced bingeing again, in order to cope with daily stressors.

She has been carrying immense fears of falling into depression. She has found it a distinctly negative experience, that she was recently left the sole group member. Anna reflected on her experience over the previous ten months and feels she has a sense of achievement, but has learned little. Despite having no negative things to say about her therapist, Anna admitted that she found the whole programme controlling and she has at times been very resistant to it. Anna confessed that she no longer fills in the diary cards, as she views them as a constant reminder of her pathology.

*“For a lot of the time there was no progress, so it was like hauling a ball and chain around all the time. So if you’ve had a couple of bad weeks, if you’re not charting it, it doesn’t seem as bad. I tend to try and forget which what happened before. It’s a constant reminder that you’re this patient, you’re in this course, you’re not making any progress. I’m sure I am, but I don’t see it, and I don’t believe it”.*

Anna commented that she still is actively suicidal, but would not act on these feelings due to her children, and sometimes feels trapped in her situation. Anna felt she is more in control of her suicidal thoughts, as her depression and impulsivity have decreased. Anna again maintained that telephone coaching would not be appropriate.

### **6.5.3 INTEGRATION OF ALL DATA**

Anna attended comprehensive DBT for ten months. Her level of commitment and motivation remained high throughout, although much of this originated through external motivators, as Anna admitted in the first interview that she did not really want to begin the skills group.

In terms of outcome measurement, no change was recorded in global psychological functioning, with level of risk maintaining a high level at every assessment. This status quo is not surprising, as Anna maintained she was not experiencing much change in terms of well being, functioning and level of problems. Anna’s level of suicidal thoughts, although becoming more manageable, were still as strong at ten months as they were at baseline. Anna experienced one psychiatric admission during treatment and found managing home life particularly difficult. Although, Anna did admit that her interpersonal effectiveness had improved at six and eight month

assessments, this improvement was not reflected in overall score of CORE. The perceived level of stress remained steady and high throughout the therapeutic year. This is reflected in the number and severity of stressors affecting Anna, as well as a reluctance to adopt distress tolerance skills that may have aided in the management of these stressors. Anna remained actively suicidal, self damaging through bingeing, worried about her young children, suffered from depression, and had low self esteem throughout the whole year. Hence, it is predictable that she remained in the severe level of hopelessness at ten months compared to baseline.

In overall scores, BPD symptoms showed improvement between pre-therapy and six month figures. Improvements were noted in impulsivity and affective disturbance. These increments can be corroborated with reference to Anna's report that both depression and impulsivity were more manageable at ten months. This measure reflected reported problems with dissociation, whereby there is deterioration in cognitive disturbance in the ZAN-BPD between baseline and six months. Relationship disturbance remained unchanged at a low level at both time periods. No change in level of quality of life was reported in the WHOQOL-BREF between baseline and six months, especially considering that Anna was readmitted as an inpatient at six months.

Level of reported mindfulness demonstrated a deterioration between baseline and ten month assessments. Although Anna reported some difficulty applying skills early on, she was able to comprehend most skills, and mentioned that she tended to stick to skills that were not linked to her flashbacks. Anna often complained that she blanked out or dissociated during skills group training, so hence may have had particular difficulty assimilating certain skills. Anna mentioned that she would prefer if the content skills group and individual sessions were more simultaneous. It could be argued that the alleged lack of continuity of new material being rehearsed in the individual sessions delayed Anna's absorption of the skills.

Anna was consistently unwilling to avail of the telephone coaching provided from her individual therapist. She preferred to manage her suicidal thoughts independently and did not want to infringe on her therapist's free time. This abstinence from this component of therapy is noteworthy. Although, Anna identified numerous irritants

about the skills group, including its restrictions around talking about self-harm, she managed to bond with one particular group member, which for a time inspired her commitment to attend. However, when this individual discontinued treatment this departure left Anna isolated once more and she maintained that she attained less information from the group. Anna found the skills group and certain skills stressful at times and this stress was associated with her use of the coping mechanism of dissociation.

Anna retained a high level of admiration for her individual therapist all throughout therapy. She described her individual therapist in many flattering terms, such as determined, motivational, hard working, supportive and interested. However, Anna described her therapist as a maternal figure, who she did not want to worry in the six month interview and therapy as being a bit scattered and not connected to the skills group. The individual therapy relationship remained consistently solid throughout treatment and was definitely a contributing factor that maintained conscientious attendance and commitment.

In conclusion, Anna faced numerous obstacles in achieving more significant progress within her ten month attendance of DBT. Dissociation was distinctly among the most distracting impediments to attaining more skills. Anna possessed a tenacious attitude and disliked seeking help when she most needed it. She found it most difficult to use skills when she was most suicidal, yet she was still reluctant to utilise the telephone coaching. Anna was disinclined to adapt from her well-learned coping strategies to alternatives. Anna admitted commencing bingeing once again during treatment and also purposely misapplying many of the skills such as over-exercising. Anna maintained a firm desire to die. However, her suicidal ideation was managed through reflecting on the impact on her children. Anna's level of BPD symptoms demonstrated improvement, and Anna herself reported improvement in interpersonal effectiveness, impulsivity and her mood. Anna's level of admissions (length and frequency) showed a decrease and stabilised during the period of attendance in DBT. DBT provided an opportunity for Anna to face her abuse history. In this case, DBT could be argued as having a mixed impact.

## 6.6 CASE STUDY 4 - EMMA

Emma (42) first presented complaining that she was experiencing domestic abuse. Emma presented several times at Emergency services after overdosing. Emma explained a lot of her self destructive behaviours with reference to a combination of impulsivity, alcohol and family arguments. Emma had been referred for detoxification as a result of her alcohol misuse, with little success as a result of poor attendance. Emma commented that she would typically drink 3 bottles of wine on a daily basis. Patterns of overdose continued with ongoing anxiety and depression. Impulsive overdoses were recorded as being due to alcohol, poor coping and marital discord. Emma attended DBT for six months and then began an inpatient detoxification programme.

### **6.6.1 QUANTITATIVE ANALYSIS**

#### **6.6.1.1 ATTENDANCE AT INDIVIDUAL THERAPY**

OVERALL AVERAGE INDIVIDUAL SESSIONS ATTENDED → 75%

##### **Commentary**

Emma demonstrated a very good level of attendance in her individual sessions.

#### **6.6.1.2 ATTENDANCE OF THE SKILLS GROUP**

OVERALL AVERAGE SKILLS GROUP SESSIONS ATTENDED → 53%

##### **Commentary**

Emma showed moderate attendance of the skills group, typically missing 2/3 sessions per skills module.

### 6.6.1.3 PSYCHIATRIC ADMISSIONS

Table 42: Psychiatric admissions for Case study 4.

	Within two years prior to DBT	During the DBT programme (6 months)
Number of appearances/admissions	7	1
Length of admissions within this period (days)	16 days (Average of 4 days per 6 months) 2% of time hospitalised Mean length of admission – 2 days	13 days 7% of time hospitalised

#### Commentary

In the months prior to beginning the skills group, Emma experienced numerous short term admissions in both the day hospital and inpatient setting, mainly connected to alcohol detoxification and support after suicide attempts. Depression and anxiety also appeared in medical record notes around admissions. At the beginning of the skills group Emma attended the day hospital for two weeks. This consistent attendance was contrary to Emma's frequent missed appointments and sporadic presentations. This day hospital admission was due to anxiety related to physical illness. After two months in the skills group, Emma experienced no further admissions.

## 6.6.1.4 OUTCOME MEASURES

### 6.6.1.4.1 Clinical Outcome for Routine Evaluation (CORE)

Table 43: CORE figures for Case study 4.

	0 month	2 months	4 months	6 months
Well Being (Max – 16)*	15	12	15	13
Problems (Max – 48)	41	41	36	36
Functioning (Max – 48) –	31	29	33	16
Risk (Max – 24)	12	13	5	0
<b>Total CORE scores</b>	<b>99</b>	<b>95</b>	<b>89</b>	<b>65</b>
(% Change from baseline)	-	(+4%)	(+10%)	(+34%)

\* Scores for “Well being” are counter-intuitive, so a higher score denotes lack of well being according to the client.

– Scores for “Functioning” are counter-intuitive, so a higher score denotes lack of functioning according to the client.

#### Commentary

Emma’s scoring of her well-being stayed fairly constant through out treatment at a high level. Problems appeared to drop back at the 4 month assessment, which could be indicative of levels of problems becoming more manageable. Functioning displayed positive change at the 6 month assessment. Finally the most revealing of all measures is level of risk, Emma was a high level of risk (to herself) in the first two months of the skills group, yet this level dropped back dramatically at 4 months to the minimum level at 6 months.

#### 6.6.1.4.2 Kentucky Inventory of Mindfulness Skills (KIMS)

Table 44: KIMS figures for Case study 4.

	0 month	2 months	4 months	6 months
Observing (Max – 60)	21	23	26	22
Describing (Max – 40)	12	14	13	14
Acting with Awareness (Max – 50)	16	16	18	17
Accepting (Max - 45)	11	12	16	15
<b>Total KIMS score</b>	<b>60</b>	<b>65</b>	<b>73</b>	<b>68</b>
(% Change from baseline)	-	(+8%)	(+22%)	(+13%)

#### Commentary

Emma’s level of mindfulness was moderate and rather consistent throughout the first 6 months in treatment.

#### 6.6.1.4.3 Perceived Stress Scale (PSS)

Table 45: PSS figures for Case study 4.

	0 month	2 months	4 months	6 months
<b>Total PSS score (Max – 40)</b>	<b>30</b>	<b>27</b>	<b>20</b>	<b>27</b>
(% Change from baseline)	-	(+10%)	(+33%)	(+10%)

#### Commentary

Emma’s level of perceived stress was high in the first 2 months of the skills group. Then by 4 month it decreased considerably. By 6 month it had returned to higher levels.

#### 6.6.1.4.4 Beck Hopelessness Scale (BHS)

Table 46: BHS figures for Case study 4.

	0 month	2 months	4 months	6 months
<b>BHS score (Max – 20)</b>	<b>17</b>	<b>18</b>	<b>7</b>	<b>3</b>
(% Change from baseline)	-	(-6%)	(+59%)	(+82%)

#### Commentary

This outcome measure demonstrated clinical change over the first 6 months. Emma scored within the severe range in her first two assessments. By 4 months this had more than halved to the mild range. At 6 months Emma displayed non-clinical minimal levels of hopelessness, indicating hope and optimism for the future.

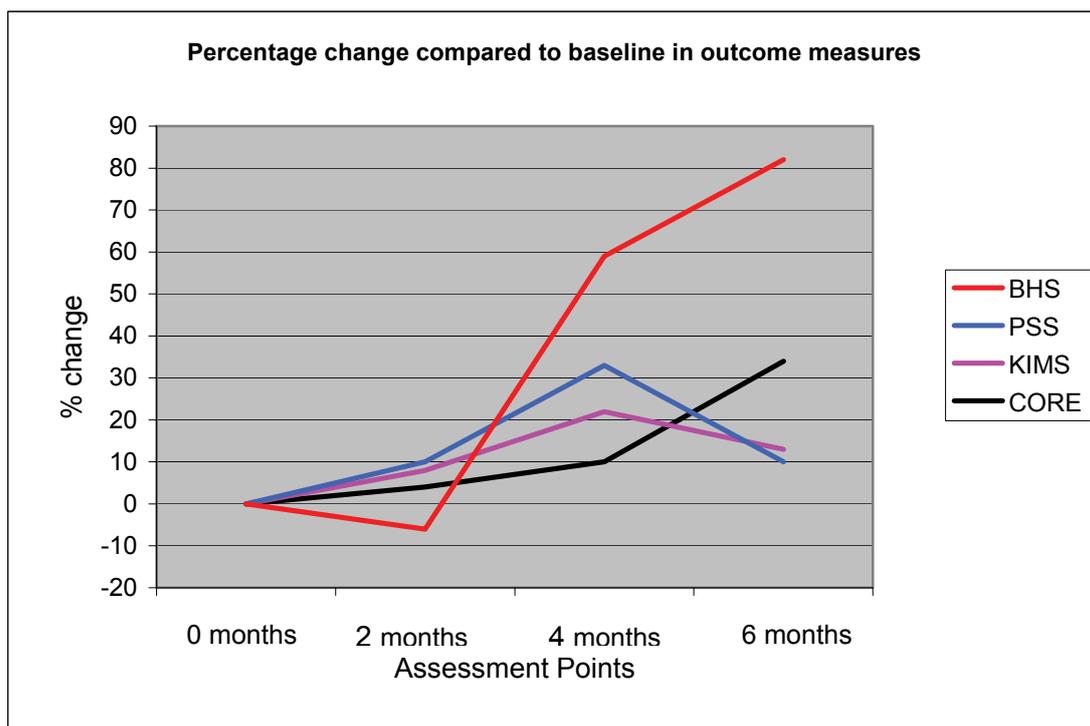


Figure 40: Percentage change from baseline in outcome measurements in Case study 4.

#### 6.6.1.4.5 ZAN-BPD

Table 47: ZAN-BPD figures for Case study 4.

	0 month	6 months
Affective disturbance score (Max – 12)	9	2
Cognitive disturbance score (Max – 8)	4	0
Impulsivity disturbance score (Max – 8)	2	1
Disturbed Relationships score (Max – 8)	5	4
<b>Total ZAN-BPD score</b>	<b>20</b>	<b>9</b>
(% Change from baseline)	-	(+55%)

#### Commentary

Between 0 and 6 months there was noteworthy change in 2 out of 4 of the areas, namely in affective disturbance and cognitive disturbance. Impulsivity disturbance remained low. Disturbed relationships showed some slight improvement. BPD symptoms halved.

#### 6.6.1.4.6 WHOQOL-BREF

Table 48: WHOQOL figures for Case study 4.

	0 month	6 months
Physical Health (Max – 35)	14	12
Psychological Health (Max – 30)	9	13
Social Relationships (Max – 20)	4	5
Environment (Max – 40)	12	19
<b>Total WHOQOL score **</b>	<b>39</b>	<b>49</b>
(% Change from baseline)	-	(+26%)

\*\* Lower the WHOLQOL-BREF scores, the less satisfactory quality of life reported by the client

## Commentary

Between 0 and 6 months, Emma’s scoring of her overall quality of life improved.

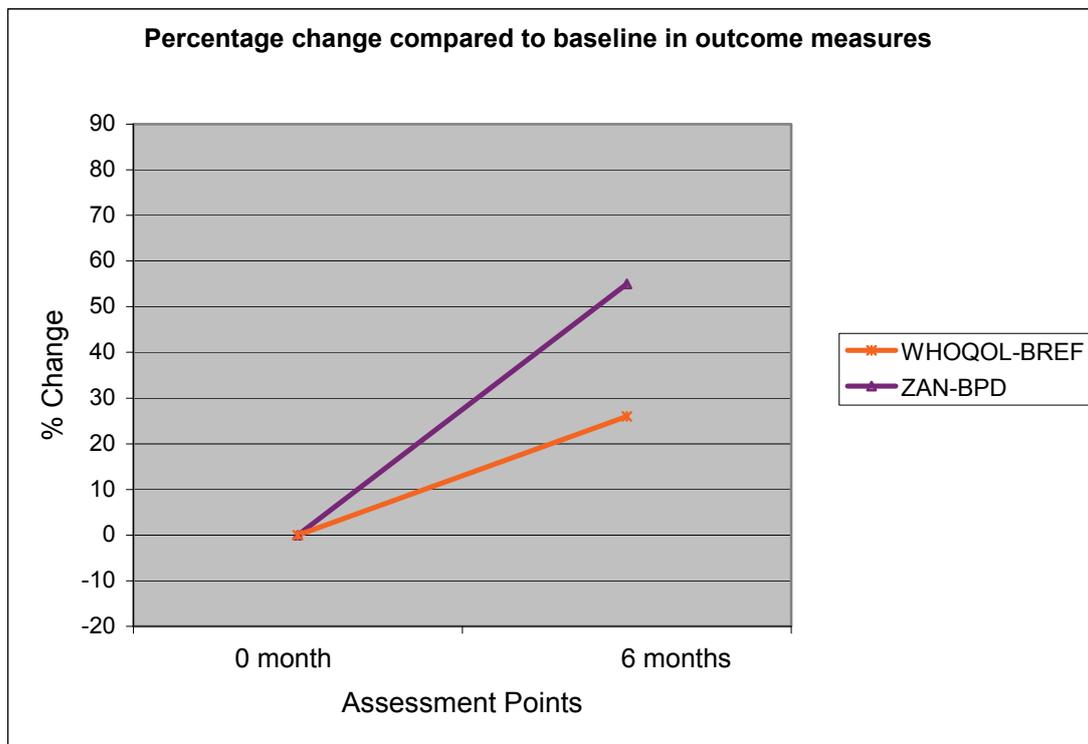


Figure 41: Percentage change from baseline in outcome measurements in Case study 4.

### 6.6.2 QUALITATIVE ANALYSIS

#### 0 MONTHS

Emma was not very talkative, but did mention some family discord, which concurred with medical records. Emma mentioned not making much progress with GP and psychiatry, feeling dissatisfied with drug treatment and little time given in each appointment.

*“I find that they only write out prescriptions on every visit. Never making any progress in the few minutes I’m in there. I come out feeling I’ve gotten very little out of the appointment and feeling very frustrated”.*

## **2 MONTHS**

Emma appeared far more positive showing engagement in all the components of DBT. She commented that she had new hope and proudly said she has not tried to take her life since beginning with her individual therapist. Emma assured me of feeling safe, listened to, unburdened in individual sessions, even mentioning feeling better coming out than going into them. It would appear that even at this early stage Emma has secured a strong therapeutic alliance. In terms of the skills group, Emma appeared to value the comradeship with other group members. Emma noted that how much worth she gets out of the group depends on how focused she was. Emma had to be encouraged by the group facilitator to attend, as on occasion she felt hopeless, yet on the whole the group has improved. Although diary cards were hard to fill in, she appreciated the positive feedback from the skills section. Emma praised the telephone contact with her individual therapist as getting her through difficult times with her family and suicidal thoughts.

*“I don’t know what I’d do without it! Great to have the contact when I’m feeling suicidal or distressed. My individual therapist will talk through things with me, even fights with my daughter which have made me feel so crap, encourage me to use the skills. I have learned to cope with many of my family problems and it all seems so much easier. Even knowing she’s in my mobile gets me through horrible thoughts and feelings”*

## **4 MONTHS**

Emma was more negative about the skills group finding it boring. She admitted that at points she has struggled to attend and has thought about giving the skills group up. However, Emma felt she has learned a lot from the skills, the interpersonal effectiveness module has been especially useful for managing conflict. She reiterated the positive feedback and encouragement from the group facilitators. Emma has not needed to use the telephone coaching over the previous two months as she felt there was less stress in her life. In terms of changes, Emma considered not attending A&E as frequently as a huge improvement. Emma felt more confident with feelings of

anger and anxiety more under control. Improved family relations were declared as an instance of positive change attributable to DBT.

## **6 MONTHS**

Emma recounted some physical health difficulties, which have made attendance more difficult. She has had feelings of giving up in therapy due to illness. Emma mentioned an attempt to withdraw from alcohol and has been experiencing sleep problems as a result. She noted that she has had bad days but was generally stronger mentally. She was more positive about the skills group and asserted that she was still getting value out of it. Emma greatly applauded her relationship with her individual therapist over the last two months, although she believed there was a growing dependency. No telephone coaching was reported.

### **6.6.3 INTEGRATION OF ALL DATA**

Emma attended DBT for six months. Outcome measurements revealed improvements in level of hopelessness, BPD symptoms, quality of life and global psychological functioning by the 6-month assessment. Levels of perceived stress showed a U-shaped curve with stress retreating to baseline high levels after an initial decrement.

This quantitative data can be clarified and explained through reference to what Emma had to say at each assessment. Emma's level of risk at 6 months on the BHS and lack of psychiatric hospital admissions would appear to be concurrent with her feelings of hope and positivity towards therapy, particular individual therapy. Emma heavily applauded her strong therapeutic alliance. Emma mentioned not needing to use the telephone coaching, which may indicate improved coping and easier management of suicidal thoughts and self harm. BPD symptoms halved by 6 months into treatment. Emma mentioned she used interpersonal effectiveness and emotional regulation skills.

Emma's level of global functioning showed improvement over the 6 month period in treatment. This pattern is complimentary to what is revealed in her descriptions of positive changes occurring for her over the 6 months. Perceived stress levels would appear to be related to health difficulties experienced at 6 months, while other areas of

stressors would appear to be more manageable in particular a tumultuous family background. Level of mindfulness did not show change, and Emma did not appear to be hugely enthusiastic about the skill set and found it to be boring.

Emma's attendance at the skills group was moderate, and this is explained by her feelings of not being motivated, finding it at times boring and possibly alcohol usage. Emma's perception of the group was heavily related to her own mood. It could be argued that Emma could have gained more from therapy if attendance had been better. Alcohol dependency was an impediment to Emma's engagement. Emma's strong relationship with her individual therapist was a possible agent of change. Emma displayed a fervent level of trust and admiration for her therapist.

It is regrettable after showing a notable degree of change and improvement that Emma discontinued treatment just before 8 months. Emma's case would imply that early change can occur. Emma's co-morbid difficulties, alcohol dependency, depression, anxiety and marital discord, would certainly be worth considering in deliberating the difficulty of showing improvement with so many complications within the picture. Emma's commencement of an alcohol inpatient detoxification was a positive outcome.

## 6.7 CASE STUDY 5 - MICK

Mick (23) was known to the adolescent Mental Health services after a serious suicide attempt. Mick was fired from a job, complaining of bullying, and had been coping with this disappointment by drinking heavily. He was admitted due to feeling down, anxious and had been repeatedly self harming. Further admissions followed after overdosing, slitting and burning his arms. Mick attended DBT for four months and returned to employment.

### **6.7.1 QUANTITATIVE ANALYSIS**

#### **6.7.1.1 ATTENDANCE OF INDIVIDUAL THERAPY**

OVERALL AVERAGE INDIVIDUAL SESSIONS ATTENDED → 100%

##### **Commentary**

Mick presented with excellent attendance, indicative of a strong therapeutic relationship and remarkable motivation and commitment.

#### **6.7.1.2 ATTENDANCE OF THE SKILLS GROUP**

OVERALL AVERAGE SKILLS GROUP SESSIONS ATTENDED → 100%

##### **Commentary**

Mick showed excellent attendance of skills group sessions, until he discontinued treatment after 4 months.

### 6.7.1.3 PSYCHIATRIC ADMISSIONS

Table 49: Psychiatric admissions in Case study 5.

	Within two years prior to DBT	During the DBT programme (4 months)
Number of appearances/admissions	6	2
Length of admissions within this period (days)	27 days (Average of 7 days per 6 months) 4% of time hospitalised Mean length of admission – 4.5 days	13 days 7% of time hospitalised Mean length of admission – 6.5 days

#### Commentary

Mick was admitted six times, before starting in the skills group. Mick had one short inpatient admission and attended the day hospital for a period in the first 2 months of the skills group. Mick did not have any other admissions after this. Length of admission appeared consistent during DBT.

### 6.7.2.4 OUTCOME MEASURES

#### 6.7.2.4.1 Clinical Outcome for Routine Evaluation (CORE)

Table 50: CORE figures for Case study 5.

	0 month	2 months	4 months
Well Being (Max – 16)*	8	8	3
Problems (Max – 48)	24	19	8
Functioning (Max – 48) †	13	15	10
Risk (Max – 24)	4	7	0
<b>Total CORE scores</b>	<b>49</b>	<b>49</b>	<b>21</b>
(% Change from baseline)	-	(0%)	(+43%)

\* Scores for “Well being” are counter-intuitive, so a higher score denotes lack of well being according to the client.

– Scores for “Functioning” are counter-intuitive, so a higher score denotes lack of functioning according to the client.

### Commentary

Mick’s level of global functioning remained pretty stable for the first two assessments, with a slight increase in risk at two months. At four months, there was a clinically significant decrease as Mick moved into the non-clinical range, with particular improvement in all measures.

#### 6.7.2.4.2 Kentucky Inventory of Mindfulness Skills (KIMS)

Table 51: KIMS figures for Case study 5.

	0 month	2 months	4 months
Observing (Max – 60)	32	34	39
Describing (Max – 40)	30	32	35
Acting with Awareness (Max – 50)	30	35	33
Accepting (Max - 45)	16	27	34
<b>Total KIMS score</b>	<b>108</b>	<b>128</b>	<b>143</b>
(% Change from baseline)	-	(+19%)	(+32%)

### Commentary

Level of reported mindfulness increased throughout the three assessment points. The measure of accepting showed most dramatic change at four months compared to baseline.

#### 6.7.2.4.3 Perceived Stress Scale (PSS)

Table 52: PSS figures for Case study 5.

	0 month	2 months	4 months
<b>Total PSS score (Max – 40)</b>	<b>22</b>	<b>15</b>	<b>11</b>
(% Change from baseline)	(-)	(+32%)	(+50%)

#### Commentary

Dramatic and clinically significant improvement occurred in the reported level of perceived stress. By four months, the total perceived stress had halved compared to baseline.

#### 6.7.2.4.4 Beck Hopelessness Scale (BHS)

Table 53: BHS figures for Case study 5.

	0 month	2 months	4 months
<b>BHS score (Max – 20)</b>	<b>13</b>	<b>8</b>	<b>5</b>
(% Change from baseline)	-	(+38%)	(+62%)

#### Commentary

Mick scored within the moderate range of hopelessness at baseline, and demonstrated clinically significant improvement as he scored within the minimal non-clinical range at four months.

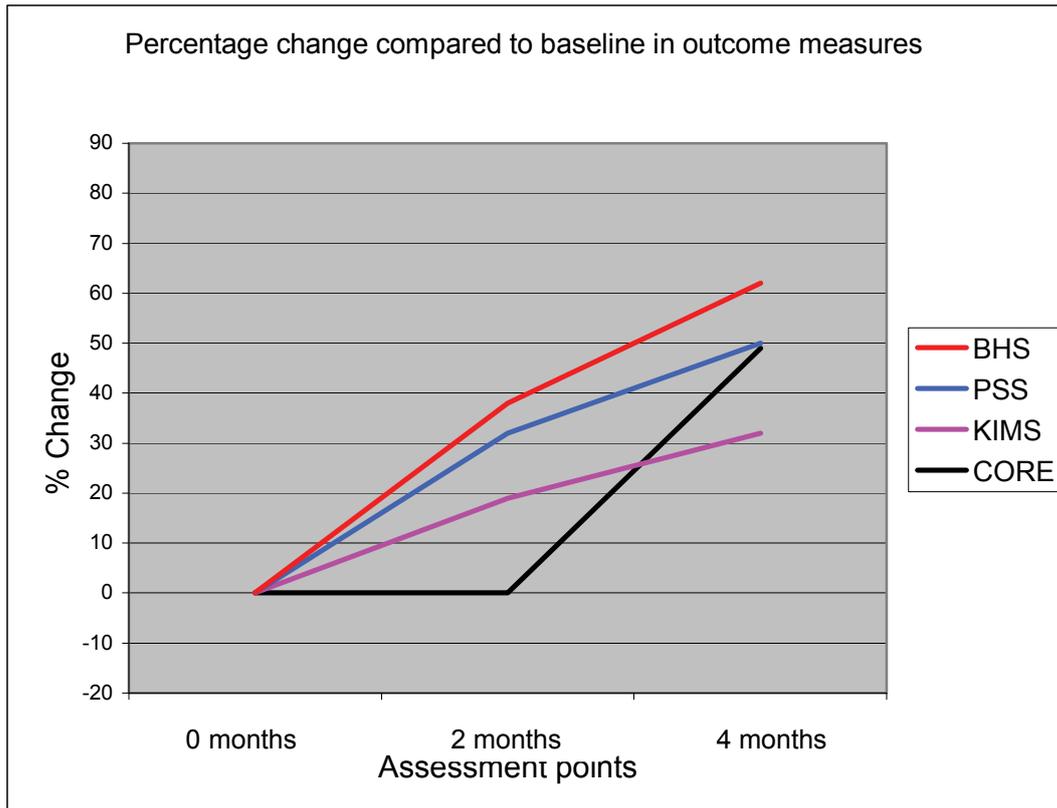


Figure 42: Percentage change from baseline in outcome measurement in Case study 5.

#### 6.7.2.4.5 ZAN-BPD & WHOQOL

Table 54: ZAN-BPD and WHOQOL figures at baseline for Case study 5.

<b>ZAN-BPD</b> (Max – 36)	Affective disturbance (Max – 12)	Cognitive disturbance (Max – 8)	Impulsivity disturbance (Max – 8)	Disturbed Relationships (Max – 8)	Total
	7	3	2	2	<b>14</b>
<b>WHOQOL</b> (Max – 135)	Physical Health (Max – 35)	Psychological Health (Max – 30)	Social relationships (Max – 20)	Environment (Max – 40)	Total
	23	14	9	30	<b>76</b>

#### Commentary

Within the WHOQOL, the main areas of difficulties for Mick were social relationships and psychological health in terms of his quality of life symptoms at baseline. Otherwise his overall reported quality of life was fairly high. Within the

ZAN-BPD, the main area of difficulty for Mick was affective disturbance. No comparative data could be collected.

### **6.7.2 QUALITATIVE ANALYSIS**

#### **0 MONTHS**

Mick presented in a garrulous and open manner. He described a history of depression, multiple suicide attempts and self harm behaviours, and alcohol bingeing. He connected a lot of his recurrent difficulties to his recent job loss, to which he reacted very badly. Mick freely talked about his numerous hospital admissions, and he described a feeling of developing reliance on the inpatient unit. Mick seemed pleased with individual therapy to date. He has taken the BPD diagnosis on board, although this was a difficult. Mick said he wants to return to work, but also to finish therapy. He feared the group might be awkward being the only male. Group comradeship, however, was something he thought he might value. Mick commented that he follows everything his consultant psychiatrist or individual therapist tells him, but nevertheless believed he is under a lot of pressure to succeed. Mick asserted that he considered another crisis is imminent, as he thinks without the medication for anxiety and depression he is taking he would be very low. He said he wished he were not so dependent on professionals.

#### **2 MONTHS**

Mick commented that the previous two months have been challenging with one admission due to feeling depressed and not being able to use skills, which did frustrate him. Despite this he has started a college course. He related his individual sessions to the high point of the week, like a rest for a boxer in a ring, as he got into muddles and needed to discuss things. Mick was very complimentary of his relationship with his individual therapist. Mick said that he holds great respect for his therapist, and learns a lot from her.

*“Mutual respect. Understanding. Compassion. Experience as well, she can relate from what she’s learned from other clients as well.... You’re never judged, I feel totally comfortable saying anything that comes into my head”.*

Mick declared that it was difficult to put the skills into action, and he often forgot the mindfulness ones, even though he did find them useful. Interpersonal effectiveness was not so applicable for Mick. In terms of evaluating the group, Mick was pleased with the comradeship of the skills group, but would prefer a more open discussion around DSH and suicidal intent when focusing on the diary cards. Over the previous two months, Mick has only availed of the out of hours of telephone coaching once. He did not want to get too over reliant on the facility and impinge on his therapist’s free time, even though she encouraged him to call. Mick repeated his desire to return to work for a sense of routine and activity.

#### **4 MONTHS**

Mick reported having applied for full-time work, which would certainly mean dropping out of the DBT programme. Mindfulness skills have worked well for Mick allowing him to relax, focus and sooth himself.

*“The mindfulness is the core of it. It is really helpful for me, as I can get really worked out of shape about the past, or worried about the future, so just coming back to the present is helpful”.*

He has used distress tolerance skills such as distraction, self soothing and cheerleading. He appeared more positive in relation to the diary cards seeing them as a means of validation. The non-disclosure of self-harm and suicidal urges in the skills group has continued to be an annoyance, but he has understood the rationale behind this. His relationship with his therapist has continued to be viewed very positively and beyond reproach. Telephone coaching and mindfulness tapes have been useful in order not to let emotions escalate. Phone calls have helped him to become rational, calm things down and make sense of things. Despite feeling like giving up two months ago, he has maintained high commitment and has attended well. In terms of changes, Mick referred to drinking less and becoming mellower.

### **6.7.3 INTEGRATION OF ALL DATA**

Mick attended DBT for four months. It would appear from the outcome measurement that considerable improvement was achieved in the areas of global psychological functioning, perceived stress, hopelessness and reported mindfulness. An average 47% improvement from baseline figures at four months was calculated between these four outcomes. It was noteworthy how quickly and strikingly improvement was reported in each outcome measures.

In terms of qualitative analysis, Mick described several improvements throughout the interviews. Mick began drinking less, was less impulsive, and more in control of his mood. Mick came across as extremely determined to make changes in his life, especially considering his excellent record of attendance. He began to a college course and eventually left therapy for the reason of returning to employment. Mick was very able to identify the skills he found most useful namely the distress tolerance and mindfulness skills. Such skills were useful in helping manage suicide thoughts.

Individual therapy played a significant role in the tremendous change observed in Mick's well being and functioning. Mick applauded both the relationship and the content covered in individual therapy. Mick suggested that he benefited from the relationship by receiving needed support in daily problems, motivation to continue attending, understanding, empathy, and help with the skills. He valued that his individual therapist shared examples of how the skills applied to her own life. Although Mick was reluctant to overuse the telephone coaching, he was also able to remember examples of how useful this facility was for crisis management. It could also be argued that the telephone coaching offered an opportunity to strengthen the therapeutic relationship further. Mick mentioned the comradeship of fellow group member as positive, as it created an environment whereby the skills could be learned as effectively as possible. Mick reported that being an only male in the skills group did not cause any problems for him.

Mick's case demonstrated that change in DBT can occur surprisingly quickly, returning to employment can be viewed as a positive outcome. Mick suffered from moderate depressive mood and mild anxiety, had strong suicidal and self harming

urges, and occasionally abused alcohol. His history lacked the debilitating childhood abuse, eating disorders, chronic substance dependency, and an abusive relationship, which are all common in other cases of DBT clients. It was possible that since Mick did not possess these particular complicating factors, improvement may have been possible at a more accelerated pace.

## 6.8 CASE STUDY 6 - JILL

Jill (28) first presented in an A&E ward following taking an overdose after an argument with her boyfriend. She was diagnosed as having depression, anxiety disorder with panic attacks and BPD. She revealed, after taking her second overdose, that she had been a victim of childhood abuse and that she had been deliberately self harming (cutting) since her mid teens. She had abused a variety of substances including heroin, cannabis, alcohol and cocaine, and attended the day hospital in order to help stabilise some of these behaviours. Jill discontinued the DBT programme after 3 months.

### 6.8.1 QUANTITATIVE ANALYSIS

#### 6.8.1.1 ATTENDANCE OF INDIVIDUAL THERAPY

OVERALL AVERAGE INDIVIDUAL SESSIONS ATTENDED → 42%

##### **Commentary**

Jill showed a fair level of attendance of her individual sessions.

#### 6.8.1.2 ATTENDANCE OF THE SKILLS GROUP

OVERALL AVERAGE SKILLS GROUP SESSIONS ATTENDED → 38%

##### **Commentary**

Jill demonstrated a dissatisfactory level of attendance within her three months of participation in the DBT programme.

### 6.8.1.3 PSYCHIATRIC ADMISSIONS

Table 55: Psychiatric admissions for Case study 6.

	Within two years prior to DBT	During the DBT programme (3 months)
Number of appearances/admissions	2	0
Length of admissions within this period (days)	61 (8% of time hospitalised) Mean length of admission – 31 days	0

#### **Commentary**

Jill attended the day hospital in two separate monthly blocks before commencing the DBT programme. No admissions were recorded within her three months of attendance of DBT.

#### 6.8.1.4 OUTCOME MEASUREMENTS

Only baseline outcome measurements were administered. Hence no comparison or estimation of change can be carried out. However, it may be useful to reflect on baseline figures in each of the areas.

Table 56: Total baseline questionnaire figures for Case study 6.

<b>CORE</b> <b>(Max – 136)</b>	Well Being (Max – 16)	Problems (Max – 48)	Functioning (Max – 48)	Risk (Max – 24)	Total
	6	25	16	0	<b>47</b>
<b>KIMS</b> <b>(Max – 195)</b>	Observing (Max – 60)	Describing (Max – 40)	Acting with Awareness (Max – 50)	Accepting (Max - 45)	Total
	40	30	28	15	<b>113</b>
<b>PSS</b> <b>(Max – 40)</b>	-	-	-	-	<b>27</b>
<b>BHS</b> <b>(Max – 20)</b>	-	-	-	-	<b>12</b>
<b>ZAN-BPD</b> <b>(Max – 36)</b>	Affective disturbance (Max – 12)	Cognitive disturbance (Max – 8)	Impulsivity disturbance (Max – 8)	Disturbed Relationships (Max – 8)	Total
	6	4	0	6	<b>16</b>
<b>WHOQOL</b> <b>(Max – 135)</b>	Physical Health (Max – 35)	Psychological Health (Max – 30)	Social relationships (Max – 20)	Environment (Max – 40)	Total
	18	21	11	29	<b>79</b>

### **6.8.2 QUALITATIVE ANALYSIS**

Jill appeared very candid and relaxed. She discussed how her childhood abuse had affected her life and how her substance abuse was used to forget her difficulties. Jill was articulate in describing the function of her cutting and overmedication in managing her problems and stress. Jill verbalised that she experienced a simultaneous hope to change and also a lingering doubt of her inability to do so. Jill mentioned that she was satisfied with how she was getting on with her individual therapist. BPD and DBT had been explained to her, and she expressed both fears and relief at being diagnosed as having BPD. Although Jill asserted that she feels hopeful, she also had significant anxiety that she cannot conceptualise another life other than how she is experiencing it now.

*“The other thing about it is that you’re afraid of change, an upset routine. You are who you are fundamentally. I think I’ve known crap all my life, so to think of a time without it is actually quite frightening. It feels alien. Even though you know what you’re being promised, if you can learn it, is a nice healthy mind and good future. It just seems so far away, like you can’t grasp it”*

Of all the possible benefits of DBT, she would like to experience mental solitude, a period without racing thoughts and negative rumination.

### **6.8.3 INTEGRATION OF ALL DATA**

Jill attended for 3 months of DBT, discontinuing through poor attendance. In terms of global functioning, CORE indicated that Jill was functioning at a reasonable level. Jill scored zero on the risk measure. The BHS score, measuring hopelessness, was within the moderate range. Perceived stress was moderately high. BPD symptoms indicated particular difficulties with relationship disturbance and affective disturbance. Mindfulness was calculated at a reasonably high level at baseline. Quality of life was within the top half of the range.

Jill presented with significant relationship disharmony, which was associated with her level of distress and potential to self harm in past incidents. She tended to adopt well-established maladaptive coping strategies such as substance abuse, which no doubt negatively impacted on her potential to attend and commit to the programme. Jill appeared to show much ambivalence about her potential to change as a result of attending the DBT programme, which is normal and to be expected. However, these doubts of achieving tangible gains perhaps outweighed her desire to learn new skills. Jill mentioned that she suffered from panic attacks, which could also have inhibited her continuation of the programme.

## 6.9 CASE STUDY 7 - JANE

Jane (49) was an inpatient for the full duration of her attendance in the DBT programme. Jane has been a victim of childhood abuse and began both cutting and overdosing in her preteens. Her history included numerous suicide attempts by slashing her wrists and throat, overdosing, and also jumping off tall buildings. Self-cutting for Jane was extensive and severe. Numerous scars were visible across her neck and arms from previous suicidal and self harm episodes. Jane was admitted 14 times to A&E due to a series of self-destructive acts, before being admitted for a period of two years. Jane mentioned she experienced dramatic fluctuations in mood and often had arguments with staff on the wards, family and friends. Jane attended DBT for the full year.

### **6.9.1 QUANTITATIVE ANALYSIS**

#### **6.9.1.1 ATTENDANCE OF THE INDIVIDUAL THERAPY**

OVERALL AVERAGE INDIVIDUAL SESSIONS ATTENDED → 89%

##### **Commentary**

Jane demonstrated an excellent level of attendance of her individual therapy, which may be indicative of a strong therapeutic alliance and commitment.

#### **6.9.1.2 ATTENDANCE OF THE SKILLS GROUP**

OVERALL AVERAGE SKILLS GROUP SESSIONS ATTENDED → 73%

##### **Commentary**

Jane showed a very good level of attendance of the skills group.

### 6.9.1.3 PSYCHIATRIC ADMISSIONS

Table 57: Psychiatric admissions for Case study 7.

	Within Two years prior to DBT	During the DBT programme (12 months)
Number of appearances/admissions	1 (long-term admission)	1 (long-term admission)
Length of admissions within this period (days)	212 days	365 days

#### **Commentary**

Jane was admitted after a series of A&E admissions for a period of almost 2 years, which encompassed the entire year of attendance at the DBT programme. Six months following the end of full comprehensive DBT, Jane was discharged into the community, indicative of some positive change.

## 6.9.1.4 OUTCOME MEASURES

### 6.9.1.4.1 Clinical Outcome for Routine Evaluation (CORE)

Case study 58: CORE figures for Case study 7.

	<b>0 month</b>	<b>2 months</b>	<b>4 months</b>	<b>6 months</b>
Well being (Max – 16)	11	13	14	11
Functioning (Max – 48)	21	39	36	27
Problems (Max – 48)	29	25	22	36
Risk (Max – 24)	16	10	10	10
<b>Total score</b>	<b>77</b>	<b>87</b>	<b>82</b>	<b>84</b>
<b>(% Change from baseline)</b>	-	(-13%)	(-6%)	(-9%)
	<b>8 months</b>	<b>10 months</b>	<b>12 months</b>	
Well being (Max – 16)	8	-	9	
Functioning (Max – 48)	25	-	26	
Problems (Max – 48)	34	-	20	
Risk (Max – 24)	8	-	7	
<b>Total score</b>	<b>85</b>	-	<b>62</b>	
<b>(% Change from baseline)</b>	(-10%)		(+19%)	

#### Commentary

Jane reported a steady level of global functioning from baseline to eight months. At twelve months, a noteworthy improvement was observed compared to baseline. Level of risk steadily decreased from baseline, reducing by 56% by the 12 month assessment.

### 6.9.1.4.2 Kentucky Inventory of Mindfulness Skills (KIMS)

Table 59: KIMS figures for Case study 7.

	<b>0 month</b>	<b>2 months</b>	<b>4 months</b>	<b>6 months</b>
Observing	20	24	39	30
Describing	18	22	22	19
Acting with awareness	25	34	29	26
Accepting	22	30	13	18
<b>Total score</b>	<b>85</b>	<b>110</b>	<b>103</b>	<b>93</b>
<b>(% Change from baseline)</b>	-	(+29%)	(+21%)	(+9%)
	<b>8 months</b>	<b>10 months</b>	<b>12 months</b>	
Observing	40	-	38	
Describing	24	-	23	
Acting with awareness	22	-	20	
Accepting	30	-	28	
<b>Total score</b>	<b>116</b>	-	<b>109</b>	
<b>(% Change from baseline)</b>	(+36%)		(+28%)	

#### Commentary

Jane appeared to maintain early progress made in reported mindfulness at twelve months, particularly in the area of observing.

### 6.9.1.4.3 Perceived Stress Scale (PSS)

Table 60: PSS figures for Case study 7.

	<b>0 month</b>	<b>2 months</b>	<b>4 months</b>	<b>6 months</b>
<b>Total score (Max – 40)</b>	<b>27</b>	<b>27</b>	<b>24</b>	<b>23</b>
<b>(% Change from baseline)</b>	-	-	(+11%)	(+15%)
	<b>8 months</b>	<b>10 months</b>	<b>12 months</b>	
<b>Total score (Max – 40)</b>	<b>24</b>	-	<b>25</b>	
<b>(% Change from baseline)</b>	(+11%)		(+7%)	

### Commentary

Jane's perceived level of stress stayed consistently at a moderately high level, showing slight improvement at six and twelve months compared to baseline.

#### 6.9.1.4.4 Beck Hopelessness Scale (BHS)

Table 61: BHS figures for Case study 7.

	<b>0 month</b>	<b>2 months</b>	<b>4 months</b>	<b>6 months</b>
<b>Total score (Max – 20)</b>	<b>15</b>	<b>17</b>	<b>15</b>	<b>12</b>
<b>(% Change from baseline)</b>	-	<b>(-13%)</b>	-	<b>(+20%)</b>
	<b>8 months</b>	<b>10 months</b>	<b>12 months</b>	
<b>Total score (Max – 20)</b>	<b>8</b>	-	<b>5</b>	
<b>(% Change from baseline)</b>	<b>(+47%)</b>		<b>(+67%)</b>	

### Commentary

Jane progressed from the severe level of hopelessness at baseline to a moderate level at six months. Clinical significant improvement was observed at twelve months as Jane had moved into the mild range of hopelessness.

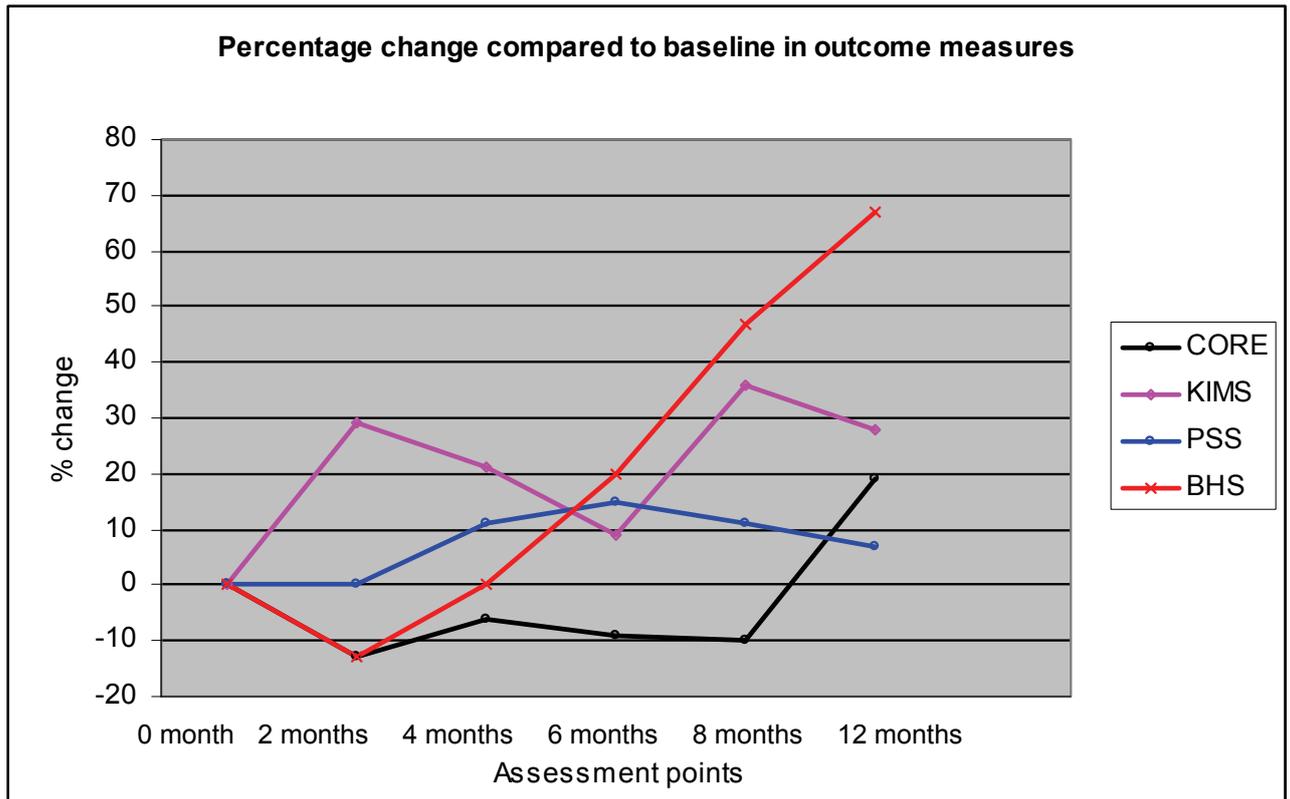


Figure 43: Percentage change from baseline in outcome measurements in Case study 7.

#### 6.9.1.4.5 ZAN-BPD

Table 62: ZAN-BPD figures for Case study 7.

	0 month	6 months	12 months
Affective disturbance (Max – 12)	9	5	5
Cognitive disturbance (Max – 8)	6	1	2
Impulsivity (Max – 8)	1	0	0
Disturbed relationship (Max - 8)	4	4	3
<b>Total ZAN-BPD score</b>	<b>20</b>	<b>10</b>	<b>10</b>
<b>(% Change from baseline)</b>	-	(+50%)	(+50%)

### Commentary

BPD symptoms halved by six months and this improvement was maintained at twelve months compared to baseline measurement. Particular improvement was observed in affective and cognitive disturbance.

#### 6.9.1.4.6 WHOQOL-BREF

Table 63: WHOQOL figures for Case study 7.

	<b>0 month</b>	<b>6 months</b>	<b>12 months</b>
Physical Health (Max – 35)	26	22	22
Psychological Health (Max – 30)	10	13	10
Relationships (Max – 15)	9	10	10
Environment (Max – 40)	26	25	31
<b>Total WHOQOL-BREF score</b>	<b>71</b>	<b>70</b>	<b>73</b>
<b>(% Change from baseline)</b>	<b>-</b>	<b>(-1%)</b>	<b>(+3%)</b>

### Commentary

No change in level of quality of life was calculated at six and twelve months compared to baseline.

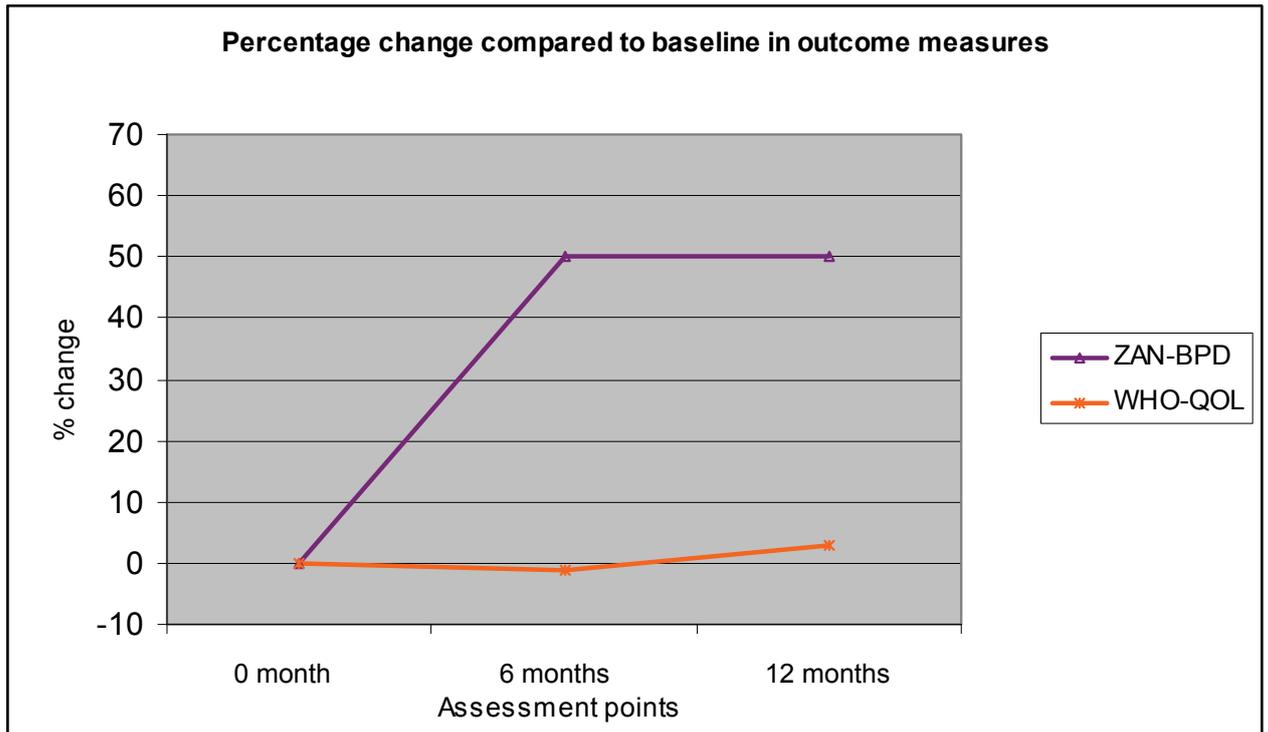


Figure 44: Percentage change from baseline in outcome measurements in Case study 7.

## **6.9.2 QUALITATIVE ANALYSIS**

### **0 MONTHS**

Jane was candid in her descriptions of her childhood sexual abuse and her self-destructive behaviour. Jane expressed immense hope at starting the DBT programme, viewing it as a lifeline to recovery. Her present consultant psychiatrist was viewed as empathetic and knowledgeable, as he explained the BPD condition to her in a sympathetic and non-judgemental manner. Jane mentioned that prior to this she had felt like a “freak” and did not have any greater understanding into the condition. She believed that many of the medical staff did not have insight into BPD. Jane recalled negative experiences of one hospital, where she believed her consultant psychiatrist became rejecting and punitive following an episode of self harm. Among Jane’s goals for the year of DBT included being able to manage her emotions without self harming and feeling suicidal and being less hateful of herself. She recognised that DBT was

going to be a substantial amount of work and it may be painful dealing with her abuse issues.

## **2 MONTHS**

Jane professed that she was comfortable within the skills group. Jane was able to give an example of using mindfulness. She admitted that her individual therapist was adept at allowing her to talk about her feelings. Her individual therapist was viewed as very patient, accepting, reassuring and supportive. She recalled one misunderstanding with her individual therapist, in which she walked out of a session and felt like abandoning the DBT programme. Jane was particularly glowing about her individual therapy as she described it as her route to recovery. Jane has been using the telephone coaching, and gave an example of where she was particularly troubled by an abuse flashback. Jane has missed a couple of sessions due to incapacitating nature of these severe and frightening flashbacks. She mentioned that she feared being abandoned by the DBT team. She experienced several episodes of fervent suicidal thoughts recently, in which she had engineered plans to take her life.

## **4 MONTHS**

Jane spoke more about how useful mindfulness has been for dealing with her suicidal thoughts and from curbing impulsivity as a result of misunderstandings with her other people and dealing with flashbacks.

*“Well a lot of the abuse flashbacks have been coming back to me so that is very wearing and very hard to deal with, but I’ve started using the skills and they certainly help. If I’m in the emotional mind, I find it very hard to come out of it. I try to be mindful, imagining a string on my head, and try to look down what’s happening to me, and then I try to observe what is happening around me and to me. Then I eventually get into wise mind”.*

Jane reflected on early changes and illustrated that prior to applying the mindfulness skills she would have impulsively exploded in anger at the offending person and then

commenced to self-harm in order to deal with the escalating stress from the conflict. She reasoned that she was handling interpersonal conflict more effectively.

*“I was very emotional, but I did go back to her, and tell her what was going on in my head in a calm way and walked away. Before DBT there is no doubt in my mind I would have been gone off the rails there is no doubt in my mind. I would have thought of the balcony and thrown myself over”.*

Jane described the skills group positively, with other group members being viewed as helpful to discuss their experiences of DBT and the skills. Jane reiterated the life saving qualities of DBT. Trust has begun to flourish within Jane’s individual sessions. She described individual therapy as supportive, empathetic and without boundaries. The telephone contact has been a source of calm when stress has built up and has prevented suicide attempts.

*“I have used it a few times over the last two months. I would use it only when I got completely emotional and I couldn’t use the skills, it’s the last thing I would do. So on the phone we would talk about skills I can use. It does work, it calms me down. There would definitely be situations where they could have escalated if I didn’t phone. I do often feel like doing something to myself, cutting or not wanting to be alive with all that is happening, and I would say things like that, but I don’t act out on them, where as before I would have. It is fantastic”.*

## **6 MONTHS**

Jane mentioned she felt more assured of the positives of attending DBT and that skills have become easier to apply. She spoke of one heated moment between herself and her individual therapist, which was eventually resolved. Jane has not needed to utilise phone contact as much. She appreciated the sense of companionship and unity between the skills group members, indicating the value of those relationships and possibly indicating their importance.

*“We’re getting to know each other very well now. If I’m upset, the girls are upset for me. They are very tolerant. It’s great to hear at the breaks about similar things we all do or did in relation to borderline. It is unifying”.*

She has noticed improved relationships and satisfaction through her increased assertiveness, giving examples of dealing with her sister and the nurse manager. Jane has committed to adopting further skills, such as self respect, as well as her well practised ones such as mindfulness and self soothing. Self harm urges and suicidal feelings have become more manageable. Jane confidently asserted she has not self harmed in one year.

*“I know since starting the DBT I am taking a step back before I jump (do something impulsive and self harming)... But when I had the blades and was about to do it, the fallout did come into mind, I put the brakes on. The skills are definitely playing a role, oh definitely, a major role. If I wasn’t doing the DBT now, I would be in ribbons with cuts”.*

## **8 MONTHS**

Jane informed me that she has negotiated with her consultant psychiatrist about discharge. She has begun a programme of independent living skills. She spoke about her simultaneous fears and excitement at starting the process. Jane mentioned that impulsivity was still there, yet through collaborative work with her individual therapist she has managed it. Setbacks are handled better and Jane stated without DBT she would be dead. She appreciated the sense of connection and confidence she can have with the skills group members. She believed that is amazing to hear that other people have experienced similar feelings and events. She declared that she enjoyed her attendance of the skills group and looked forward to it. She directed that her listening skills have improved and she has refrained from self-harm.

## **12 MONTHS**

Jane was satisfied to have reached a full year in DBT and exclaimed that she would definitely recommend it to anyone. Impulsiveness and interpersonal effectiveness have been among the most noticeable improvements.

*“Before I started DBT I had no control over my impulsiveness...flying off the handle without thinking, I had no interpersonal skills. I would just roar and shout, then have to go back and apologise. Now I think before I open my mouth and I’m not so impulsive. I might think of getting a blade, but I can weigh up the pros and cons of it, and decide that it is going to achieve nothing. I have taken that away from DBT and that has definitely helped me”.*

The discharge plan was successfully implemented following a full year’s attendance of the DBT programme.

### **6.9.3 INTEGRATION OF ALL DATA**

Jane completed the full year of DBT. Some changes were calculated from outcome measurement. Moderate change was observed in global functioning at twelve months compared to baseline figures, with most noticeable change occurring in the component of risk. This decrement in risk was reflected in Jane’s description of her increased competence in managing her suicidal urges and her reduced impulsivity. Level of problems and well being both displayed slight improvement, which was related to Jane’s improved handling of interpersonal conflicts and her skilful management of her abuse flashbacks. Her improvement in well-being was validated by the discussions around discharge mentioned at the eight month interview. Discharge into the community occurred successfully six months after finishing the DBT programme.

Perceived level of stress showed little change across the year of assessment. This stagnancy can be explained by the fact that Jane remained in an inpatient setting with the same level of stressors. However, Jane had reported that she was managing her

interpersonal conflict more effectively through the use of telephone coaching, individual support and skill usage. It was surprising that improvement within this scale was not augmented by this reported improved competency in dealing with stress.

Mindfulness remained high ever since two months, which can be corroborated by Jane's references to her usage of several mindfulness skills in order to manage her impulsivity and suicidal urges. Jane appeared to assimilate some interpersonal effectiveness and distress tolerance skills. She provided several examples of using each set of skills, particularly in situations of heightened distress and suicidal thoughts.

Among the most dramatic improvements in the outcome measurements was in the BHS. At baseline, Jane was within the severe range of hopelessness, by six month clinical improvement was calculated by moving into the moderate range of hopelessness. By twelve months Jane reported hopelessness within the lower mild range. This encouraging change in hopelessness was elucidated by Jane's description of DBT as life saving and her reiteration of the changes due to DBT. Jane asserted that DBT provided that hope for a better life, which again was corroborated by her discussion of discharge at eight and twelve months, in which she spoke of possibly living independently, returning to training and employment. For an individual, that 18 months previously had been firmly caught in the revolving door of A&E admissions (a total of 14) to be planning to return to a fully functioning life is no mean feat and is quite a triumph. It was reported that the period of not self-harming became steadily lengthier.

No change was found within the quality of life scale, which was not surprising as Jane was still an inpatient at the end of the year in DBT. Her level of BPD symptoms showed considerable improvement by six months, which was maintained at twelve months. The main areas of improvement included affective and cognitive disturbances, which are supplemented by reported changes in mood stability in interview data.

An examination of the ‘active ingredients’ of DBT to produce such impressive changes would tend to indicate the involvement of individual therapy, group member companionship and relationships, skills of mindfulness, interpersonal effectiveness and distress tolerance, and also essentially telephone coaching. Jane was extremely complimentary about the level of support provided by her individual therapist. Such a strong and consistent level of respect for this component of therapy would certainly indicate its role in producing change. The relationship with her individual therapist appeared to be one of support, validation, encouragement and empathy. Jane spoke of building trust, which on occasion was threatened through a misunderstanding. Nevertheless, it was noted that the individual therapist consistently handled these ruptures skilfully. The telephone coaching was used for relationship repair, as well as being instrumental in preventing self harm and suicide attempts. Jane found that both the telephone coaching and her individual sessions were vital in remaining stable and alive, while she was experiencing abuse flashbacks. Jane reiterated the role of the companionship of fellow group members on several occasions. It appears the group format provided additional support through skill learning and an opportunity to discuss past experiences in an informal way.

Jane’s case of long-term hospitalisation (2 years), in order to secure her own safety, was certainly among the more challenging. Jane’s case reported severe and long term childhood sexual abuse. At the beginning of DBT, Jane clearly did not want to live. However, she was able to maintain her initial commitment and motivation, remaining in the programme for a full year and witnessed significant changes around interpersonal effectiveness, management of self destructive behaviour, dealing with anger outbursts and mood changes and also being able to survive abuse flashbacks. The impact of DBT in Jane’s life was beyond question.

## 6.10 CASE STUDY 8 - CIARA

Ciara (31), a mother, presented with chronic alcohol abuse and a diagnosis of BPD. Ciara experienced childhood sexual abuse and developed anorexia in her early teens. Ciara displayed both low mood and low self esteem, particularly related to her appearance. Ciara has a long term relationship, which can be described as chaotic and tumultuous. Ciara has reported that she can become physically and verbally abusive. Ciara described numerous incidents of intense and irrepressible anger. Maladaptive behaviours reported include alcohol binges and abuse of prescription medication. It is under the influence of alcohol, in an impulsive rage, or in chronic dysphoria, that Ciara described her suicidal urges as being at their strongest.

### 6.10.1 QUANTITATIVE ANALYSIS

#### 6.10.1.1 ATTENDANCE OF INDIVIDUAL THERAPY

OVERALL AVERAGE INDIVIDUAL SESSIONS ATTENDED → 79%

##### **Commentary**

Ciara attended 4 out of every 5 scheduled individual sessions, indicating very good level of attendance. This figure was indicative of a relatively high commitment from Ciara.

#### 6.10.1.2 ATTENDANCE OF THE SKILLS GROUP

OVERALL AVERAGE SKILLS GROUP SESSIONS ATTENDED → 91%

##### **Commentary**

Ciara attended almost all of her scheduled skills group sessions, which denoted an excellent level of attendance.

### 6.10.1.3 PSYCHIATRIC ADMISSIONS

Table 64: Psychiatric admissions for Case study 8.

	Within Two years prior to DBT (2 years)	During the DBT programme (1 year)
Number of appearances/admissions	2	1
Length of admissions within this period (days)	2 days	1 day

#### **Commentary**

Ciara's frequency and duration of psychiatric hospitalisations were very low. It was recorded that she has only two admissions of one day duration in the two years prior to beginning in DBT. During DBT, Ciara was seen briefly in A&E for one act of deliberate self harm, to which she referred to in interview at six months. Ciara's levels of self injurious and suicidal behaviour have been maintained at a low level.

## 6.10.1.4 OUTCOME MEASURES

### 6.10.1.4.1 Clinical Outcome for Routine Evaluation (CORE)

Table 65: CORE figures for Case study 8.

	<b>0 month</b>	<b>2 months</b>	<b>4 months</b>	<b>6 months</b>
Well being (Max – 16)	14	7	10	7
Functioning (Max – 48)	31	24	31	21
Problems (Max – 48)	36	21	25	18
Risk (Max – 24)	3	1	2	3
<b>Total score</b>	<b>84</b>	<b>53</b>	<b>68</b>	<b>49</b>
(% Change from baseline)	-	(+37%)	(+19%)	(+42%)
	<b>8 months</b>	<b>10 months</b>	<b>12 months</b>	
Well being (Max – 16)	9	9	14	
Functioning (Max – 48)	17	21	40	
Problems (Max – 48)	31	20	31	
Risk (Max – 24)	1	2	6	
<b>Total score</b>	<b>58</b>	<b>52</b>	<b>91</b>	
(% Change from baseline)	(+31%)	(+38%)	(-8%)	

#### Commentary

Improvement on the CORE was demonstrated quickly as early as the two-month administration. Increases (deterioration) in the reported CORE totals occurred at 4 and 8 months. At twelve months there was a noteworthy negative change in the direction of improvement in CORE scores, which can be viewed in Figure 45.

#### 7.10.1.4.2 Kentucky Inventory of Mindfulness Skills (KIMS)

Table 66: KIMS figures for Case study 8.

	<b>0 month</b>	<b>2 months</b>	<b>4 months</b>	<b>6 months</b>
Observing (Max – 60)	18	28	34	32
Describing (Max – 40)	13	20	24	22
Acting with awareness (Max – 50)	18	24	22	25
Accepting (Max – 45)	27	25	22	25
<b>Total score</b>	<b>76</b>	<b>97</b>	<b>102</b>	<b>104</b>
(% Change from baseline)	-	(+28%)	(+34%)	(+37%)
	<b>8 months</b>	<b>10 months</b>	<b>12 months</b>	
Observing (Max – 60)	32	26	22	
Describing (Max – 40)	22	30	20	
Acting with awareness (Max – 50)	22	24	22	
Accepting (Max – 45)	24	22	21	
<b>Total score</b>	<b>110</b>	<b>102</b>	<b>85</b>	
(% Change from baseline)	(+44%)	(+34%)	(+12%)	

#### Commentary

Improvement in reported level of mindfulness was calculated as early as two months, with the overall level of improvement peaking at eight months. Observing and describing appeared to be the most useful of the elements of mindfulness for Ciara. There is a dip in level of mindfulness reported at twelve months, yet there remains a small improvement in mindfulness at the end of the programme.

### 6.10.1.4.3 Perceived Stress Scale (PSS)

Table 67: PSS figures for Case study 8.

	<b>0 month</b>	<b>2 months</b>	<b>4 months</b>	<b>6 months</b>
<b>Total score (Max – 40)</b>	<b>29</b>	<b>26</b>	<b>24</b>	<b>25</b>
(% Change from baseline)	-	(+10%)	(+17%)	(+14%)
	<b>8 months</b>	<b>10 months</b>	<b>12 months</b>	
<b>Total score (Max – 40)</b>	<b>30</b>	<b>25</b>	<b>27</b>	
(% Change from baseline)	(-3%)	(+14%)	(+7%)	

#### Commentary

A slight improvement (7-17%) was calculated in the perceived stress levels between two months and twelve months compared to baseline. However, a small dip in perceived stress occurred at 8 months.

### 6.10.1.4.4 Beck Hopelessness Scale (BHS)

Table 68: BHS figures for Case study 8.

	<b>0 month</b>	<b>2 months</b>	<b>4 months</b>	<b>6 months</b>
<b>Total score (Max – 20)</b>	<b>17</b>	<b>16</b>	<b>9</b>	<b>7</b>
(% Change from baseline)	-	(+6%)	(+47%)	(+59%)
	<b>8 months</b>	<b>10 months</b>	<b>12 months</b>	
<b>Total score (Max – 20)</b>	<b>12</b>	<b>10</b>	<b>17</b>	
(% Change from baseline)	(+29%)	(+41%)	-	

#### Commentary

Ciara was within the severe range of hopelessness at 0 and 12 month assessments indicating no overall change. At six months, Ciara had entered the mild range of hopelessness, which is a clinically significant change. Change in levels of hopelessness also occurred particularly early.

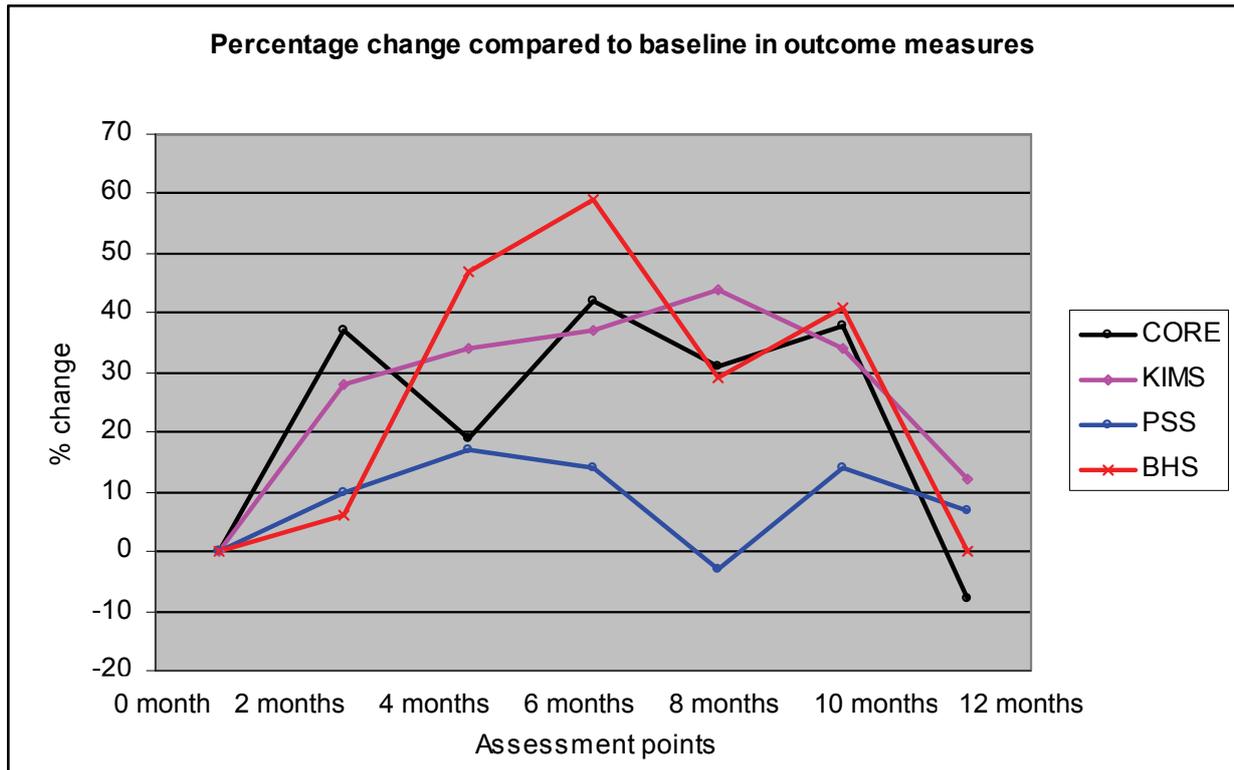


Figure 45: Percentage change compared to baseline in outcome measurement in Case study 8.

#### 6.10.1.4.5 ZAN-BPD

Table 69: ZAN-BPD figures for Case study 9.

	0 month	6 months	12 months
Affective disturbance (Max – 12)	10	2	7
Cognitive disturbance (Max – 8)	6	0	3
Impulsivity (Max – 8)	6	3	1
Disturbed relationship (Max - 8)	2	2	4
<b>Total ZAN-BPD score</b>	<b>24</b>	<b>7</b>	<b>15</b>
<b>(% Change from baseline)</b>	-	(+71%)	(+38%)

#### Commentary

Although significant change in overall BPD symptoms was calculated at six months, this was not fully maintained at twelve months. However, a moderate reduction in

BPD symptoms still occurred, especially noteworthy in impulsivity and cognitive disturbance. Disturbed relationships increased within this period.

#### 6.10.1.4.6 WHOQOL-BREF

Table 70: WHOQOL figures for Case study 9.

	<b>0 month</b>	<b>6 months</b>	<b>12 months</b>
Physical Health (Max – 35)	14	29	16
Psychological Health (Max – 30)	10	17	9
Relationships (Max – 15)	3	9	6
Environment (Max – 40)	15	31	20
<b>Total WHOQOL-BREF score</b>	<b>42</b>	<b>86</b>	<b>51</b>
<b>(% Change from baseline)</b>	-	(+105%)	(+21%)

#### Commentary

Slight improvement was observed in the quality of life measures between 0 and 12 months. However, at 6 months areas such as physical health and environment improvement dramatically from baseline.

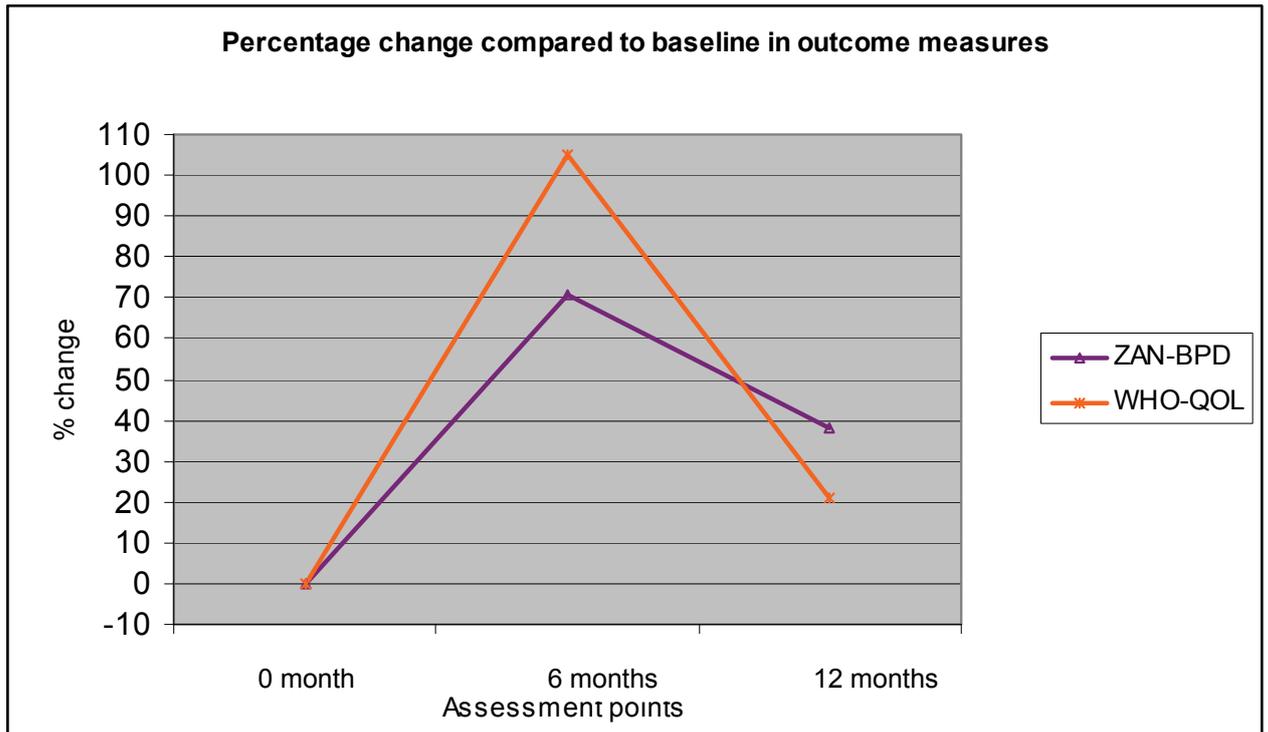


Figure 46: Percentage change compared to baseline in outcome measurements in Case study 8.

## **6.10.2 QUALITATIVE ANALYSIS**

### **0 MONTHS**

Ciara was very open and candid about her experiences that led to her beginning the DBT programme. She described a range of difficulties, from substance misuse, eating disorders, and depression, with numerous vivid examples. Ciara illustrated that she clearly possessed many of the complications of a person diagnosed with BPD, including sense of despair, anger outbursts, relationships under strain, self destructive and suicidal behaviours. Ciara appeared very frustrated at her psychiatric care, as it did not offer hope through continual changes in prescription, provision of an opportunity to overdose, sinister side-effects, and it failed to deal with the underlying causes of her complex difficulties. Ciara mentioned that it was not until she tried to take her life that she finally felt taken seriously. Ciara identified family issues and childhood abuse as precursor to her escalating problems. Ciara gave examples of anger outbursts due to feeling thrown aside by her doctor. Ciara believed that drug treatment has contributed heavily towards her current difficulties. Among her goals

for treatment included beginning to decrease medication, being more independent and confident, more in control of her moods and anger, being more positive and at ease, and also not behaving in a self destructive manner.

## **2 MONTHS**

Ciara commented that treatment was giving her a focus. She found all the elements of the DBT programme to be beneficial, feeling supportive and connected. Ciara initially thought she would not attend, but she has pushed herself to attend. Ciara appeared convinced of the assets of attending the programme. Ciara described her individual therapist in very positive terms as being reassuring and supportive, and that they had clicked with an absence of arguments. Ciara referred to her relationship with other skills group members as positive and with an absence of arguments. Ciara exemplified a time when she used the telephone contact effectively, and it helped calm her down and prevented her from assaulting someone.

*“I have used it (telephone coaching), because I had to. If I hadn’t used it, I might have done something stupid, not something self harming, but more impulsive, out of anger”.*

Ciara spoke enthusiastically, although tentatively, about the skill learning so far, mentioning breathing, describing and “DEARMAN” as being useful.

## **4 MONTHS**

Ciara connected recent poor attendance to disagreements with her partner. However, she pointed out that, although she should have attended her individual and skills group sessions and/or phoned out of hours, she did not deal with the distress with the usual means of alcohol binges and overdosing. The skills group was viewed as an opportunity to explore emotions and has good group cohesion. Ciara commented that the skills are still very novel and can be difficult to absorb. Ciara mentioned she has been finding it challenging to trust her new therapist, and felt particularly awkward phoning her and felt disappointed hearing “what skills will I use” response. Ciara felt she will struggle with improving her self confidence about her appearance and

socially. Ciara has managed her anger outbursts effectively, by taking a step back and reflecting on the consequences of her actions on maintaining the relationship.

*“I have a tendency to blow my top when I something gets on my nerves, I can’t help it, I have an anger issue for years; I find I have got better since I started DBT, definitely, unreal. I notice myself getting angry, (but) stepping back”.*

## **6 MONTHS**

Ciara reported that her relationship was back together after a stormy period and feeling depressed. She mentioned that in midst of her distress and confusion about her relationship, she had one slight incident of self harm. Although she felt frustrated after having done this, she understood that if she had binged with alcohol she may have taken an overdose. Ciara declared she has not used the phone facility recently, as she found it difficult to complain to her therapist over the phone. Ciara asserted that she enjoys attending the skills group, and will absorb more skills when they are repeated. She particularly believed observing and breathing were helpful for her. Ciara was more assured of her relationship with her therapist, talking positively about her and that she was pleased with how things were going. She asserted that she would have dropped out if she did not feel comfortable or satisfied with her relationship with her.

*“I find she will always think of something I should do, she’s good like that. I’m getting used to her, there is a growing trust between us, she is very good. She is very professional. She’ll talk to you about anything. She’s very easy going and down to earth, I’m very happy with her. It’s worked brilliantly”.*

## **8 MONTHS**

Further relationship dissatisfaction and another break up were recalled at eight months. Ciara again complained that she has not been looking after herself and felt dissatisfied with her appearance and her self confidence. Ciara has successfully managed to stay off drink, however has found it difficult to adopt an effective substitute in times of distress.

## **10 MONTHS**

Her relationship has settled down. Alcohol urges are no longer a problem. Ciara commented that she has found repeating the skills to be beneficial and has confidence in her individual therapist. Ciara acknowledged that she fought depressive feelings by leaving the house and becoming more active. However, her level of self confidence and acceptance of her appearance remained minimal. Impulsivity and anger outbursts are now negligible and under control. Ciara reported that she no longer uses the telephone coaching.

## **12 MONTHS**

Ciara was very despondent, anxious and depressed. She mentioned that she felt as if she had regressed to the way she was prior to DBT and has found the cessation of DBT has created a significant gap in her life. Persistent relationship questions and medication changes have contributed to a sense of immense emptiness and hopelessness. Despite her low mood, Ciara was able to acknowledge positive changes from the year including her anger and mood under control, no longer physically abusive to her partner, no suicidal acts within the year, and no longer misusing alcohol and tablets.

*“I might have suicidal thoughts, but I’m not acting on them. Years ago, I would be in A&E every other week”.*

Ciara commented that she will miss the companionship of the skills group, however she will not miss her individual sessions and felt therapist did more of the talking and not enough listening. It appeared Ciara was more pessimistic about her individual therapy in general.

### **6.10.3 INTEGRATION OF ALL DATA**

Ciara completed the full year of DBT. It would appear that until 10 months clinically significant improvement was calculated in the areas of hopelessness, BPD symptoms, and quality of life. Moderate improvement was observed in global functioning,

perceived stress and mindfulness. However, despite such gains being recorded at 10 months, by 12 months many of the strong positive improvements had been reduced to minimal improvements or no change compared to baseline measurements. This pattern was paralleled to qualitative analysis, which indicated considerable increase in negative outlook on therapy and the future. At twelve months, Ciara testified that she had become more depressed and anxious, having considerable difficulty leaving the house and coping with daily strains. Hence this depressed mood could have contributed to Ciara feeling less optimistic about what has been achieved to date. Ciara may have been disillusioned about the end of the skills group training and scaling down of the contribution of the individual therapy occurring after one year.

Despite Ciara's low self esteem and negative view of her appearance appearing unchanged at twelve months, much improvement had been acknowledged in other areas. Ciara had managed through the support of skills, telephone consultation and her individual therapist to curb her anger outbursts. Into the second half of the therapeutic year, Ciara maintained she had not needed to use the telephone coaching to help with this problem. In the past Ciara's anger had been so uncontrollable and ferocious she would get into physical fights with her husband, family members and others who aggrieved her. Although Ciara had one recorded act of self harm within the therapeutic year, she reported that she no longer abused prescription medication as she once did. Among the greatest feats during the therapeutic year was that Ciara ceased drinking. She connected much of her self destructive behaviours, escalated anger and impulsivity to her alcohol binges.

Throughout the whole therapeutic year, Ciara remained firmly preoccupied by her relationship with her partner and father of her child. Many of the reported break ups and relationship discontent coincided with deceleration in percentage change from baseline in her global psychological functioning measured at that at four months and eight months and perceived stress scale at eight months. Her relationship was a source of significant confusion, disgruntlement and disharmony, and hence this was reflected in the bi-monthly measures. This revolving relationship appeared to cause her much distress and hopelessness.

Change, according to outcome measures, occurred very early on in treatment. Improvement was observed in scores in hopelessness and perceived stress as early as four months and global functioning (particularly well being and problems) as early as two months. The Perceived Stress Scale revealed least change (on average 10% improvement compared to baseline), which is not surprising given the level of strain attributable to relationship dynamics. Although Ciara reported improvements in impulsivity and anger control, this did not appear to be reflected for a sustained period in a improved, more stable relationship.

Ciara's level of attendance at both the skills group training and individual sessions was very good. This can be explained by reference to Ciara's strong level of commitment and her determination to achieve her goals. Ciara was particularly approving of her first therapist, mentioning qualities of acceptance as key to their strong rapport. Ciara managed her change of therapist well, although there was a period of adjustment. It was noteworthy that Ciara maintained a positive attitude of her therapist up to ten months, however at twelve months Ciara did not appear to value her individual sessions as highly as previously, and this could perhaps be related to some anger at the termination of treatment. Ciara appeared to benefit from the sense of companionship provided in the skills group. In terms of skills, Ciara mentioned using observing and describing, which can be viewed in the KIMS. However accepting is also highly used throughout according to the KIMS. Ciara identified use of the interpersonal effectiveness set of skills. Ciara appeared to attach a lot of value to the out of hours telephone contact for crisis intervention and rapport building. However, she did not approve as much of the skills coaching element of this modality.

In the case of Ciara, it appears the important 'active ingredients' of DBT were the support fostered from her individual therapist and her fellow group members, interpersonal and mindfulness skills, and the structure provided by the DBT framework. Gains may have been minimised by the onset of negative thinking at twelve months, which may have been precipitated by the void left due to the cessation of DBT. Many of Ciara's chronic difficulties of depressed mood, social anxiety, poor self esteem, unsteady relationship, and abuse issues remained ongoing at the end of therapy. However, it is worthwhile to recognise the gains of improved anger control,

discontinued alcohol and medication abuse and less suicidal behaviours within the short period of one year of DBT attendance.

## 6.11 CASE STUDY 9 - LISA

Lisa (20) has been self cutting since her preteens, which was worsened by a family bereavement. Lisa has had a turbulent history of relationships within her family and has a series of boyfriends. Lisa described herself as having explosive anger, which often lead to significant arguments with those closest to her. Lisa mentioned having frequent suicidal thoughts, which are connected to her bereavement, emptiness and low self esteem.

### **6.11.1 QUANTITATIVE ANALYSIS**

#### **6.11.1.1 ATTENDANCE OF INDIVIDUAL THERAPY**

OVERALL AVERAGE INDIVIDUAL SESSIONS ATTENDED → 87%

##### **Commentary**

Lisa displayed excellent attendance of her individual sessions.

#### **6.11.1.2 ATTENDANCE OF THE SKILLS GROUP**

OVERALL AVERAGE INDIVIDUAL SESSIONS ATTENDED → 83%

##### **Commentary**

Lisa showed very good attendance of skills group training.

#### **6.11.1.3 PSYCHIATRIC ADMISSIONS**

No psychiatric admissions were recorded for Lisa in the two years prior to DBT and during attendance of the DBT treatment.

#### 6.11.1.4 OUTCOME MEASURES

##### 6.11.1.4.1 Clinical Outcome for Routine Evaluation (CORE)

Table 71: CORE figures for Case study 9.

	<b>0 month</b>	<b>2 months</b>	<b>4 months</b>	<b>6 months</b>
Well being (Max – 16)	10	6	6	3
Functioning (Max – 48)	18	12	12	6
Problems (Max – 48)	18	16	16	2
Risk (Max – 24)	2	2	5	0
<b>Total score</b>	<b>48</b>	<b>36</b>	<b>39</b>	<b>11</b>
<b>(% Change from baseline)</b>	-	(+25%)	(+19%)	(+77%)

#### Commentary

Lisa demonstrated considerable improvement in global psychological functioning between baseline and six months. Clinically significant improvement was observed by 12 months, with particular improvement in well being, functioning and problems.

##### 6.11.1.4.2 Kentucky Inventory of Mindfulness Skills (KIMS)

Table 72: KIMS figures for Case study 9.

	<b>0 month</b>	<b>2 months</b>	<b>4 months</b>	<b>6 months</b>
Observing (Max – 60)	34	42	48	59
Describing (Max – 40)	31	35	35	39
Acting with awareness (Max – 50)	25	32	34	38
Accepting (Max – 45)	36	37	37	37
<b>Total score</b>	<b>126</b>	<b>142</b>	<b>154</b>	<b>173</b>
<b>(% Change from baseline)</b>	-	(+13%)	(+22%)	(+37%)

### Commentary

Steady and increasing improvement was observed in level of reported mindfulness. At six months, Lisa reported very high mindfulness, with almost maximum levels in observing, and describing.

#### 6.11.1.4.3 Perceived Stress Scale (PSS)

Table 73: PSS figures for Case study 9.

	<b>0 month</b>	<b>2 months</b>	<b>4 months</b>	<b>6 months</b>
<b>Total score (Max – 40)</b>	<b>20</b>	<b>22</b>	<b>19</b>	<b>10</b>
<b>(% Change from baseline)</b>	-	(-10%)	(+5%)	(+50%)

### Commentary

Lisa did not report much change in the level of perceived stress, until the six months point when her level of perceived stress halved in comparison with baseline.

#### 6.11.1.4.4 Beck Hopelessness Scale (BHS)

Table 74: BHS figures for Case study 10.

	<b>0 month</b>	<b>2 months</b>	<b>4 months</b>	<b>6 months</b>
<b>Total score (Max – 20)</b>	<b>7</b>	<b>7</b>	<b>3</b>	<b>3</b>
<b>(% Change from baseline)</b>	-	-	(+57%)	(+57%)

### Commentary

Lisa was in the mild range at baseline and two month assessment. By four months, she moved into the minimal range and this improvement was maintained at six months.

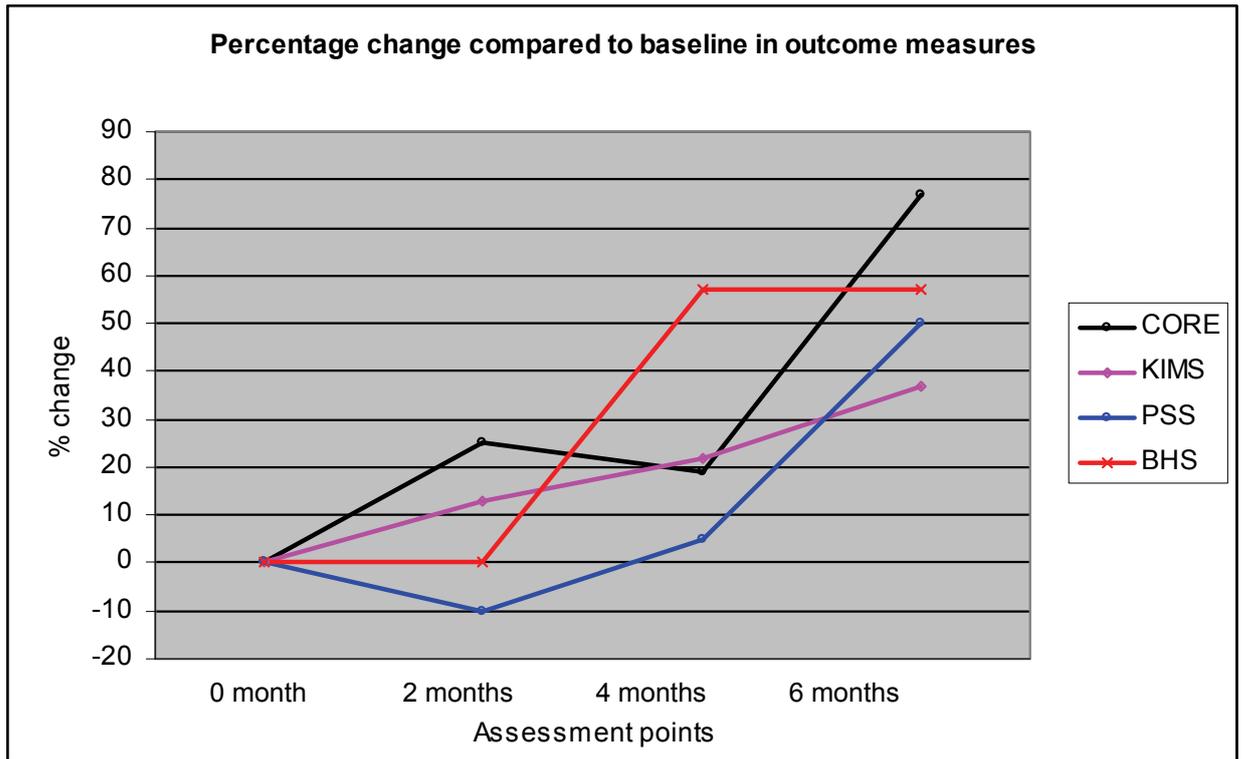


Figure 47: Percentage change from baseline of outcome measurements in Case study 9.

#### 6.11.1.4.5 ZAN-BPD

Table 75: ZAN-BPD figures for Case study 9.

	<b>0 month</b>	<b>6 months</b>
Affective disturbance (Max – 12)	6	0
Cognitive disturbance (Max – 8)	3	0
Impulsivity (Max – 8)	4	1
Disturbed relationship (Max - 8)	7	0
<b>Total ZAN-BPD score</b>	<b>20</b>	<b>1</b>
<b>(% Change from baseline)</b>	-	(+95%)

#### Commentary

Clinically significant and very dramatic improvement in BPD symptoms was observed between baseline and six months. All components showed improvement, with affective, cognitive and relationship components all returning to the lowest level.

### 6.11.1.4.6 WHOQOL-BREF

Figure 76: WHOQOL figures for Case study 9.

	<b>0 month</b>	<b>6 months</b>
Physical Health (Max – 35)	20	33
Psychological Health (Max – 30)	15	25
Relationships (Max – 15)	11	13
Environment (Max – 40)	22	25
<b>Total WHOQOL-BREF score</b>	<b>68</b>	<b>96</b>
<b>(% Change from baseline)</b>	-	(+41%)

#### Commentary

Lisa demonstrated improvement in reported quality of life between baseline and six months, particularly in areas of physical and psychological health.

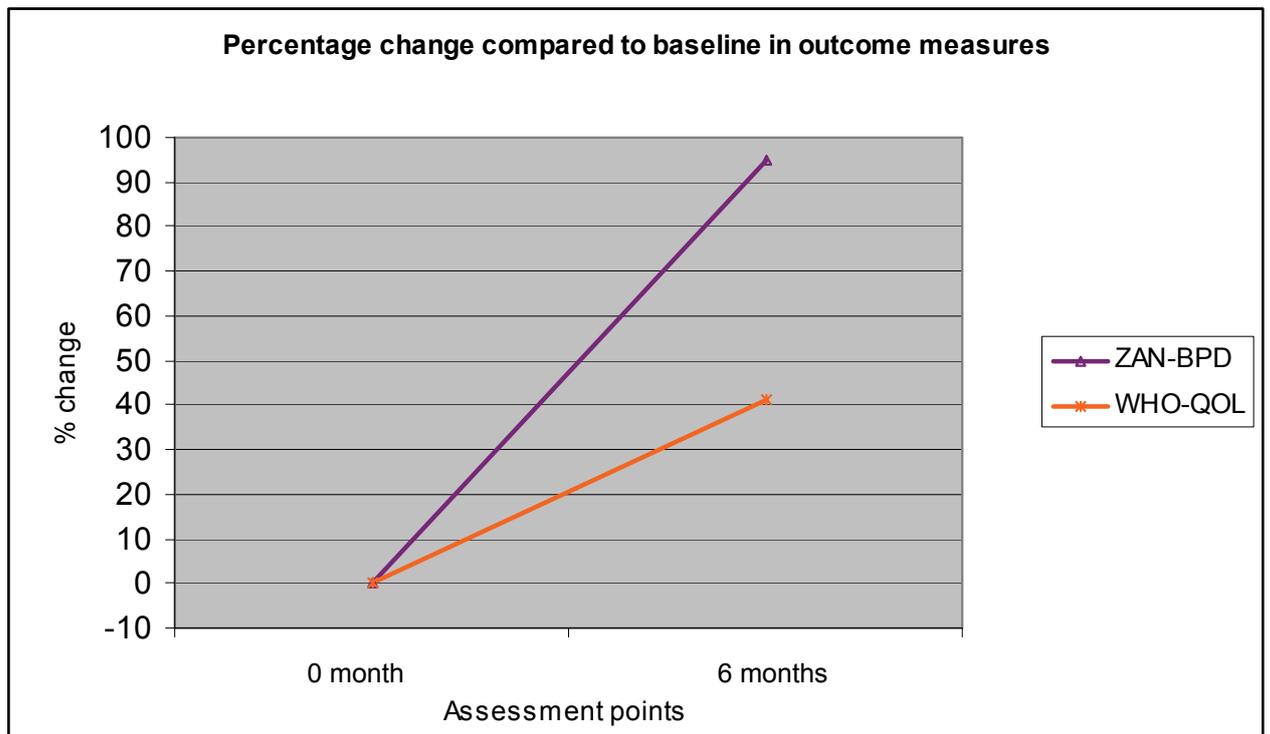


Figure 48: Percentage change from baseline of outcome measurements in Case study 9.

## **6.11.2 QUALITATIVE ANALYSIS**

### **0 MONTHS**

Lisa described the role of self harm has in her life. She clarified its function as one of stress relief. She mentioned that she has strong suicidal urges, and that her boyfriend helps her through this. Feelings of loss, isolation and anger were experienced after a family bereavement. Stability in emotions and relationships, as well as being in control of self destructive feelings, were among the goals Lisa identified at this interview. Lisa anticipated considerable commitment needed to succeed in DBT. She mentioned fears of losing the colour of her personality.

### **2 MONTHS**

Lisa talked about her skills training and pointed out that she found the group too regimented in terms of rules and she found one skills trainer irritating. Lisa mentioned that it will take considerable time to trust her individual therapist and that they frequently had disagreements. Lisa also declared she does not believe in using the telephone coaching, and preferred to contact her family or friends instead. Lisa hoped that she would continue to refrain from self cutting.

### **4 MONTHS**

Lisa admitted multiple source of interpersonal stress with family members and friends. She described a situation in the skills group, in which she divulged a situation of stress with her family, and she was not pleased with one of the skills group trainer's response and felt very angry as a result. She mentioned she was dissatisfied with her individual therapist who she believed talks over her and interfered with family issues. She articulated some family tension.

### **6 MONTHS**

Lisa mentioned growing boredom in the skills group and said she would like to get a job. Her relationship with her individual therapist has improved, although she does

blank out in sessions occasionally. She has been lot calmer, has not self harmed in three months, and managed her suicidal feelings better than previously through binge drinking.

*“It’s three months since I self harmed. It would be great if the scars would go away.... There are still times when I’d love to do it right now, but I say no to myself, especially when I’m stressed. I’ve been through times in the last couple of months, that if I’d been through six months ago, I would have been off hammered out of my head, crying on the phone that I couldn’t do this, I’m going to kill myself. Now I don’t do that”.*

### **6.11.3 INTEGRATION OF ALL DATA**

Lisa attended DBT only for six months, in order to start full time employment. Lisa demonstrated considerable improvement in all outcome measurements by six months compared to baseline. Dramatic improvement was observed in reported global functioning at the six months point, compared to previous measurement points that had shown more gradual improvement. Areas of well being, functioning and problems returned to non-clinical levels. Perceived stress showed a similar pattern of more dramatic improvement at six months after a period of slower improvement in the earlier months. Level of hopelessness demonstrated clinically significant improvement moving from the mild to the minimal range by four months into DBT treatment. BPD symptoms showed huge positive change between baseline and six months. Considerable improvement was calculated for quality of life and reported mindfulness between baseline and six months.

Despite all the outcome measurements demonstrating improvements in all areas by six months, Lisa was less gushing about changes in her qualitative interview. At six months, she remarked that she had witnessed some changes including that she was a lot calmer, has not self harmed in three months, and managed her suicidal feelings better than previously through binge drinking. Lisa declared she wanted to return to full time employment, indicating that she felt she was well enough to manage the stressors of working.

Lisa was cautious about trusting her individual therapist. She believed that her individual therapist talked over her and interfered in family situations that did not concern her. Lisa disliked the rules around self disclosure in the skills group and a specific skills group trainer. Although Lisa did use telephone contact initially, she later commented that it was too much skills focused and no longer availed of it, preferring to contact her friends in crisis. Despite finding many of the elements of treatment irritating, Lisa maintained a high level of attendance and demonstrated considerable improvements.

It was arguable that Lisa's case was one that was less severe and therefore demonstrated more changes more quickly, as she presented with no childhood abuse, substance dependency nor chronic eating disorder. However, Lisa was the youngest candidate for DBT and certainly displayed BPD symptoms, particularly in the form of relationship disharmony, changeable self concept and low self esteem, explosive anger and sudden mood changes, and considerable impulsivity. She presented with frequent suicidal thoughts, self cutting and mild binge drinking. Lisa described use of numerous key skills sets. Skills themselves were quickly assimilated for Lisa, so that by six months she was beginning to find the repeating skills boring. Lisa was particularly able and motivated, and also her individual therapist enabled her to keep on track. Lisa experienced some family and relationship disharmony throughout treatment, yet these disturbances did not affect her commitment to the programme. At six months, Lisa believed she was empowered and well enough to leave prematurely for employment, which may have been due to the support offered through individual therapy and the application of the skills.

## 6.12 CASE STUDY 10 - CORINA

Corina (40) presented after a lengthy admission with chronic and severe alcohol dependency. Corina a mother, unemployed and separated had also been previously diagnosed with depression and Attention Deficit Disorder (ADD). Poor self esteem binge eating, bulimia nervosa and a poor relationship background formed further difficulties. Corina also noted an immense level of emptiness and loneliness. Corina completed the full six months of full comprehensive DBT.

### **6.12.1 QUANTITATIVE ANALYSIS**

#### **6.12.1.1 ATTENDANCE OF INDIVIDUAL THERAPY**

OVERALL AVERAGE INDIVIDUAL SESSIONS ATTENDED → 68%

##### **Commentary**

Corina demonstrated moderate attendance of her individual sessions within her participation of the DBT programme. This pattern indicated that Corina was reasonably well engaged and committed to treatment.

#### **6.12.1.2 ATTENDANCE OF THE SKILLS GROUP**

OVERALL AVERAGE SKILLS GROUP SESSIONS ATTENDED → 57%

##### **Commentary**

Corina showed moderate attendance of the skills group sessions.

### 6.12.1.3 PSYCHIATRIC ADMISSIONS

Table 77: Psychiatric admissions for Case study 10.

	Within Two years prior to DBT	During the DBT programme (6 months)
Number of appearances/admissions	1	0
Length of admissions within this period (days)	64 days (Average of 16 days per 6 months) 9% of time hospitalised	0 days

#### Commentary

These figures are an accumulation of day hospital and inpatient admissions. Corina had one admission before DBT attendance.

### 6.12.2.4 OUTCOME MEASURES

#### 6.12.2.4.1 Clinical Outcome for Routine Evaluation (CORE)

Table 78: CORE figures for Case study 10.

	0 month	2 months	4 months	6 months
Well Being (Max – 16)*	16	15	16	12
Problems (Max – 48)	33	39	46	28
Functioning (Max – 48) ↯	39	33	39	29
Risk (Max – 24)	2	11	8	5
<b>Total CORE scores</b>	<b>90</b>	<b>98</b>	<b>119</b>	<b>74</b>
<b>(% Change from baseline)</b>	-	(-9%)	(-32%)	(+18%)

\* Scores for “Well being” are counter-intuitive, so a higher score denotes lack of well being according to the client.

– Scores for “Functioning” are counter-intuitive, so a higher score denotes lack of functioning according to the client.

**Commentary**

Almost 20% improvement was noted between baseline and six month assessment points. Measures of problems and functioning showed considerable improvement. Measures of risk to oneself and well being showed change in a positive direction.

**6.12.2.4.2 Kentucky Inventory of Mindfulness Skills (KIMS)**

Table 79: KIMS figures for Case study 10.

	0 month	2 months	4 months	6 months
Observing (Max – 60)	34	20	-	34
Describing (Max – 40)	25	30	-	34
Acting with Awareness (Max – 50)	13	12	-	18
Accepting (Max - 45)	10	12	-	16
<b>Total KIMS score</b>	<b>82</b>	<b>74</b>	-	<b>102</b>
<b>(% Change from baseline)</b>	-	(-10%)		(+24%)

**Commentary**

Improvement was indicated in self reported mindfulness, especially in the domain of describing. Accepting and acting with awareness, although showing some increment, remained low.

**6.12.2.4.3 Perceived Stress Scale (PSS)**

Table 80: PSS figures for Case study 10.

	0 month	2 months	4 months	6 months
<b>Total PSS score (Max – 40)</b>	<b>32</b>	<b>27</b>	<b>28</b>	<b>26</b>
<b>(% Change from baseline)</b>	-	(+16%)	(+13%)	(+19%)

### **Commentary**

Level of perceived stress demonstrated almost 20% improvement within the six month period.

#### **6.12.2.4.4 Beck Hopelessness Scale (BHS)**

Table 81: BHS figures for Case study 10.

	0 month	2 months	4 months	6 months
<b>BHS score (Max – 20)</b>	<b>18</b>	<b>17</b>	<b>15</b>	<b>7</b>
<b>(% Change from baseline)</b>	-	(+6%)	(+18%)	(+61%)

### **Commentary**

Dramatic and clinically significant change was noted between baseline and six months for reported level of hopelessness. Movement from severe range to mild range of hopelessness was calculated.

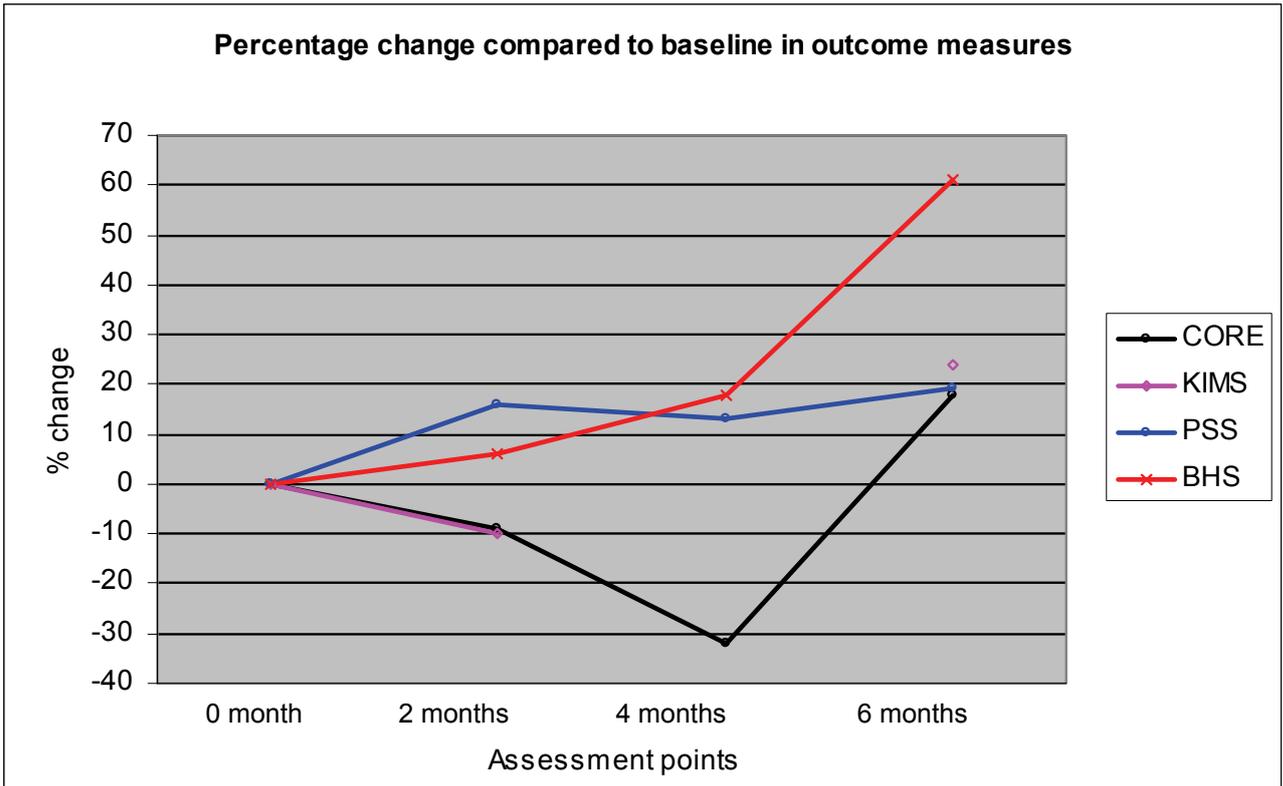


Figure 49: Percentage change from baseline of outcome measurements in Case study 10.

#### 6.12.2.4.5 ZAN-BPD

Table 82: ZAN-BPD figures for Case study 10.

	0 month	6 months
Affective disturbance score (Max – 12)	8	6
Cognitive disturbance score (Max – 8)	4	3
Impulsivity disturbance score (Max – 8)	4	1
Disturbed Relationships score (Max – 8)	3	4
<b>Total ZAN-BPD score</b>	<b>19</b>	<b>14</b>
<b>(% Change from baseline)</b>	-	(+25%)

#### Commentary

Some moderate improved was calculated in BPD symptoms, with particular improvements in affective disturbance and impulsivity at six months compared to baseline.

### 6.12.2.4.6 WHOQOL-BREF

Table 83: WHOQOL figures for Case study 10.

	0 month	6 months
Physical Health (Max – 35)	23	31
Psychological Health (Max – 30)	10	10
Social Relationships (Max – 20)	3	4
Environment (Max – 40)	26	33
<b>Total WHOQOL score **</b>	<b>62</b>	<b>78</b>
<b>(% Change from baseline)</b>	-	(+26%)

#### Commentary

Some quality of life improvements, in environment and physical health, were observed at six months compared to baseline figures.

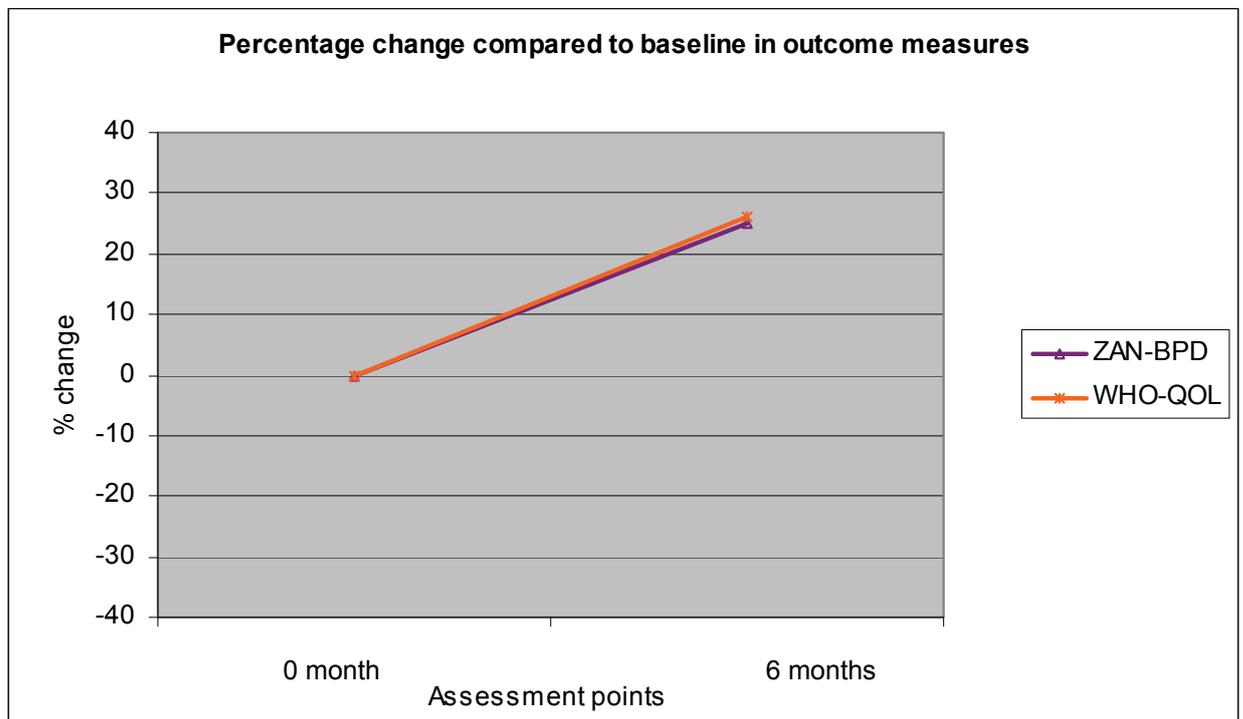


Figure 50: Percentage change from baseline of outcome measurements in Case study 10.

## **6.12.2 QUALITATIVE ANALYSIS**

### **0 MONTH**

Corina presented as talkative, although a little uneasy and reassurance seeking. She described a long history of alcohol abuse, failed relationships with partners and family members, body dissatisfaction and accompanying eating disorders, and crippling emptiness and loneliness. Corina illustrated examples of daily negative ruminations around comparing herself to others, poor self image, failed endeavours, relentless ambivalence in decision making and overall lack of direction in life. The level of pessimism of failed acquisition and application of DBT skills appeared to be high at this point.

*“I see (DBT) as frightening as I’m being shown a way to live a life, but I’ll look at all those skills and won’t do them...I find her (individual therapist) nice, but I feel like I’m wasting her time, because they probably could meet someone else who could cop on easily”.*

Corina continually returned to her self image of being “fat, miserable and forty”.

### **2 MONTHS**

Corina elaborated on difficult family dynamics. Skill application was difficult with growing levels of frustration.

*“I find the DBT is good, when I’m here, but when I go home it’s gone. Nothing in my life seems to stay with me more than a couple of hours”.*

Corina mentioned that she was not taking her medication due to the uncomfortable side effects. The cycle of alcohol abuse has become very tiring and no longer produces required effects. Corina confirmed she was relating better to her fellow group members and has good rapport with her individual therapist. There appeared to be a couple of days boost following attending individual therapy.

## 4 MONTHS

Desperate loneliness was described such that Corina felt she would be better off in hospital. Immense unhappiness and disconnection with the world, including the skills group, was mentioned. Corina still valued her individual therapy.

## 6 MONTHS

Despite description of her difficulties of procrastination, not taking responsibility, and over-scrutinizing, Corina identified some improvements at six months, including having connected with her neighbour and starting to taking “Antabuse” medication.

*“I’m feeling miserable drinking, I’m feeling miserable not drinking. Something has to change. So if I change one thing not to drink, I can try and ride out these feelings of hopelessness, emptiness....I think I want to learn to deal with it without drinking and then something might change. I’m hoping to stay not drunk, and suffer out the horrible feelings”.*

Although she reported that she had a close relative who took her life recently, Corina appeared determined to begin to work on issues of increasing self awareness, improving interpersonal effectiveness and self acceptance.

*“I’ve noticed I’m learning things. I’m aware of things more.... it’s learning how to do things in a different way. I used to not know how to communicate with people, and I’d let my thinking take me home and I wouldn’t come back....DBT will teach me for the future, giving me a wise mind, so I’ll be able to stay in any situation and weigh it up. I often do role plays with my individual therapist...learning to hold back, and not say anything”.*

Corina was positive about both skills training and individual therapy.

### **6.12.3 INTEGRATION OF ALL DATA**

Corina attended comprehensive DBT for six months and then continued only with individual sessions. Some changes were calculated within the outcome measures, as well in her qualitative report. Global psychological functioning displayed improvement between baseline and six months in all measures, risk, functioning, problems and well being. Corina was more positive at the six month interview about the constructive changes in her life, including connecting with a neighbour, starting anti-buse medication, improving her interpersonal effectiveness, and working on self awareness and acceptance. It would appear according to both qualitative interview and the CORE measure that change occurred between four and six months.

Perceived stress showed a decrement from baseline figures as early as two months and this was maintained for the following two assessments. Corina perhaps displayed better coping with the stressors in her life due to the support of attending the skills group and individual sessions. Stressors included occasional disharmony with her family members, binge drinking, being unemployed, and immense dissatisfaction with her appearance. At six months, Corina pointed to better management of three out of five of these stressors, through refraining from alcohol, working on self acceptance and interpersonal skills. Hopelessness also demonstrated dramatic improvement between baseline and six months. Corina stayed within the severe range of hopelessness, according to the BHS, for the first three assessment, and then showed clinically significant improvement by moving into the moderate range of hopelessness at six months. This pattern in hopelessness mirrored the improvement from four to six months in global psychological functioning. In the early stages of therapy, Corina upheld a distinctly depressive and pessimistic outlook on her chances of recovery. At six months, Corina showed some movement towards optimism.

Corina illustrated improvements in affective disturbance and impulsivity components of the ZAN-BPD between baseline and six months. Much of Corina's impulsive actions and self harming behaviours were connected to her use of alcohol, so this could explain the improvement in this figure. Corina's mood may have shown improvement through her abstinence from alcohol. Reported quality of life showed development at six months, particularly in the area of physical health, which can be

explained by reference to Corina's exercising with her new acquaintance and through her self-denial of alcohol.

Improvement in mindfulness was evident at six months compared to baseline. This upward pattern was encouraging, as Corina at two months exclaimed that she was experiencing difficulties with skill application and she had distinct attention difficulties within the skills group setting. Despite some initial problems, Corina mentioned she was able to get on with other group members easier than previously. Corina maintained a positive outlook on her relationship with her individual therapist, viewing her as warm, helpful, pragmatic and encouraging. In conclusion, although her attendance has been moderate due to her alcohol binges and depression, Corina appeared to want to change. It can be argued that DBT played a role in producing some improvements, even if these changes were in the early stages. A full year of comprehensive DBT was not offered to Corina, as the DBT team could no longer offer all components of the treatment due to limitations in staff resources.

# **CHAPTER SEVEN**

## **DISCUSSION**

## **CHAPTER 7**

### **DISCUSSION**

#### **7.1 INTRODUCTION**

The study was divided into two phases in order to gauge the client impact and describe the ‘active ingredients’ of DBT practiced in three Adult Mental Health settings. Client impact was assessed through investigating how DBT participation affected clients who were currently involved in, completed and those who dropped out of treatment. By use of a case study evaluation approach combined with qualitative investigation, the client impact could be fully addressed, the treatment could be evaluated from the clients’ perspective and description could be provided about the ‘active ingredients’ of DBT.

This chapter will first deal with how the findings addressed the research questions below. The strengths of the research will be discussed and will be reflected against the limitations of the study. Clinical implications of the findings will be clarified and further recommendations for service delivery and research exploration will be described. Conclusions will be drawn as a synopsis of the findings of the research.

#### **7.2 RESEARCH QUESTIONS**

In the Phase 1 of the research, contributions from interviewees who had completed the research fell into three main themes: 1) Life before DBT; 2) Views of DBT; and 3) Impact of DBT. Contributions from interviewees who dropped out of the research subdivided into three main themes: 1) Life before DBT; 2) Experiences of DBT; and 3) Reasons for leaving DBT. Phase 2 of the research, each case study provided feedback on the person’s experiences of therapy, life before DBT, expectations of treatment and any change associated with treatment. Each case study regularly filled in outcome measurements.

The following research questions were outlined from the outset of the research:

## **7.2.1 TO DETERMINE THE SERVICE AND RESEARCH IMPLICATIONS OF THE FINDINGS**

The above research question is addressed in 8.6 Recommendations.

## **7.2.2 TO EXAMINE THE CLIENTS' EXPERIENCES OF THE MENTAL HEALTH SYSTEM**

### **7.2.2.1 COMPLEX HISTORY AND DIFFICULTIES**

Unsurprisingly the present research revealed a high incidence of abuse history across research participants. Six participants in Phase 2 reported childhood and later life sexual abuse. Bullying and domestic violence were also common. This research confirmed the contributory factor of an invalidating home environment to the development of BPD. The condition has been viewed as an “adaptation” to a home environment that is characterised by fear, betrayal and lack of nurturing or reliable caregivers (Perry & Herman, 1993). Research participants were candid in their reports of neglect, violence, abandonment and emotional abuse, and supplied testimony of the crushing impact of such home environments.

The research substantiated the present knowledge of the complex presentations of individuals diagnosed with BPD, who are referred for the DBT programme. A high level of multiple diagnoses was reported. Affective disorder (mainly Major Depressive Disorder) and Substance Abuse/dependency (mainly alcohol dependency) were the most common secondary diagnoses in the research sample. It has been reported that half of those with BPD have a lifetime substance abuse diagnosis, with alcohol misuse being the most common variety (Feske, Soloff & Tarter, 2007). Co-morbidity of BPD with major depression is considered most common, with rates between 53%-83% (Bellino *et al*, 2005). Bodily dissatisfaction, especially among Phase 2 participants, was extremely frequent and an eating disorder (particularly binge eating or bulimia nervosa) was moderately common across the research participants, which has been reported in some research previously (Bruce & Steiger, 2005). Problematic relationships, anger control issues, anxiety were also fairly common among this sample. Dissociation and attention difficulties were reported. The

research reiterated the high and complicated level of needs that a BPD sample present with and consequently this group of individuals raise extra demands on the Mental Health services (Sansone & Sansone, 1996; Skodol, *et al* 2002; Bender, *et al* 2001; Bateman & Fonagy, 2006).

#### **7.2.2.2 MULTIPLE FAILED INTERVENTIONS - PHARMACOTHERAPY AND HIGH DEMAND ON SERVICES**

The current research concurred with findings that individuals with BPD tend to be extremely high users of Mental Health and medical services. A diagnosis of BPD is a distinct risk factor for suicidal behaviour (Oldham, 2006; Akiskal, Chen & Davis, 1985; Fryer, Francis, Sullivan, Hurt & Clarkin, 1988) and non-suicidal self-injurious behaviours is considered the BPD client's "behavioural speciality" (Oldham, 2006; Gunderson, 2001). The present findings agreed with the high prevalence of both attempted suicides and non-suicidal self-injurious behaviour. Many participants spoke about periods of presenting at A&E on a weekly basis.

Participants discussed having completed many unsuccessful psychiatric and less commonly psychotherapeutic interventions. For all participants contact with the Mental Health service was long standing, stagnant, had early onset and was inevitable. The level of disillusionment and hopelessness was elevated at the time of referral to DBT. Patients with BPD have more extensive histories of psychiatric outpatient, inpatient, and psychopharmacological treatment than patients with major depressive disorder (Bender *et al*, 2001).

Pharmacotherapy was definitively seen as insufficient in managing their difficulties and only having an impact on a superficial level. Many participants commented that the prescriptions were frequently altered and they had suffered uncomfortable side effects. Medication was on occasion badly managed by those prescribing it, as many participants admitted abusing this medication and using it as a means of overdosing. Participants admitted that they were oblivious to the effects of drug treatment and other options possibly available to them.

In Ireland, a strong and persistent adherence to the medical model of managing mental illness appears to be an obstacle to reducing the level of and range of drug treatment administered to individuals with BPD (O'Donovan & Gijbels, 2006). It is noteworthy that all participants in the present research were at some point heavily medicated with a range of medications. Participants admitted knowing little about the side effects, duration of treatment, purpose of specific medication and research behind its effectiveness. Participants appeared to be strongly encouraged to begin and continue medication, despite incapacitating side effects and little positive effect shown. Although the range of drug treatment recommended for BPD in the research is huge, the evidence base underpinning psychotropic intervention falls a long way short of supporting a general treatment for all patients with BPD (Paton & Okocha, 2006; Dimeff, McDavid & Linehan, 1999). Even though BPD patients are heavily prescribed medications with greater frequency than any other diagnostic group, much of this is based on hunches or anecdotal evidence rather than on rigorous or widely replicated data (Triebwasser & Siever, 2007). It appears extraordinary that psychotropic intervention is so ubiquitous across the reports of research participants in this study and yet the quality of the evidence of the effectiveness and appropriateness of use of certain drug treatments appears highly questionable.

### **7.2.2.3 HIGH DISSATISFACTION WITH THE MENTAL HEALTH SYSTEM**

The level of dissatisfaction with the mental health system was very high at the time of referral for DBT. Many participants commented that they met with dismissive, apathetic and derogatory comments and actions following a self destructive behaviour. This staff behaviour was perceived as further rejection enhancing their level of hopelessness and despair. Psychiatric care was rebuked for having little impact, being drug-focused, lacking continuity and providing minimal time invested into dealing with the source of difficulties. Poor experiences of nursing and A&E care were reported.

This finding of the high level of dissatisfaction with care before DBT adds to research of staff responses to BPD, which has already revealed that BPD is a condition that receives more negative responses from Mental Health and medical staff than many other conditions (Markham & Trower, 2003; Gallop, Lancee and Garfinkel, 1989;

Cleary, Siegfried & Walter, 2002). Dissatisfaction with psychiatric care in BPD samples has been reported previously (Perseus, Ojenhagen, Asberg, Ekdahl & Samuelsson, 2003), in terms of not being understood and being confronted with disrespectful attitudes. Patients stressed the experience of discontinuity and betrayal. Hence it appears extremely necessary at this point to take action against stigma and negative staff responses. Training in BPD, possibly from a DBT model of skills and motivation deficit, should be offered as a form of professional development training for mental health professionals, in order that BPD clients receive the best possible care when accessing medical and Mental Health services. Increasing awareness (Aviram, Brodsky & Stanley, 2006) and training programmes (Miller & Davenport, 1996; Krawitz, 2001 & Krawitz, 2004) have been proposed and outlined in the literature to tackle this thorny issue.

### **7.2.3 TO ASSESS THE CLIENTS' PERSPECTIVE ON THEIR PARTICIPATION IN THE DBT PROGRAMME**

Theme Area 2) Views of DBT with the sample of those who completed DBT specifically addressed this research question. Theme Area 2) Experiences of DBT with the sample of those who dropped out of DBT targeted the above research question. In Phase 2, case studies provided their own perspective of their participation in DBT in each qualitative interview. Each of these three data sets contributed to fully assessing the clients' perspective of their participation in the DBT programme.

#### **7.2.3.1 COMMITMENT AND ORIENTATION TO DBT**

The tremendous role of the individual therapist in orientating and committing a client to DBT was verbalised by all three samples. Many interviewees elaborated on the difficulty focusing on attendance of DBT, especially in the early stages of beginning the treatment. The heavy level of involvement required by the client in the early stages can appear insurmountable. This multiple mode therapy can appear to be a heavy burden to distressed clients who are unconvinced initially of its effectiveness.

More reference is needed in the research about the large effort by the DBT team to successfully commit a client to begin the programme and to maintain this

commitment when client motivation levels are minimal. The literature to date has not reported on the frequency of clients who fail to begin DBT, due to insufficient and dissatisfactory commitment or readiness to change. The numbers of clients, who do spend many sessions being oriented to DBT, but fail to successfully commit for whatever reason, could be substantial, and it may be useful for services delivering DBT to be aware of this preliminary challenge in orientation and commitment.

Among the factors behind successful commencement of the DBT programme were instilling clients with clear expectations from treatment and therapists using client-friendly simple analogies to explain the benefits of partaking in DBT. It appears that many clients voiced some lack of clarity about their expectations for treatment and understanding of the nature of treatment at the beginning of their participation in DBT. Examination of client understanding of the undertaking and motivation around potential benefits should be an essential component of the orientation and commitment stage prior to commencing the programme, in order to maximise level of client investment and insight into the therapeutic process. A video outlining therapy expectations and potential benefits of participation may be beneficial during this period.

Research examining the role of expectations of therapy in outcome variance has been surprisingly limited (Weinberger & Eig, 1999). Clear expectations of forthcoming treatment might have an impact on producing more positive results in treatment (Greenberg, Constantino & Bruce, 2005). Greenberg *et al*, 2005 discussed the importance of a therapist to clarify that therapy will not produce immediate or miraculous effects, rather that the intervention should be presented convincingly as producing relatively reliable and typically gradual change over time. A greater understanding of how expectations of treatment in DBT influence outcome and commitment is needed and should be investigated.

The impact of the therapeutic contract was positively reported. Some participants commented that being reminded of the contract was useful, as it prevented them from dropping out and re-focused their attention to the benefits of attendance. The present research finding agreed with views of the therapy contract as bringing support and a challenge (Perseus, Ojenhagen, Asberg, Ekdahl & Samuelsson, 2003). The

therapeutic contract instils ownership in the clients that they have agreed to the terms and conditions of this contract during the commitment stages and they must comply with these pledges, in order to actualise any improvements. It appears this component is definitely useful and worth continuing. Periodic and scheduled examination and if needed collaborative modification of the contract may augment benefits, so that clients can absorb and have possession of an evolving and needs-based contract.

### **7.2.3.2 INDIVIDUAL THERAPY AND THE THERAPEUTIC ALLIANCE**

Individual therapy appears to be a pivotal component of the overall DBT programme. The vast majority of participants in all samples spoke highly of their individual therapist. Positive feedback about individual therapy was ample and was reported early in descriptions of therapy. A balance between warm, validating reciprocal communication and motivational, challenging irreverent style appeared to work well. Many interviewees identified that their individual therapist could encompass both polarities and still manage to preserve constructive rapport. The individual session itself typically served the functions of providing a boost for the week, help with the skills, positive feedback, gave focus, creation of a safe place to discuss feelings, an opportunity to problem solve and to stay grounded. The individual therapy and the therapeutic alliance provided the foundation stone from which the other elements of treatment could prosper and reach fruition. The individual therapy relationship served to minimise potential for early termination, as discussed in the literature (Ben-Porath, 2004; Horvath, 1995).

Linehan (1993 a) clearly identified dialectical strategies as key to maintaining balance and progress within the therapeutic framework. If a treatment impasse exists it is most likely due to the therapist failing to balance treatment strategies on one side (e.g. change) with their polar counterparts (e.g. acceptance). Linehan (1993 a) compared this use of therapeutic strategy within the alliance as “ballroom dancing”, in which “the therapist (is required) to move quickly from strategy to strategy, alternating acceptance with change, control with letting go, confrontation with support, the carrot with the stick, a hard edge with softness, in rapid succession” (p. 203). Specific dialectical strategies are adopted in order to maintain movement and progress with targets in treatment, including playing devil’s advocate (deliberate and systematic

disproving of a believed proposition believed by the client), extending (emotional equivalent of devil's advocate, taking client's statements literally and seriously), activating 'wise mind' (asking a client to respond from deep centred and balanced thought), making lemonade from lemons (turning problems into benefits), allowing natural change (encouraging acceptance of changes occurring naturally), use of metaphor (analogies used to adopt balanced flexible thinking) and entering the paradox (unexpected attention grabbing strategy by highlighting contradiction).

It is not surprising that research participants claimed that their relationship with the individual therapist could be tumultuous and demanding one. Some participants spoke about necessary rupture repair with their individual therapist in the early months of their participation in DBT. Issues mainly focused around commitment, attendance, trust and level of motivation. Despite occasional dispute and misunderstanding, the individual therapist was observed as being long-standing and resilient, with a never-ending source of support for the clients. All interviewees acknowledged the intrinsic value of the relationship and the content of these weekly sessions. Many participants viewed this component of therapy as central in keeping on track to attain their goals and in staying alive.

Some process research has emphasised the importance of this key relationship and the DBT individual therapy itself in leading to change for clients (Shearin & Linehan, 1992; Linehan, Dimeff, Reynolds, Comtois, Welch & Hegarty, 2002). The balance between change and validation strategies within individual therapy has been highlighted in playing a significant role in reduction of suicidal ideation and parasuicidal behaviour. Validation has been implicated in preserving attendance. The present research reiterated the importance of balance between these two therapeutic strategies and also the role of validation to foster feelings of being understood, strengthen the relationship and protect against ruptures.

Previous research has indicated the difficulty of forming and maintaining an enduring relationship with clients diagnosed with BPD (Piccinino, 1990; Cleary, Siegfried & Walter, 2002). Staff members, dealing with clients with BPD, have previously been documented to voice feelings of helplessness, betrayal and resentment. Research has indicated that many professionals tend to interact with clients with BPD in a less

empathetic manner (Fraser & Gallop, 1993). The therapeutic alliance is recognised as an essential and consistent component to produce positive therapeutic outcome (Martin, Garske & Davis, 2000; Horvath & Symonds, 1991; Gaston, 1990). Therapeutic alliance is a variable of immense importance to the investigation of process of change for clients with BPD (Frieswyk *et al*, 1986), which overall has received surprisingly little attention in BPD research. According to Frieswyk *et al* (1986), clients with BPD can often be associated with low motivation, poorly developed self-concept, and are frequently predisposed to respond to therapeutic efforts with hostility and have poor outcome. Thus, the inability of these clients to experience others as benevolent and their predisposition to distrust those who seek to help clearly interfere with their capacity to make good use of a treatment relationship. Furthermore, their inability to sustain a stable, coherent sense of self and others exposes them to panic, depression, loss of self-esteem and catastrophic reactions to perceived separation (Frieswyk *et al*, 1986). There is a general agreement among psychotherapists that the development of a strong therapeutic alliance is a critical factor in the treatment of these patients because of their impaired capacity to develop and maintain a stable, trusting relationship with others.

The present findings suggested that DBT strategies practiced within the therapy session lead, in fact, to quick-forming, durable and productive relationships for the majority of clients. Almost all participants accentuated the fruitful role of the relationship with their therapist and the content of the sessions themselves in producing positive change in their lives. The level of satisfaction with the individual therapy component of DBT was high overall and is indicative of its association with and contribution to positive changes. The ease with which strong therapeutic relationships were formed as illustrated in this research may be explicable by the training received by DBT therapists and their adherence to DBT dialectical strategies, which establish and sustain a productive relationship with a client group that is reportedly difficult to manage therapeutically and present with numerous challenges in the formation of robust alliance.

### 7.2.3.3 SKILLS GROUP TRAINING

Most interviewees were moderately positive about the benefits of the skills group. Many participants mentioned benefits of attending and enjoying the experience of it. The skills group training was viewed as an opportunity to receive some support from skills trainers and fellow group members, learn some skills, talk about how they were feeling, receive positive feedback and give focus to their week. Among the most important issues arising from client commentary on this component were the impact of fellow group members dropping out, sense of cohesion and restricted nature of the skills group.

Disruptions in the cohesive nature of the skills group came from the premature discontinuation of established members and the arrival of new members mid-way. Some interviewees spoke of feeling disappointed and disheartened as fellow group members discontinued prematurely, especially when there was a strong connection between the group members. It can also be an intimidating experience for new members entering an established skills group, in which established members are more advanced. Linehan (1993 a) has discussed the pros and cons of open and closed skills group. A diverse skills group with multiple level of ability has been reported as beneficial to encourage reassurance and motivation (Cunningham, Wolbert & Lillie, 2004). A prominent feature in descriptions was the strong bond between group members. Any therapy group appears to offer the standard benefits of group context including comradeship, connectedness, reduced isolation, supplementary support and encouragement from fellow group members. However, the DBT skills group appeared to offer an opportunity to meet their peers, who were also tackling the same issues and willing to bond with others similar to them and who may understand them. The relationship between group members and level of group cohesion appears to be a variable undervalued by the research to date, but which may contribute the overall effectiveness of the treatment. Many interviewees mentioned being motivated to attend by other skills group members, receiving direction from them on using skills and being offered supportive listening. A recommendation for DBT practice from this finding could be to pay increased attention to facilitating group cohesion as much as possible and increased attention in individual and group components of DBT to monitoring the specific difficulties that have been highlighted by this research.

Another common theme running through the interviewee reports in relation to the skills group was around the rules of self-disclosure and non-discussion of self-harm. Many interviewees desired a 'process group', whereby they could talk about their difficulties, rather than learn how to deal with or manage them. Most participants understood the restrictions imposed around open discussion of self-destructive behaviour and they realised the reasons behind its enforcement. However, this limitation in discussion created a sense of artificiality and restricted open expression within the skills group. Linehan (1993 a) viewed self-harm as a valid and effective coping strategy, given the circumstances and limitations on range of coping strategies. However, such restriction within the skills group may lead to further invalidation of clients when they are requested not to discuss their experiences in front of the other group members. Obviously, Linehan (1993 a) clearly designed such restriction, so that the focus of the skills group is learning productive coping strategies to deal with self-harm, rather than a process forum for open discussion about experiences, and that clients would not become emotionally involved in hearing the self-destructive experiences of other group members. Coming from a behavioural perspective, Linehan was keen not to reinforce any self destructive behaviour by responding to self destructive acts with possibly reinforcing attention and comforting open discussion. It is interesting that the present research found numerous reports of dissatisfaction with this particular element of the skills group. It may be worthwhile considering, in what ways the therapy could be adapted in order to minimise this dissatisfaction or discomfort, or perhaps the therapy should not be moulded, as altering such a restriction could lead to negative ramifications. Turner (2000) compared DBT to a client-centred control group therapy (CCGT) for the treatment of BPD. He found that those allocated to the CCGT condition deteriorated in terms of number of psychiatric hospitalisations, number of self harm attempts and measures of suicidal ideation. Turner (2000) reasoned that the DBT intervention offered firmer boundaries around self harm disclosure, which allowed for reduction in self destructive behaviours. Turner (2000) commented that the quality of the therapeutic alliance accounted for significant variance in patients' outcomes across both treatments.

#### **7.2.3.4 DIARY CARDS**

Clients largely named diary cards as a major source of frustration. Numerous complaints were focused around the amount of labour that was devoted into filling them in compared to feedback given, difficulty filling them in and difficulty admitting self-destructive behaviours. Diary cards do require much therapeutic input, in order that they are filled out correctly and fully and the client understands the rationale behind them. Consequently the diary cards tend to absorb a lot of time within the skills group and can lead to other group members becoming distracted. Benefits of diary card usage include that clients continue to focus on skills and reduce self-destructive behaviours during the week, keeping a record of progress made to date, and taking more responsibility in the reduction of their maladaptive coping strategies and increase of appropriate alternatives. Some clinical recommendations for the use of diary cards were made based on the feedback, including removal of its double jointed place in both skills group and individual therapy. It is interesting to note the respondents tended to associate diary cards, particular their drawbacks, with the group context.

#### **7.2.3.5 SKILLS**

Skill acquisition was a source of frustration. Some interviewees identified initial difficulties understanding certain skills, while many participants mentioned problems applying skills. Situations of high distress were found to be particularly difficult in which to use skills. Despite this initial challenge many participants were able to identify examples of using sets of skills within the first six months of treatment. Nearly all DBT graduates were able to name, explain, rationalise usefulness of, and give example of their use of some skills. The number and range of skills used tended to grow from the second six months and onwards, as reported in other research (Lindenboim, Comtois & Linehan, 2007).

Mindfulness tended to be challenging for some participants to grasp, perhaps due to concentration, attention or comprehension difficulties. Mindfulness was particularly viewed as useful in calming emotions, returning to wise mind, stepping back from impulsivity and staying in the moment. Tasks using the body, especially breathing,

were the easiest and most effectively used examples of mindfulness. Observing and describing were easiest grasped, however accepting and acting with awareness took longer and caused more trouble, as these are perhaps more abstract. For those who did master mindfulness, it appeared to have benefits of being able to relax, sooth and focus. Mindfulness helped clients to stay within the moment, return to the ‘wise mind’, and thus reduce potential to become impulsive and do something self-destructive.

Emotional regulation and distress tolerance skills were particularly acclaimed for their pragmatic function of coping with emotional stimuli and also attempting to ease emotional response. These sets of skills tended to be commonly used (e.g. self soothing) and allowed quick gratification when applied properly, which perhaps underlying their popularity. Radical acceptance was a powerful, but difficult skill to master, which was also shown in other research (Cunningham *et al*, 2004). Interpersonal effectiveness was especially positive for numerous participants who mentioned that prior to commencement of DBT they experienced daily distress through interpersonal conflict and anger outbursts. Numerous applications of this skill set were specified in qualitative reports, with the main benefits endorsed including maintaining relationships, assertiveness, communication of needs and effective conflict management and resolution. Several participants witnessed improved relationships with family members and partners and became more confident in dealing with interpersonal issues.

The vast amount of qualitative data has indicated and illustrated the advantages of the DBT skills. Participants were almost entirely positive about skills that they had mastered and were willing to give evidence to demonstrate its effectiveness. Although this study did not attempt to quantify skill usage, it would appear from qualitative report that distress tolerance and mindfulness were overall the most commonly used skills, similar to previous research (Lindenboim *et al*, 2007).

### **7.2.3.6 TELEPHONE COACHING**

The findings across the two phases found approximately a 50-50 split between those who used telephone contact and those who did not use it. For those who availed of the

facility, all interviewees found the facility helpful and even essential. The benefits from telephone coaching were relationship repair with their individual therapist, skill learning and application, and management of distress, crisis and self-harm urges. The telephone contact itself was useful to prevent emotional escalation, allowing the participants to become rational, calm things down and make sense of things. The frequency of calls tended to decrease over time. Detailed examples of effective usage of this facility were reported. It is an interesting finding that contrary to stereotyped views from some mental health professionals; clients with BPD were reluctant to overuse this facility and were very much respectful of their therapist's input in running it. Clients with BPD had to be actively encouraged to use the facility.

For those who did not use the facility, reasons such as not impinging on therapist's free time, not wanting to contact the therapist to discuss suicidal thoughts, having alternative sources of support, and being unwilling to become dependent on the reassurance of telephone were voiced. Another interesting theme around telephone contact was a frustration that the content of the telephone contact was focused around skills coaching and taking responsibility to manage the situation via skills. Many participants believed the telephone contact should be more validating, open and they should be able to vent without having to focus on possible solutions.

It is not surprising that the telephone contact is considered so valuable and life saving to those who implement the facility. Both findings of surprisingly low usage of telephone contact and the level of frustration of the techniques used by the therapist on the phone are very interesting, as they have not been reported in the literature to date. Mechanisms by which telephone contact can be encouraged need to happen in order that clients maximise their potential gains from DBT (Ben-Porath, 2005). The style of contact itself perhaps also needs to be examined, as it could be overly skills focused, so that clients who have contacted their therapist may feel little understood, not listened to, cold, pressurised to find a solution, and confused following a skills-focused conversation and thus reluctant to call again in a similarly distressing situation. Perhaps when clients consider contacting their therapist in a distressing situation, and they do not already know what skill to use or have become frustrated with applying skills, they may choose not to phone, as it will be a further source of disillusionment and frustration. Despite these misgivings, it may be that if contact is successful in terms of outcome, clients may be more likely to contact subsequently

even if difficult. Therefore, it is essential that early out-of-hours contact is encouraged and facilitated, and that such contact is productive and outcome-focused to increase likelihood of future contact. The reasons client do not contact their therapist are telling clinically and require further attention. It has been suggested that telephone contact may be one of the ‘active ingredients’ of DBT effectiveness (Ben-Porath, 2005), therefore it is critical that all DBT clients be fully encouraged and prompted to access the telephone contact. Among the benefits of the telephone contact may be the strengthening of the bond and understanding between client and therapist following telephone contact in times of distress and relationship rupture. Therefore, if clients do not avail of the facility, the individual therapist and client has lost out on a course of fortifying the therapeutic alliance, which is the cornerstone of therapeutic change.

#### **7.2.4 TO GAUGE THE IMPACT THAT DBT HAS HAD ON THE LIVES OF CLIENTS**

The impact of DBT on client’s lives was gauged by reference to the following categories, which came from the findings in both Phases of the research.

##### **7.2.4.1 REACTION TO BPD DIAGNOSIS**

In the initial stages of DBT orientation and commitment, individual therapists spent extended periods of time explaining the diagnosis of BPD in DBT terms. Many participants described the powerful impact of this clarification of their difficulties at the commencement of DBT. A majority of participants reported little understanding of their diagnosis at referral and also a lot of confusion caused by their multitude of diagnoses. Interpretations of the diagnosis tended to go through a cycle of feeling their difficulties have been finally explained and that they are not alone in having their problems to further questioning and anxiety around the label, the longevity of the condition and treatment options. The careful and skilful presentation and explanation of BPD in the DBT model appears to be helpful as it is explained as recoverable, in validating and non-blaming terms, and treatable with DBT. It became clear from reports that the way a diagnosis is presented and explained to a client is instrumental in the client’s own understanding and acceptance of it. It is noteworthy that prior to

DBT the vast majority of clients have little or insufficient understanding of their diagnosis and range of treatment options available.

Explanation of and encouragement to accept the BPD diagnosis, within a DBT framework, is particularly important. The drop-out group admitted that they had distinct difficulties accepting the BPD diagnosis. The core aspect of the treatment hampered client participation in other key components of the treatment, especially the skills group. If BPD is not understood and assimilated from the perspective of a skills and motivation deficit model by the client, then there is a redundancy in learning skills to fill this gap.

Only one study in the literature has specifically examined service user perspectives on the diagnosis of BPD (Horn, Johnstone, & Brooke, 2007). This study used Interpretative Phenomenological Analysis with five service users who had been given the diagnosis of BPD. Five super-ordinate themes were uncovered: Knowledge as power, Uncertainty about what the diagnosis meant, Diagnosis as rejection, Diagnosis is about not fitting, and Hope and possibility of change. Knowledge as power referred to finally having the knowledge and avenue to explore, and also that many ‘experts’ about the diagnosis gave that little explanation or information. Many of the above themes were mirrored in the present study’s findings, in terms of the misunderstandings the diagnosis can cause, restriction of full information from clients by Mental Health professionals and the positive feelings that can result from clarity around their problems through diagnosis. Hersch (2008) commented on the myths and stereotypes about BPD and illustrated examples of myths that clients with BPD should not be informed of their diagnosis because it would cause them undue distress and that the provision of such information would hinder not help their treatment. Further research into the openness around diagnosing BPD, its presentation and explanation appears to be necessary.

#### **7.2.4.2 EXPOSURE TO AND MANAGEMENT OF CHILDHOOD ABUSE FLASHBACKS**

Another theme of the impact of DBT that arose was that DBT encouraged participants to face their past with the coping strategies provided by their skills. In the reports of

the case studies, several participants spoke of experiencing flashbacks of abuse and that the provision of their individual therapist and skills allowed them to cope more effectively with them than they had previously. Many participants illustrated examples of being more empowered and efficacious in handling memories of their past and dealing with crises in the present. Hence DBT provided clients with the opportunity to face their past and go through a process of acceptance, which may not have occurred otherwise.

#### **7.2.4.3 REDUCED LEVEL OF RISK – LESS SELF-DESTRUCTIVE BEHAVIOUR AND CONTACT WITH MENTAL HEALTH SERVICES.**

Life threatening behaviour is a primary target behaviour in all components of DBT within the first year of DBT. The present research showed reductions in the frequency and length of psychiatric admissions and reports of less suicidal and self-harm behaviours after participation in DBT. The case studies suggested that self-destructive behaviour become more manageable by six months into therapy, as the clients became more adept at managing suicidal and self-harm urges through improved usage of the skills, especially mindfulness and distress tolerance. Impulsivity and coping with distress demonstrated clinically significant improvements. However, it must be noted that some participants admitted that skills were still difficult to use during times of high distress. Although the morbidity potential for DBT completers has certainly decreased, it is not completely extinguished as suicidal ideation can reappear for clients.

As a note of caution, one research participant in the Phase 1 “DBT completer group” completed suicide several months following participation in the research. Thus, DBT certainly is associated with a positive impact in reduction of risk and frequency of suicide completion. However, research should be cautious not to interpret encouraging findings as “DBT completers” being free from risk of taking their lives or relapsing to previous self-harm strategies.

#### **7.2.4.4 IMPROVED FUNCTIONING**

The present findings certainly indicated dramatic and noteworthy improvements in overall functioning following participation in the DBT programme. Many participants attributed positive changes in functioning to their involvement in DBT. Functioning improvements include interpersonal effectiveness, community reintegration, and improvement in associated incapacitating difficulties (e.g. reduced use of alcohol). Positive change in interpersonal effectiveness was reported by many participants, in which there were reconnections with and improved relations with family members, less conflict, easier expression of needs and assertiveness. One case study was discharged from hospital and two others returned to employment. Among the Phase 1 “DBT completer” sample, there were parallel improvements of returning to employment, disconnection with the Mental Health services, and family unification. All former clients referred to using some level of adaptive coping strategies. Most interviewees appeared to no longer be fearful of presenting difficulties. Problem solving skills gave DBT graduates a sense of mastery and empowerment. Management of emotions had vastly improved for participants through the use of skills. Thinking demonstrated slow and steady changes of becoming less extreme, more balanced and positive, and less emotionally-driven.

#### **7.2.4.5 POSITIVE CHANGE TO WELL-BEING**

Among the case studies in Phase 2, improvements in well-being were less dramatic than the other areas. By the end of their participation in DBT, numerous interviewees admitted being more hopeful and positive. Increments in self confidence and esteem and self acceptance were slower to be realised. In the ‘DBT completer group’, participants were more vivid in their descriptions of improvements in well-being, perhaps due to the longer length of time since commencement of the DBT programme. Several participants highlighted participation in DBT as creating a new pathway and the start of a new life. The ‘DBT completer group’ had come further in terms of self confidence, self acceptance, and reduction in self hatred.

It can be concluded that much positive impact of DBT was perceptible within the first year of DBT participation or even earlier, which were mainly improvements in

functioning and risk. Further improvements in well-being appeared to take longer and were more common in the reports from the “DBT completer” group.

### **7.2.5 TO CALCULATE THE SIGNIFICANCE OF DBT ON THE CLIENT GROUP**

Significance was defined as gauging the extent of change across time in Phase 2, case study design. The methodology used for this was a test of statistical significance, by calculation of the effect size (Cohen, 1992) and Wilcoxon Signed Rank Test, and also commentary on the clinical significance in outcome measurement that allowed this.

Effect size calculations were based on 8 out of 10 case studies, who completed pre and six-month measures. Effect size estimates the size of changes across all case studies between these two time intervals. Hence, effect size indicates the strength of a given effect. It was found that change in the ZAN-BPD and BHS demonstrated huge and very large effect size respectively, between 0 and 6 month intervals. This calculation is reflected by the Wilcoxon Signed Rank Test, which showed statistically significant change between 0 and 6 months for BPD symptoms and hopelessness, measured by the ZAN-BPD and BHS respectively. The measures of mindfulness (KIMS) and perceived stress (PSS) showed large effect sizes and approached significance on one tailed calculation on the Wilcoxon Signed Rank Test. Medium and small effect sizes were found in the WHOQOL and CORE in that order and neither measurement demonstrated significance between the two time periods. Consequently, BPD symptoms and hopelessness have shown a strong direction towards positive change, which may have been attributed to the therapeutic intervention. However, this outcome is tentative due to the lack of control group and the small sample size.

Clinically significant change was calculated in the BHS and CORE in each case study. Other outcome measurements did not supply suitable norms and interval data needed to make these conclusions, as specified by the reliable change indicator (Jacobson & Truax, 1991). Between pre-measurement and six months, CORE demonstrated clinical improvement in two cases (movement from clinical to non-clinical range), no change in five cases, and clinical deterioration in one case study.

Between 0 months and 6 months, BHS showed clinical improvement in five cases (4 cases moved from the severe range to moderate (1), mild (2) and minimal (1) ranges and 1 case study improved from mild to minimal range of hopelessness) and no clinical change in three cases (all remained within the severe range of hopelessness). In the BHS, clinical significant change is defined as any movement from one interval range to another.

In conclusion, in Phase 2 significant improvement was demonstrated in BPD symptoms and hopelessness between 0 and 6 months, which may be associated with participation in DBT. Improvements towards significance were demonstrated in perceived stress and mindfulness within this period. Improvement in hopelessness added to established research to date, which has shown change in hopelessness associated with DBT with a shorter standardised version (Koons, *et al* 2001) and standard DBT for co-morbid BPD and a substance misuse diagnosis (Linehan, *et al* 2006). The rate of improvement in the level of hope has not been hugely emphasised in the literature. The present research has indicated the improvement in level of hope is in fact possible in the first half year. Change in BPD symptoms was reported early on in treatment (at six months), which was a relatively surprising result. Similar yet slower improvements in global BPD symptoms have been reported previously, although not using with ZAN-BPD, in a forensic setting (Nee & Farman, 2005) and in a substance misuse setting (Van den Bosch, *et al* 2002). Improvement in mindfulness is an area of DBT, which has not been evaluated at peer review level. Hence, this research has suggested that statistically significant improvement in both hopelessness and global BPD symptoms is possible six months into treatment.

#### **7.2.6 TO INVESTIGATE THE REASONS WHY CLIENTS DROP OUT OF THE DBT PROGRAMME**

The rate of discontinuation in DBT has been somewhat under-reported in the research. The present research showed a 60% drop-out rate in Phase 2, which is an accumulation across two sites. In Phase 1 of the research, Site A and Site B reported a premature discontinuation rate of 29% and 50% respectively. Hence an accumulation across all three sites (n=44) showed an overall drop-out rate of 41%. This figure is

higher than the figures reported in effectiveness studies of comprehensive outpatient DBT to date, which has typically been reported between 10-20% (Scheel, 2000).

There is clear recognition that BPD is a condition synonymous with early termination of treatment. Research on early termination in individuals with BPD has found a premature discontinuation rate of 47-70%, which is significantly more than patients diagnosed with schizophrenia and Major Depressive Disorder (Skodal, Buckley & Charles, 1983; Gunderson, Frank & Ronningstam, 1989; Kelly, Soloff, Cornelius, George, Lis & Ulrich, 1992). Drop-out typically has been reported to occur within the initial months of treatment, be related to level of self-harm and increase the likelihood of completed suicide (Dahlsgaard, Beck, & Brown, 1998).

No empirical study to date has examined accounts from clients to clarify why they drop out prematurely in DBT. An investigation of the predictors of drop out of inpatient DBT participants using outcome measurement (Ruesch, Schiel, Corrigan, Leihener, Jacob, Olschewski, Lieb & Bohus, 2008) found that experiential avoidance and anxiety may be associated with dropout in inpatient DBT. They reported that low life-time suicidality and high anger could reflect a subtype at risk for discontinuation of inpatient treatment.

The present study revealed that drop-out participants showed an equal level of confusion around their diagnosis of BPD, however there appeared to be firm disbelief and non-acceptance of the established BPD label and much more overt resistance was evident among the 'DBT drop-out group'. Many interviewees were at the time deeply offended about being diagnosed with a Personality Disorder, with resulting strong emotional reactions of anger and fear. Overall, the 'DBT drop-out group' were fairly positive about their experiences of DBT. However, a majority of the 'DBT drop-out group' mentioned that they would have had anxiety specifically about working in a group and found the format restrictive. Non-acceptance with the BPD diagnosis also created difficulties around attendance of the skills group and completion of diary cards. External factors played a role in attendance also. Many interviewees felt they wanted to continue therapy but were experiencing too many additional problems that impinged upon attendance of treatment.

To conclude, non-acceptance of the BPD diagnosis, group format anxiety and frustration, and additional co-morbid difficulties appeared to be the core reasons why this particular sample discontinued the DBT programme prematurely. It must also be noted that later ‘drop outs’ spoke more positively of their experiences of the DBT programme, particularly of their views of individual therapy. More research is needed to explore the possible differences in the presentation of late and early ‘drop-outs’ of DBT, in order to more reliably predict and safeguard against early discontinuation. Client profile and DBT team level of skill should also be investigated as predictors of early client termination.

### **7.2.7 TO ISOLATE THE MOST EFFECTIVE COMPONENTS OF DBT**

The above research question aimed to comment on the ‘active ingredients’ of the DBT programme. This is a difficult prospect for a therapy that is multi-component, interrelated and complex. Based on the qualitative information provided from a range of DBT service users, Linehan (1993a&b) and research literature to date, the following conclusions can be drawn in relation to commenting on the ‘active ingredients’.

According to the author, the therapeutic alliance and related individual therapy factors appear to be central in the success of the treatment. However, it is one of four essential components of DBT that need to come together to ensure effectiveness, as shown in Figure 51. It is the quality of the relationship and the DBT dialectical strategies used that facilitate immense stage 1 work to be completed on life threatening behaviour, therapy interfering behaviour, and quality of life interfering behaviour. DBT Individual therapy, when utilised to its greatest extent, provides a base for coaching and mastering skills, dealing with ongoing crises, a model of a constructive and validating relationship, opportunity to rebuild functioning and well-being, and reduction in risk. The present research reported the immense support of individual therapy, the early onset and strength of the positive client feedback, and the range of gains that the clients believed are attributable to work completed in individual therapy. The author asserts that individual therapy (using the DBT model) is core, irreplaceable, and of most importance of all components of DBT. As well as supporting adherence to the DBT model and cohesion between the team, ongoing training and fortnightly team consultation is essential in maintaining motivation and

interest for the individual therapist (as well as the skills group facilitators). The team consultation is also fundamental in minimising potential for staff burn out, ensuring the optimal level of DBT care is provided to the client (Linehan, 1993 a).

Another key element of DBT effectiveness is telephone coaching and it can also be considered vital in DBT, when it is specifically used for crisis and self-harm prevention, skills coaching and generalisation, or relationship rupture repair. The telephone coaching cements the therapeutic alliance, allows for dramatic reduction in self-destructive behaviour, prevents suicide completion, and facilitates skill learning and generalisation to the most appropriate and necessary settings. In the present research, interviewees maintained the ‘life saving’ role of this component of DBT. Hence, this facility is essential in keeping clients alive, in order that they can continue to attend and benefit from DBT. Based on participant report, it is estimated that telephone coaching produces a considerable element of the change and is also linked heavily to skill acquisition, therapeutic alliance and client variables.

The third component of ‘active ingredients’ includes three layers the group context benefits, the instruments of change (diary cards, emotional regulation, interpersonal effectiveness) and acceptance (mindfulness and distress tolerance). If a participant is able to assimilate both skill domains and also benefit from being in the skills group and form meaningful relationships (reduced isolation, peer support, greater understanding of condition and skills, augmented motivation to attend), it can be argued that the participant has maximised their particular participation in this component of DBT and has contributed to the overall improvement possible. This component is also heavily related and reliant on the quality of the therapeutic alliance, client variables and use of telephone coaching.

Finally the fourth component of determining the level of possible effectiveness is the client contribution, in terms of readiness for change, commitment, ability and motivation to change. DBT cannot be effective without the client being able, willing and truly wanting to change. Psychotherapy research in general has long recognised the contribution of the client in producing change (Prochaska & Norcross, 2001; Miller & Rollnick, 2002; Littell & Girwan, 2002) and much research has examined its role and importance in numerous conditions, for example anorexia nervosa (Geller,

2002), substance abuse (DiClemente, 2001). However, DBT research has only begun to examine the impact of client variables in producing change. Recent research concentrated on the examination of the stages of change in DBT for BPD (Soler *et al*, 2008). Authors demonstrated the applicability of the Trans-Theoretical Model (TTM) stage of change construct to DBT, which is a framework developed to describe and predict the process of intentional change of any behavioural problem. The TTM has five stages including 1) precontemplation – no current intention to take action to deal with the problem 2) contemplation – ambivalent yet active consideration of taking action to manage problem 3) preparation – commitment to change 4) action – commitment to change and active application of change strategies 5) maintenance – change has been achieved and focus is now on relapse prevention. Soler *et al* (2008) found this stage of change model was a useful predictor of DBT drop-out and that patients at the precontemplation stage were prone to drop-out before completing all DBT group sessions. Hence client motivation and readiness-to-change are important variables to consider in producing change. Variables of client ability and commitment level are also variables that require attention. Linehan (1993 a) asserted that a client can not fail DBT. However, it must be the case that a client may not be suitable or not ready for DBT resulting in poor commitment, poorly formed reasons and motivation to change. Sub-borderline intellectual ability or significant cognitive difficulties in attention or concentration, and an array of complicating factors may impede effectiveness. Discussion of client impediments in the effectiveness of DBT is non-existent in the literature.

In conclusion, it is argued that DBT effectiveness is based on four inter-related components that together form the “active ingredients”, including 1) the therapeutic alliance, individual therapy and supporting team consultation and training; 2) the telephone coaching component; 3) the instruments of change (diary cards, emotional regulation, interpersonal effectiveness) and acceptance (mindfulness and distress tolerance), as well as the benefits of the group context client variables involved in DBT effectiveness; and 4) client variables involved in DBT effectiveness. If one component is missing, not used or insufficient, it will affect the overall additive effect of the effectiveness of DBT and potential for change. If one component is particularly beneficial, it will augment the performance of the other components, and produce greater change.

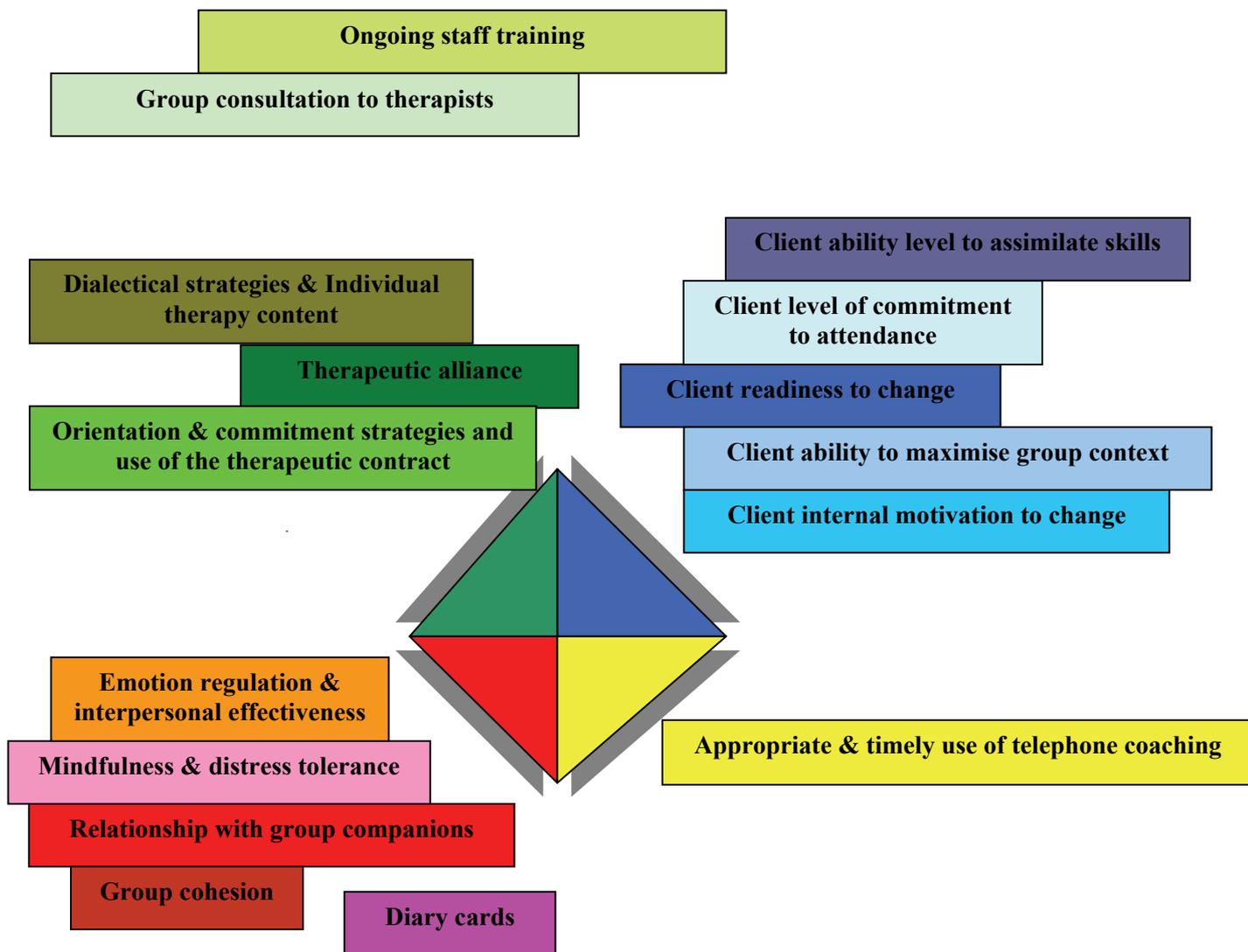


Figure 51: the interrelationship of the ingredients of DBT. According to the author, it can be divided into four sections. 1) Blue represents the important client variables involved in DBT effectiveness 2) Yellow denotes the telephone coaching component; 3) Green illustrates the therapeutic alliance, individual therapy and supporting team consultation and training; 4) Red represents the instruments of change (diary cards, emotional regulation, interpersonal effectiveness) and acceptance (mindfulness and distress tolerance), as well as the benefits of the group context. All sections or ‘active ingredients’ are inter-related and symbiotically enhance the effectiveness of the others.

## 7.3 STRENGTHS OF THE STUDY

The present research has seven main strengths within it and many conclusions and recommendations can be made based on these strengths.

### 7.3.1 TRIANGULATION OF EVIDENCE

The use of mixed methodology in the present research was advantageous on a number of levels. Seven research questions could be addressed due to the extent of the applicability and flexibility of this research methodology. Mixed methods allow for more complete analysis and complement each other (Creswell, Fetters, & Ivankova, 2004; Crawford, Weaver, Rutter, Sensky & Tyrer, 2002). Phase 1 allowed for a deep understanding of the themes affecting a considerably large cohort of clients who completed and dropped out of DBT, including life before DBT, impact of and change possibly attributable to DBT, perspectives of treatment and reasons for early discontinuation. Phase 1 provided direction, focus and impetus for closer, more detailed case study evaluation of DBT using mixed methods. Phase 2 adopted and integrated outcome measurement data and qualitative interview data. The integration of these methods within and across case studies served the following functions of elaboration (development of understanding of quantitative data via reference to qualitative data), corroboration (strengthening of possible conclusions drawn due to convergence in two data sets), initiation (divergent findings between the two data sets allowed further investigation and analysis), expansion (broadening the understanding of the phenomenon through use of different paradigms) and development (using each paradigm to develop the strengths of the other). It also minimised the opportunity of making conclusions based on weak or insufficient evidence from just one data set (Weinholtz, 1995).

Use of mixed methods in the present study was more appropriate and feasible than use of more rigorous quantitative methods. The emphasis of this study was the exploration and development of both the impact of DBT and understanding of the 'active ingredients'. The purpose of this study was not to augment further the accumulation of effectiveness data on DBT, but to have a greater understanding of

‘nuts and bolts’ of DBT, in particular from the service users’ perspective. The study aimed to be flexible in its outlook and approach, so that more specific research recommendations could come to fruition from the research and the emphasis was maintained on inductive and integrative theory building. Applied research cannot be perfectly planned; rather it is a process that involves ongoing decisions and management of unexpected events (Morgan & Stewart, 2002).

In conclusion, the use of mixed methods within the present research was certainly viewed as a methodological strength, a purposeful and deliberate paradigm choice and an augmentation to the overall understanding and conclusions to be drawn.

### **7.3.2 EMPHASIS ON SERVICE USER INCLUSION**

The involvement of service users in the evaluation of interventions is becoming steadily more recognised, in demand and expected (Stevenson, Jackson, Crowe & McGowan, 2005; Barnes & Wistow, 1994; Lelliott, 2000). The present study placed considerable emphasis on the involvement and value of contributions of all clients who were involved in DBT. The study was broad and all-encompassing in its involvement of clients, including those who discontinued treatment, those who completed treatment and those who were currently involved in the programme. This wide sampling allowed the research to illuminate how DBT affected all client groups involved, gauged the impact of DBT based on such feedback and identify the ‘active ingredients’ of treatment.

### **7.3.3 INVESTIGATION OF LITTLE RESEARCHED AREAS**

The research was able to investigate and discuss areas that had not received sufficient attention in DBT research. The current study is the only research published to date to investigate the reasons why clients fail to complete full comprehensive outpatient DBT using qualitative methods, which until this point was a little understood and often ignored area of DBT investigation. The research facilitated service users in an Irish context to provide their feedback of DBT and their interpretation of its impact in their lives. Such qualitative investigation of DBT had not taken place within an Irish context and was minimal in worldwide literature. The present research emphasised the

role of mindfulness in change in DBT by using a relevant outcome measurement (e.g. KIMS), which until this point has not been explored. The research also investigated how changes may occur in perceived stress, BPD symptoms, hopelessness, quality of life and global psychological functioning.

The research augmented our understanding of the key components and ‘active ingredients’ of DBT and it also called for further attention to be paid to dismantling studies. The research added insight into which elements of the BPD condition typically change within the first and second six months of treatment.

#### **7.3.4 NUMEROUS DATA COLLECTION POINTS IN PHASE TWO**

Among the strengths of Phase 2 was the close and frequent examination of change across time using numerous outcome measurements and in depth interview investigation. The frequency of outcome measurement allowed pinpointing of any change when it happened and allowed linking with qualitative report at the same data collection point. Change in outcome measures could be clearly connected to changes in interviewee report in each assessment, which allowed greater understanding of the process of change. The range of outcome measurement administered demonstrated consistency across time and allowed observation and analysis of change in different domains.

#### **7.3.5 INDEPENDENT RESEARCH**

Apart from the data collection occurring within the same building as the DBT skills group training took place in each site, the main researcher was entirely independent of the implementation of the DBT programme in all of the three sites. The author was not involved in any part of the therapeutic input of DBT. This independence from the implementation of DBT allowed for minimal confusion by research participants of the role of the researcher and purpose of the research. It was emphasised during the process of informed consent that involvement in the research was not compulsory, participants could leave at any time, and it did not affect the provision of the therapy. The importance of participant understanding of these terms was stressed, so the research could not at any point become a burden or intrusion, particularly given the

nature of the client group. Research has only begun to touch on the challenges of attaining genuine and safe informed consent for research with individuals diagnosed with BPD (Dew, 2007). Any negative or extreme emotional reaction to any aspect of the research was taken seriously and the individual therapist was informed to follow-up with the research participant on this issue of distress. Distancing of the research project away from the therapy allowed participants to feel safe and be honest in their evaluation of DBT.

The role as qualitative researcher could perhaps have served as a pseudo-therapeutic function for some participants. Eide & Kahn (2008) described the phenomenon as follows “although qualitative research does not begin with the intent of therapeutics, the very nature of the qualitative interview, with its open and uncontested listening to the other, with its recognition that the interview process is but part of the person’s ongoing process of change and becoming, lends itself inescapably to addressing yet again the line between what is and is not accepted in qualitative research” (pp. 203). Typically during research interviews, participants recalled traumatic past events, present crises, suicidal ideation and self-harm urges, and tentative hopes for the future. Interviewees were progressively more candid as they became more comfortable in the process of regular research interviews in Phase 2. It may have been the case that research participants benefited somewhat from the active listening, intrinsic support and opportunity to recount and reflect on the negative and positive experiences of DBT. It was occasionally challenging when research participants sought advice, sought solutions and asked for suggested alternatives, as such efforts had to be reflected back to the research participants, in order to clarify the research role and minimise involvement in problem solving strategies. The author recognised that although there was a clear and regular reiteration the role of researcher, any quasi-therapeutic benefit or budding bond between research participant and researcher could not be ruled out or ignored.

### **7.3.6 MULTI-SITE SAMPLING AND HIGH INVOLVEMENT**

The study included a high level of participation. In Phase 1 Section 1 – “DBT completer group”, 13 out of a possible 17 in Site A (76%) and 3 out of a possible 5 in Site B (60%) agreed to take part. In Section 2 – “DBT drop-out group”, 4 out of a

possible 7 (57%) and 2 out of a possible 5 (40%) agreed to participate. A total of 3 possible participants could not be contacted to enable participation. In Phase 2, 100% of possible participants from Site A (n=6) & C (n=4) took part in the study. Hence, overall the study encompassed a sizeable sample (n=32 out of possible 44) of clients with BPD who participated in DBT in the three outpatient adult mental health settings across Dublin. Three sampling sites and a high level of participation can be argued to increase the possible representativeness of the present findings to similar settings.

### **7.3.7 INTER-RATED ANALYSIS**

Another methodological strength of the present research is the use of inter-rater analysis in the content analysis. There was a high concordance between the themes found by the main researcher and independent psychotherapy researcher (non-expert in and not involved in DBT). This procedure ensured that analysis maintained a close relationship to the reports given by all interviewees.

## **7.4 LIMITATIONS OF THE STUDY**

There were ten main limitations to the present study:

### **7.4.1 SMALL SAMPLE**

In Phase 2, there was a relatively small sample, so that while the findings are true for this particular target group, they may not be representative of all DBT clients with BPD in Adult Mental Health settings. Generalisability of the findings is confined, as the overall number, especially in Phase two, is small. Studies that encompass larger, more gender balanced, ethnically and economically diverse samples are required.

However, if the findings are interpreted in the realm of analytic generalisation, rather than statistical generalisation, certain transferability of the findings in both Phases is possible, especially given the triangulation strategies that have been implemented (Jones & Lyons, 2004).

#### **7.4.2 CONTROL OF EXTRANEOUS VARIABLES**

In Phases 1 & 2, the level and range of current and previous medication for research participants was not recorded in this study. Therefore, it may have been possible that changes in medication may have resulted in some of the improvements attributed to DBT. The amount and array of previous intervention work completed prior to participation in DBT was not recorded and may have been a variable in producing quicker improvements. It was noted that research participants in Phase 1 varied between 6 months and 3.5 years since the commencement of their participation in comprehensive DBT, so consequently may have had differing clarity in memory of their experiences, had varying time to recover, and varying opportunity to reflect on their therapeutic experiences.

Given the small numbers in Phase 2 of the study, it was impossible to control for medication and previous interventions completed. However, it must be noted that most participants stated that previous and allied interventions were unhelpful, which may be argued to reduce the possible contributing role of other interventions apart from DBT. The passage of time and spontaneous recovery may also have been a factor that cannot be ruled out in some cases.

Although in Phase 2, case studies served as their own baseline. Limitations in ethical and safe sampling prior to the commencement of comprehensive DBT reduced the possible number of baseline measurements that could have occurred.

#### **7.4.3 ABSENCE OF A CONTROL GROUP**

The absence of a control group limits conclusions about how much improvement reported can be attributed to the DBT programme itself. A suitable control group could have consisted of individuals wait-listed for DBT, but who were not offered treatment. Any delay in the provision of treatment due to research control measurement may have unduly heightened distress and considerably increased potential for self-harm or completed suicide. For ethical reasons, this was clearly not an option. Although much evidence in this study indicates the contributory role of DBT in a range of improvements, it cannot be argued that these improvements could

not be achieved through alternative pharmacological or psychotherapeutic intervention or through spontaneous recovery.

#### **7.4.4 LEVEL OF ATTRITION AND NON-PARAMETRIC STATISTIC ANALYSIS**

The non-parametric statistical analysis administered in Phase 2 may not have been sensitive enough to detect changes between baseline and treatment time periods (Pallant, 2001). However, this limitation in inferential rigour was minimised through the supplementation of effect size (Cohen, 1992). Effect size is an important component of putting significance into an empirical context (McCartney & Rosenthal, 2003). Effect size must also be interpreted cautiously, in reference of methodological error, random error and bias (Loannidis, 2008), and its meaningfulness should be deciphered with reflection on the type of research, anticipated application of the findings obtained and the research history of the domain of inquiry (Fern & Monroe, 1996).

The high level of attrition and also contributing factors in the staff provision of the DBT in two sites limited the number of research participants who reached full term of comprehensive DBT and therefore reduced overall numbers for post-therapy statistical analysis. Wilcoxon analysis was limited to comparing pre-therapy measurement with mid-point, which did not reflect the change possible within the full year of DBT. The fact that this number was limited to eight participants denoted that the potential for finding statistically significant change was limited. However, since significance was reached in two outcome measures and approached in two outcome measures, a certain level of confidence in the current findings is indicated.

#### **7.4.5 LEVEL OF BIAS**

The level of bias in the study was minimised through the use of an independent researcher. However, in both Phases, research participants may have answered qualitative interview questions or outcome measurements more favourably, as they may have falsely believed that the researcher was involved in the implementation of the programme. Participants were reminded of the separation of their involvement in

the research and the DBT programme. However, it may have been a possibility that interviewees were hesitant to criticise and wanted to minimise the negative aspects of the programme, in order to come across as more favourable. In the interview schedule, an opportunity for interviewees to discuss negative components of DBT was given and it was found that they did describe the downside as well as positives of the programme.

The arrangement around informing the relevant individual therapist and consultant psychiatrist of their client's participation in the research and also whether an increased risk or distressed existed following a research assessment may have had slight impact on the results and impinged on the perception of 'independence' or 'working outside the system'. However, necessary and client consented communication between researcher and key workers was judged to be an ethical and safe decision to minimise possible distress resulting from research participation.

#### **7.4.6 UNKNOWN INFLUENCE OF NON-RESPONDENTS**

The level of participation in Phase 1 could have been even higher, particularly in the "DBT drop-out group". The contribution of the possible participants who refused to partake in the study may have been different than those who agreed to be interviewed and have changed the overall content analysis.

#### **7.4.7 UNKNOWN THERAPIST FACTOR**

Since the research occurred in three different sites and over an extended period of time, a range of different professionals were involved in the implementation of DBT. A therapist factor could be argued to have contributed to some of the overall changes and this could not be feasibly controlled or evaluated during the research. No measure of DBT fidelity took place in the current research. However, it would be expected that there would not have been a large difference in therapeutic approach, since all therapists were similarly trained by the same training facility and hence followed a standardised treatment protocol.

It must be noted that two out of the three teams recently ceased DBT training at the time of the research and none of the three teams received ongoing expert DBT supervision. It is difficult to gauge what effect if any both of these factors had on the overall findings and whether the DBT programme implemented in all three sites strictly adhered to the specified model. It is also unknown whether a discrepancy existed among how the teams and indeed individual members of the teams delivered DBT.

#### **7.4.8 RESEARCH ASSESSMENTS – AMOUNT OF AND SPECIFIC DIFFICULTIES WITH OUTCOME MEASURES, TIMING OF ASSESSMENTS AND THE INFLUENCE OF SELF REPORT**

A large number of questionnaires were administered in Phase 2 of the research. Research assessments were frequent, every two months, involving outcome measurement and in depth qualitative interview. Research assessment often took place on the same day as skills group training or individual therapy to facilitate attendance. The researcher is mindful that this was an exhausting and sometimes burdensome experience for the participants given the intensity and commitment requirement for their sustained involvement in comprehensive DBT.

In terms of specific administrative difficulties with the outcome measures, the BHS caused some confusion due its dichotomous “True/False” responses, while the KIMS was unanimously viewed as repetitive and overly long.

Apart from inpatient admissions, Phase 2 relies exclusively on self-report data. All outcome measurements were found to have suitable and appropriate psychometric value. The cautions of self-report data must be acknowledged. However, since there was considerable overlap between outcome measurement and qualitative data in Phase 2, it can be argued that self-report data in the outcome measures was strengthened by the contextual information provided by the qualitative report in each research assessment.

Numerous research assessments were rescheduled and postponed due to lack of client attendance, client crises or poor well-being. An attempt was made by the researcher to

be flexible and facilitate the research participant's attendance as much as possible. However, research participants may have been unwilling to attend a research assessment when they were feeling low or most suicidal, and hence this may have affected overall findings. It can be argued that given the client condition and frequent co-morbid difficulties flexibility in attendance of research commitments is needed and cannot be avoided.

#### **7.4.9 ABSENCE OF FOLLOW -UP**

As no follow-up measurements were carried out with the research participant in either phase of the study due to time restraints, it is unknown whether any of the reported changes have been maintained over the long-term. However, informal reports from individual therapists have suggested that for many of those who participated many of the gains have been extended to other areas of improvement.

#### **7.4.10 PREDOMINANCE OF FEMALE PARTICIPANTS**

Research is needed to assess the effectiveness of DBT with an outpatient adult male population. The present study's low number of male involvement reflected the typical demographic breakdown of DBT programmes across multiple settings. The BPD condition has been predominately diagnosed in females, so thus it was expected that research sample would reflect this skewed gender breakdown.

### **7.5 CLINICAL IMPLICATIONS OF THE STUDY**

The findings highlight six major clinical implications in relation to running of a DBT programme. Some of the below implications may fall into the category of being relevant for the therapy as a whole, or more specifically for the DBT practitioner or both.

### **7.5.1 ROLE OF CO-MORBIDITY – OBSTACLE OF ADDICTION**

The present findings emphasised the role of co-morbidity in attenuating potential gains for change in BPD through participation in the DBT programme. Although Major Depressive Disorder was particularly common and often incapacitating, Alcohol misuse/dependency appeared to be extremely problematic in successful attendance and commitment to the DBT programme. Difficulties controlling alcohol consumption were directly related to reduced attendance in all components of DBT, decreased overall functioning, and contributed to an amplified sense of hopelessness.

Substance abuse poses noteworthy difficulty for the effectiveness of DBT in BPD clients. In recent literature, there has been a movement towards recognition of and need for screening for co-morbid difficulties and multi-targeted services with staff trained in dealing with a range of impulse spectrum disorders. The present research has indicated that there is a need to reflect on how best clients with BPD and co-morbid alcohol misuse/dependency can be maintained within treatment. Linehan *et al* (2002) has suggested recently that DBT focusing more heavily on validation and supportive treatment may be helpful in maintaining BPD clients with substance use disorders. However, perhaps further alterations of DBT structure need to occur in order to provide the best possible services for a large number of clients with this challenging dual diagnosis. Further research is required to investigate how adapted or standard DBT could best minimise relapse prevention and maximise treatment benefits for this particular client group (Sacks, Chandler & Gonzales, 2008).

### **7.5.2 LEVEL OF DROP OUT FROM THE DBT PROGRAMME**

The area of attrition has been virtually overlooked in DBT research to date. The present research reported a 60% drop-out rate in Phase 2. Three out of these six research participants left the DBT programme due to significant difficulties with their alcohol dependency. One client discontinued as a result of poor motivation levels, whereas two clients left treatment to return to employment, which may be viewed as a positive outcome possibly related to DBT participation. Findings in Phase 1 indicated that the recurring reasons behind early termination of treatment included non-adherence and discomfort with BPD diagnosis, anxiety and frustration related to

group work, and additional co-morbid difficulties in particular alcohol misuse. The level of satisfaction among the “DBT drop-out” with their participation in DBT was reasonably high. The findings lead to a recommendation that therapeutic teams pay particular attention to the presence of the above issues, in order to tackle them early on in treatment, minimising the possibility of early termination through an escalation of the issue.

DBT teams need to understand what factors may lead to early discontinuation of treatment based on an extensive assessment period and take appropriate steps to prevent this from occurring. An important role for the DBT team exists to monitor early termination and decipher whether patterns exist related to insufficient initial assessment of not spending enough time on orientation and commitment. It could be the case that DBT teams and referring agents are overly eager to allow a client to begin the programme. There may also be a difference in the presentation of and context behind late and early DBT termination. Further research is needed to illuminate the array of early discontinuation in DBT, in order to establish early intervention protocols around preventing or minimising drop-outs.

A client “buddy” system could be set up to supplement the established DBT programme, whereby previous clients who have completed the DBT programme successfully encourage current DBT participants to stay in the programme, empathise with their current difficulties and reason with them that benefits can occur through continued participation. The current contract states that if a client misses four consecutive sessions, she is out of treatment until her contract elapses. It may be worthwhile to shorten this discontinuation penalty to six months, so that everything can be done to re-commit and re-orient willing and motivated clients to reengage with programme without unnecessary delay. Contracts should also be shortened to six months in length, so that successful attendance is more quickly awarded and the contract can be renegotiated based on up-to-date information. More open discussion within the skills group and individual therapy about thoughts and feelings of dropping out should be incorporated, so that ideation can be infiltrated and addressed as swiftly as possible.

It is surprising that research has not paid more attention to the factors behind early discontinuation of the DBT programme, given the immense level of costs involved, distress, anxiety and frustration caused to the client, individual therapist and to the skills group.

### **7.5.3 TELEPHONE USAGE**

In these findings, the level of usage of telephone coaching has been mediocre, given the usefulness and benefits of this facility. It is clear that telephone coaching has not been used to its fullest potential. For those who did avail of this component, many important benefits were reported. Individual therapists should strive that clients quickly manage all suicidal and self-harm urges with distress tolerance or mindfulness skills, and in all situations that clients have difficulty applying such skills, a telephone contact is made to the individual therapist. This is not an easy task, as many of the interviewees have demonstrated distinct resistance to making contact, especially when suicidal. Reminder texts to phone and check-up phone calls made by the individual therapist need to occur. Support from the team consultation should be available to quell feelings of being overwhelmed in individual therapists, especially in cases of therapist ambivalence in delivering the facility. Some teams operate a roster between DBT team members, so each team member takes a turn being on call for telephone coaching, thereby reducing the burden of out-of-hours contact.

Interviewees have complained that the format of the telephone contact is skills-focused. It should be debated whether the telephone contact should remain focused on coaching skills, rather than evolve into more validation style contact. BPD is clearly understood as a condition of skills deficit (Linehan, 1993 a), so therefore it is essential that each contact should reiterate the need for use of specific skills by clients to manage immediate difficulties. It is tempting for clients to vent and talk around their problems without taking ownership of them and looking for means of tackling them. This direct, focused and time-limited facility may not suit everyone, however, given enough prompting to use appropriately clients may learn to make contact at the opportune moments. An opportunity following telephone contact to reflect on the usefulness and encourage client input within the individual sessions, in order that any perceived gaps in validation are quickly filled. The level of contact tends to wane over

the therapeutic year, which is indicative of clients becoming more au fait and comfortable with skills application in times of distress.

#### **7.5.4 SKILLS GROUP**

Two main clinical implications arose from the qualitative report about the skills group. Interviewees reflected that it is a difficult experience beginning the skills group, when there are established members, in which relationships and group identity are already in place. It is a significant decision for a service to decide whether to provide closed or open group DBT. Closed group format would continue with the same clients for a full year, without taking on any new clients at the end of skills group components. If there were not a high level of attrition, this would appear to be the preferred choice. However, a closed group format would limit opportunities to adapt to changing situations, more closely matching real life. Acute attention to group cohesion and facilitation of friendship building within the skills group should be an element of the group protocol. The impact of new members and group cohesion should be openly discussed at appropriate moments within the skills group and individual sessions, in order to encourage increased insight into emotional responses to fellow group members.

Rules around disclosure of self-harm and suicidal ideation were frequently brought up as an issue. Many interviewees found this restriction difficult. It is clear that despite understanding the rationale behind this boundary, it is still challenging for some interviewees not to openly talk about their self-destructive behaviour. Discussion of diary cards within the skills group can become artificial and stilted. Perhaps naming the self-destructive behaviour, within a group that has established confidentiality, and allowing some proactive discussion around skill usage would allow open admission of difficulties with skills and suicidal thoughts. Linehan (1993 a) advocated a therapeutic style for DBT that does not treat clients as fragile. However, this rule around disclosure of self-harm is primarily in place to protect from clients having extreme emotional reactions to the discussion of self-harm by other group members and to minimise possible reinforcement of self destructive behaviour. In the second six months of DBT skills training, perhaps a more open discussion of experiences could take place with a clear focus on group members stimulating their own and joint

solutions and being able to deal with the emotional response such discussion instigates.

### **7.5.5 DIARY CARDS**

Diary cards, although occasionally referenced as a source of positive feedback, were frequently viewed in a negative light. Interviewees proposed a number of issues about the diary cards. Diary cards were seen as a constant reminder of their difficulties. This is a valid point and clients with BPD tend to avoid situations that will expose them to emotionally escalating stimuli. However, diary cards are useful for monitoring both skills and self-destructive behaviour, so clients can be reminded of the skills that will help manage their difficulties.

Diary cards within the skills group and individual therapy have been named as double-jointed. The time devoted to filling diary cards in and the limited time allocated to them within the skills group have not been in balance. It could be suggested that diary cards should only be adopted within the individual therapy and specific home skills assignments be used instead in the skills group. Since there is a restriction on the open discussion of self-destructive behaviour within the skills group anyway, diary card material is not fully maximised within this context and takes up time that could be allotted to skill practice.

### **7.5.6 STAFF TRAINING OF BPD FROM A DBT PERSPECTIVE**

The high prevalence of poor treatment by certain mental health professionals in this client group prior to commencement in DBT is alarming. A range of qualitative reports from all groups testified that they had experienced apathetic, negative, condescending, judgemental and narrow-minded attitudes. Clients have been frequently stigmatised, ignored and misunderstood. Staff training in understanding BPD symptoms, basic DBT skills, and appropriate responding should be compulsory, so that best practice can occur in the treatment of clients diagnosed with BPD (Miller & Davenport, 1996; Krawitz, 2001 & Krawitz, 2004). All staff coming in contact with clients with BPD (nurses, doctors, psychotherapists, A&E staff, and psychologists) should be knowledgeable about the condition and strategies to respond to typical

behaviours. If this is not possible, perhaps certain key staff could be offered ongoing training, which they themselves could disseminate in team meetings with their own colleagues.

## **7.6 RECOMMENDATIONS**

### **7.6.1 FUTURE RESEARCH**

The first set of recommendations pertain to direction future research should take. Four recommendations for future research have been suggested.

#### **7.6.1.1 IMPORTANCE OF DISMANTLING RESEARCH**

Dismantling research is a clear recommendation based on the findings of this study, in order to build upon the findings from the present research. DBT effectiveness has been reported with an expanding number of client groups and in a range of modified structures and settings. However, much more research needs to concentrate on outlining both the stages of change in BPD (Soler *et al*, 2008), clarifying the mechanisms of change (Clarkin & Levy, 2006; Lynch, Chapman, Rosenthal & Linehan, 2006) and the isolation of the “active ingredients” in DBT. Hence, more needs to be known about how the therapy works, rather than demonstrating its outcome. Multi-level research that compares the different effectiveness of isolated components of DBT in matched samples should take place. Understanding of the process of change in DBT participants should be a priority.

#### **7.6.1.2 INVESTIGATION OF THE CLIENT VARIABLES INVOLVED IN DBT EFFECTIVENESS**

As outlined by the ‘active ingredients’ theory in this study, client variables may play a significant and underreported role in DBT effectiveness. Research should assess the impact of client motivation, client commitment, client intellectual ability and client readiness for change on mediating level of success in the DBT programme. A multi-level investigation could compare at baseline whether for example clients assessed through outcome measurement as “particularly ready for change” do in fact produce

better outcomes than those clients who are considered “not ready/almost ready for change”. Understanding client factors in producing change in DBT could increase potential for better outcomes and higher client satisfaction.

The role of intellectual functioning and level of insight may be worth further investigation as well. Many clients may find certain skills incomprehensible or too abstract due to their level of intellectual functioning. Perhaps certain DBT skills could be simplified or modified for individuals who have specific cognitive impairments or learning difficulties. Research needs to clarify whether modified DBT can be applied for clients diagnosed with BPD and intellectual disability or other cognitive challenges.

### **7.6.1.3 FURTHER QUALITATIVE INVESTIGATION – FAMILY & STAFF INVOLVEMENT**

The impact of DBT should be investigated by interviewing family members (who are not estranged or disconnected) to gauge how participation in DBT has changed the family member and what impact this has had on the family functioning and interrelationships. One study looked at the impact of families dealing with a family member diagnosed with BPD (Buteau, Dawkins & Hoffman, 2008). This study described the stigmatising health care system, prolonged hopelessness, shrinking social networks, financial burdens, and difficulty accessing current evidence-based knowledge of and treatment options for BPD.

Staff involved in the DBT programme should be interviewed to further assess theories around “active ingredients” and gain greater understanding of DBT through reports from those who deliver the programme. Case series investigation could include commentary from and outcome measurement completed by the individual therapist at each assessment point, in order to provide best understanding of change occurring for a client.

#### **7.6.1.4 FOCUS ON LONG-TERM EFFECTS OF DBT**

Research has only begun to investigate the medium to long-term effects of DBT and assess whether gains made throughout treatment are maintained in one-year follow-up (Linehan *et al*, 2006). Research should build on this and decipher whether therapeutic gains, decreased use of services and skill usage are sustained by five-ten year follow up periods. Research to date has not investigated the impact of later stage DBT (Stages 2-4) on dealing with emotional trauma from the past and unravelling the pursuit of “a capacity for a sustained joy”. Hence the focus of research would move towards measures of well being, rather than primarily of risk or functioning.

Research should also investigate the impact of a “refresher course” for DBT and whether such a follow up intervention would be useful in stabilising behaviours, reengaging with the skills, and strengthening therapeutic gains.

#### **7.6.2 IMPLICATIONS FOR SERVICE DEVELOPMENT AND DELIVERY**

The second set of recommendations is related to service development and delivery. Three propositions are described.

##### **7.6.2.1 A RESOURCE HEAVY THERAPY – COST EFFECTIVENESS EVALUATION NEEDED**

DBT is a particularly resource heavy therapy in terms of high level of staff time, intensity of work involved and cost of running the programme. It was reported that two out of the three sites providing DBT were no longer doing so at the end of the DBT research, due to limitations in funding provided and staff drift. In one particular site, the team began steadily to fall apart due to reducing team members, as those who had been trained in DBT by the service left the service to work elsewhere. Eventually it became unfeasible and impractical to keep running comprehensive DBT with a limited staff involvement. More research needs to take place to determine the cost effectiveness of providing the DBT programme against treatment as usual for clients diagnosed with BPD in the service. In the present study, length and frequency of psychiatric admissions typically decreased between prior to DBT commencement to

during DBT. However, it cannot be concluded that service expenditure was reduced, as this decrease in admissions was not balanced with the costs of running the programme.

#### **7.6.2.2 POSSIBLE STRATEGIES FOR MAINTAINING SERVICE DELIVERY**

A number of possible strategies for maintaining DBT delivery can be suggested, including linking services, provision of adapted or modified DBT, and contracting staff members. The present research has touched on the challenges of continued delivery of DBT, especially when isolated small services attempt to provide a service with limited staff resources and training opportunities. It could be possible for these smaller services within one particular region to link up and integrate the provision of their service within a central location and work together to maintain a service to a larger catchment area, as indicated in the Vision for Change (2006) Mental Health policy document. Another alternative might be the establishment of an outpatient and inpatient service specialised for clients diagnosed with BPD (and co-morbid conditions) with a large regional/national catchment area with staff exclusively employed and specifically trained to work with individuals with BPD.

An adapted or modified DBT could be an option for services that have only begun to provide DBT. A provisional and trial period of providing some of the components of DBT could be measured in terms of outcome and further expansion to run comprehensive standard DBT could be justified based on the findings of this trial period. It is better that limited well-run service be provided for individuals with BPD rather than an overstretched ineffective service. A new DBT team should take considerable time to reflect on the level of resources and funding possible within a certain time-frame before rushing into beginning running a DBT programme.

A substantial obstacle to continued provision of a DBT programme is the movement of staff from one service to another service. Staff should be requested to contract time (e.g. minimum two years) that they will provide their expertise and time to running a DBT programme. Funding for training for a staff member should not be endorsed if such a guarantee has not been agreed.

### **7.6.2.3 INVOLVEMENT OF SERVICE USERS IN THE PROVISION OF AND EVALUATION OF DBT**

The present research has demonstrated the benefits of involving and consulting service users in evaluating DBT. It increases staff understanding and awareness, client ownership and also allows for modifications of the programme to increase effectiveness and client satisfaction. Consultation of service users in the evaluation of an intervention should be universal, compulsory and time-framed.

Involvement of service users, who have graduated from DBT and made considerable improvements, in the provision of the DBT programme, could also be a worthy possibility. A “DBT graduate group” could be called upon to meet potential new clients in an ‘Open Day’ and help to increase commitment and motivation. Interested “DBT graduates” could also work as co-facilitators in the skills group.

## **7.7 CONCLUSIONS**

### **7.7.1 CLIENTS DO BENEFIT FROM DBT**

The research has indicated that clients do benefit from their participation in the DBT programme. In Phase 1, interviewees were overall very positive about their time in the DBT programme and attributed numerous changes in well-being, functioning and risk to their participation in treatment. Hence, according to multiple qualitative reports, DBT had a tremendous and positive impact on service users’ lives. In Phase 2, statistical significant change was demonstrated in the level of hopelessness and borderline symptoms between baseline and just six months into the DBT programme. Many case studies continued to show further improvements beyond six months. Outcome measurement and qualitative report both indicated noteworthy changes over the therapeutic year for numerous case studies.

### **7.7.2 DBT IS NOT SUITABLE FOR EVERYONE**

The present study proposed that when BPD and co-morbid difficulties (e.g. alcohol misuse/dependency) are present, DBT is slower to produce positive changes and there is a higher likelihood of early termination. Alcohol misuse/dependency was common in the sample and caused challenges for successful treatment. There was a high drop-out rate in Phase 2 and this was heavily related to alcohol misuse/dependency. Phase 1 reported that early termination was also linked to such co-morbid difficulties, anxiety and frustration with the skills group, and non-adherence and non-acceptance of the BPD diagnosis. The level of satisfaction with DBT in the “DBT drop-out” group was moderately high.

Other client variables, such as readiness for change, motivation, ability and commitment, should be evaluated at baseline and during treatment, in order that insufficient levels of certain client factors (e.g. readiness for change) can be tackled and it can be deciphered whether DBT is suitable for such a potential client.

### **7.7.3 “ACTIVE INGREDIENTS” IN DBT**

The research suggested that DBT effectiveness is the subject of four elements – 1) client variables 2) therapeutic alliance and related components 3) telephone coaching 4) skills group and skills. It was proposed that each of these four elements is active, interacts and relies on the other elements in order to produce change.

### **7.7.4 DBT IS WORTH CONTINUING AND FUNDING**

The research indicated that DBT is certainly worth continuing and funding should still be allocated to its delivery and further research. DBT can produce dramatic changes to a person’s life. The research participants mentioned high dissatisfaction with numerous previous interventions, especially drug and psychiatric treatment. DBT is no doubt a worthwhile, productive, appropriate, needed and appreciated intervention for clients diagnosed with BPD.

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# APPENDICES

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## **APPENDIX A: SEMI-STRUCTURED QUESTIONNAIRE FOR “DBT COMPLETER GROUP”**

### ***Background***

*OPEN Q: HOW HAVE YOUR DIFFICULTIES IMPACTED ON YOUR LIFE?*

When did you first know something was different?

What problems were you experiencing?

What have been the major difficulties you have been confronted with in getting on with life?

How did you try to overcome these difficulties?

*OPEN Q: WHAT HAS YOUR EXPERIENCE OF THE MENTAL HEALTH SYSTEM BEEN LIKE?*

Was it easy to find professional help? How did you go about doing this?

What were you told about your difficulties? How did you react?

What were you first diagnosed as having? How did you feel about that?

When were you first diagnosed?

Have there been negatives and positives of being diagnosed?

What treatment was first proposed? How did you feel about that? What was your reaction?

Were you placed on medications? Did they work? Did they make a difference?

Side-effects?

*OPEN Q: DESCRIBE THE IMPACT OF THE LABEL BPD/YOUR DIFFICULTIES ON YOUR INTERACTIONS WITH MHP'S?*

Has it been difficult with the label BPD/with your difficulties dealing with MHP's?

Have you found much difference in attitudes of various mental health professionals?

Are certain people more understanding or sympathetic? Why is that?

What have been the reactions to your difficulties by MHP's?

*OPEN Q: WHAT DO YOU KNOW ABOUT DBT?*

When did you first find out about DBT?

How was it described to you?

Who referred you for DBT?

How was DBT explained to you?

How did you feel about it?

### ***Symptoms & change***

*OPEN Q: TELL ME ABOUT YOUR PARTICIPATION IN DBT?*

*OPEN Q: DID YOU NOTICE ANY CHANGES DURING THAT PERIOD AND BEYOND?*

- In how you feel about yourself? Do you like yourself? Has your attitude to your self changed?
- In how you get on with others? Is it easier, more difficult or no change in how you get on with family? How easy has it been to keep friends? Have your friendships altered? Become closer? Less stressful? More satisfying? In what ways have your interactions with close ones changed, if at all?
- In how you deal with problems? Have you become more proficient in dealing with challenges in life or no change at all? E.g. Work? Has your approach to these problems changed? Do you believe your behaviour/thinking has altered? When did this occur?

- In your parasuicidal behaviour? Are the thoughts to take your life as frequent as before? Are the actions to take your life as intense? Have you developed strategies to combat thoughts? What are they? What is most helpful?
- In how others view/treat you? Are people easier or more difficult to get on with or have you noticed any change? Why is that? What has changed about the situation?
- In getting work/study done? Has it become easier to achieve goals? Are these situations as stressful as before? Have your feelings/thoughts about work/study changed? How?

To what would you attribute these changes to? What part(s) of therapy has specifically helped you? What factors have contributed to these changes?

### ***DBT Components***

It sounds as if DBT has resulted in some/large/little change.

*OPEN Q: CAN YOU TELL ABOUT THE COMPONENTS OF THERAPY YOU HAVE PARTICIPATED IN, AND HOW YOU FIND EACH ONE?*

What changes occurred relatively quickly/slowly?

What elements of therapy had the biggest/least impact?

What part of therapy did you find most/least challenging to take on board?

What part of therapy did you find least useful?

What part of therapy did you enjoy the most?

Which part did you find most frustrating?

*OPEN Q: HOW DID YOU FIND PARTICIPATING IN THE GROUP?*

What did you feel about the group skills weekly meeting?

Did you find it helpful? How? Thoughts about it? What was the most frustrating thing/difficult thing about it? What would you change or improve on? Did you find it easy to attend? Did it take some getting used to, being around people with similar difficulties? Were they supportive?

What do you feel about the structure? The elements of group skills, homework, new learning and the break?

*OPEN Q: HOW DID YOU FIND THE INDIVIDUAL THERAPY COMPONENT?*

What did you feel about the individual therapy sessions?

Did you find it helpful? How? Thoughts about it? What was the most frustrating thing/difficult thing about it? What would you change or improve on? How did you find the structure? How quick/slow was progress? When did you first notice a difference? What was it? Tell me more.

Anything you would alter about it?

*OPEN Q: WHAT DID YOU THINK OF HAVING TELEPHONE ACCESS TO YOUR THERAPIST?*

What did you feel about telephone consultation with your therapist? Did you use this facility? How often? When did you use it? What effect did it have on you? Did it stop you self-injuring? Thoughts about it? Was it open or restricted at times? Anything you would change about it?

*OPEN Q: ARE YOU GLAD YOU PARTICIPATED IN THE DBT PROGRAMME SO FAR?*

## **APPENDIX B: SEMI-STRUCTURED QUESTIONNAIRE FOR “DBT DROP-OUT GROUP”**

*This questionnaire/interview is designed to explore the reasons for which treatment was discontinued by clients who ended contact with the DBT programme.*

You completed X months of DBT, tell me about the circumstances or reasons surrounding your discontinuation of treatment?

How did you feel when treatment was ended?

Were you satisfied with treatment? Any parts in particular?

What elements of treatment if any were you unhappy with? Tell me about it.

Did you find many parts of therapy difficult? What parts?

How did you manage since leaving? Have you been involved in any treatments since you left?

Are there many alternative treatment options out there, what ones have you come across? How did they work/how is it working?

## **APPENDIX C: QUALITATIVE INTERVIEWS GIVEN TO CURRENT CLIENTS**

### **A semi structured interviews will cover the following areas**

Socio-demographic information about age, gender, income source, medical history, educational level, socio-economic status, length of contact with mental health services and social and interpersonal relationships and supports.

The layout of the questions over the interview period will loosely follow this order:

- 1) Interpretation and impact of diagnosis\*\*
- 2) Expectations of DBT treatment\*\*
- 3) Positive and negative views of DBT\*
- 4) What is hard and easy about DBT treatment\*
- 5) What they like/dislike about DBT treatment\*
- 6) The affect of the different components of DBT\*
- 7) Symptoms or other changes attributable to DBT (if any)\*

\*\* - Asked at baseline interview at start of attendance at skills group.

\* - Asked at subsequent interviews every two months following end of a skills group module

## **APPENDIX D: INFORMATION SHEETS/CONSENT FORMS**

### **Information Sheet (a) (For those about to start in DBT)**

#### **Title of study**

An Evaluation of the Client, Staff and Economic Impact of Dialectical Behaviour Therapy in an Irish Mental Health Setting.

#### **What is the study about?**

The focus of the study is about exploring the impact that DBT has had on several levels since it was introduced to St Vincent's Hospital. The study will involve interviewing a number of clients who have completed DBT, or who started but did not complete DBT, or who are just about to start in DBT, as well as a number of staff who have worked in St Vincent's Hospital Services before and after the introduction of DBT

#### **Who is doing the study?**

Maeve Kenny, Principal Clinical Psychologist and member of the DBT team, St Vincent's Hospital, Fairview and Austin Bayley, Post-graduate Researcher, School of Nursing, DCU are doing the study on behalf of the DBT team.

#### **What will your participation involve?**

If you agreeable to participate, you will be asked to participate in a number of interviews and to complete some questionnaires. The questionnaires will ask about your symptoms, quality of life and your use of health services. The interviews will consist of me asking you some questions about your positive and negative experiences of the mental health services, DBT and your expectations about treatment. There are no right or wrong answers. My goal is to hear your opinions and experiences.

If you have been an inpatient in a psychiatric hospital during the two years prior to the DBT programme or during and up to two years after the DBT programme, I will ask for your written consent for the Medical Records Department in the relevant hospital to give me information about the number of admissions you had and the length of those admissions.

#### **How often and how long will you be interviewed for?**

You will be asked to come along on three occasions before you start in DBT, on six occasions during your DBT treatment and on four occasions after you have completed your DBT treatment. Three of the interviews will last about 60 minutes and the others will last about 30 minutes. The interviews will be tape recorded, as it would not be possible for me to remember or write all your contributions during the interview.

#### **What will happen to the information once collected?**

Once the interview is over, the information will transcribed onto paper so I can read it and begin the process of looking at the information for common meanings between participants. The tape recordings, transcripts and questionnaires will be stored in a locked press. Any information transferred to computer will be password protected. The only people who will have access to these materials are myself and my two supervisors (one from college and one who is also a member of the DBT team), who have assured me confidentiality. Your name will not appear on any materials, instead you will be given an ID number. Myself and my clinical supervisor are the only ones who will know who this ID number indicates and we will not divulge this information. All research information will be destroyed after the research has been completed and written up.

**Are there any consequences if I choose to be a part of the study or I want to opt out during the study?**

There is no obligation on you to participate in this study. If you choose to participate you are free to withdraw at any time. I will give you my contact details so that you can let me know at any time if you choose to opt out of the study. If you chose not to participate this will in no way affect you receiving therapy in this service.

**Will people know that I took part in the study?**

The DBT team will let me know when they are going to assess someone for DBT and that is how I will first contact you. Participation in the study will not cause harm, however, if you agree to participate I will inform the DBT team and your treatment team that you are participating in the research. This is to help monitor that the research is not too much of a burden for you and in case you need some extra support during the time of the research. While every effort will be made to maintain anonymity, since numbers participating in the research are likely to be small, this cannot be guaranteed.

**Will everything I say be treated in confidence?**

Most things you tell me will be treated confidentially. However, if during the interviews you tell me something that gives me cause for concern, then I am obligated to pass on this information, for example if I am concerned about the risk of harm to you or others. In this instance while I will tell you what I intend, I must highlight that I do not require your consent to pass on such information. This is an obligation of everyone who works in the Health Service.

**Is the study being funded?**

The study is being partially funded by St Vincent's Hospital and I am undertaking part of this study to obtain a postgraduate degree.

**Is the study approved?**

The study has received ethics approval from the Ethics Committee, St Vincent's Hospital.

**How can you contact me?**

You can contact me at any time for further information about the research or if you no longer choose to participate. My phone number is 8842404 and my email address is [austinbayley@svhf.ie](mailto:austinbayley@svhf.ie). Should you have any worries about this research, please feel free to contact Maeve Kenny, Principal Clinical Psychologist, St. Vincent's Hospital, Fairview, Dublin 3 by phoning 01) 884 2475 or by email at [maevekenny@svhf.ie](mailto:maevekenny@svhf.ie). Alternatively any concerns about the conduct of this research project can be directed to the Secretary, Research Ethics Committee, Office of the Vice-President for Research, Dublin City University, ph: 01-7008000; fax 01-7008002

Thank you for taking the time to read this leaflet and to consider taking part in this research study.

**Information Sheet (b)**  
**(Those who have dropped out of DBT)**

**Title of study**

An Evaluation of the Client, Staff and Economic Impact of Dialectical Behaviour Therapy in an Irish Mental Health Setting.

**What is the study about?**

The focus of the study is about exploring the impact that DBT has had on several levels since it was introduced to St Vincent's Hospital. The study will involve interviewing a number of clients who have completed DBT, or who started but did not complete DBT, or who are just about to start in DBT, as well as a number of staff who have worked in St Vincent's Hospital Services before and after the introduction of DBT.

**Who is doing the study?**

Maeve Kenny, Principal Clinical Psychologist and member of the DBT team, St Vincent's Hospital, Fairview and Austin Bayley, Post-graduate Researcher, School of Nursing, DCU are doing the study on behalf of the DBT team.

**What will your participation involve?**

If you are agreeable to be a participant, I will arrange to meet you. If it is not possible to meet you in person I can talk to you by phone. I will ask you some questions about your positive and negative experiences of DBT and your expectations about DBT treatment. There are no right or wrong answers. My goal is to hear your opinions and experiences.

**How often and how long will you be interviewed for?**

You will be asked to participate in an interview lasting about 60 minutes. The interview will be tape recorded, as it would not be possible for me to remember or write all your contributions during the interview.

**What will happen to the information once collected?**

Once the interview is over, the information will transcribed onto paper so I can read it and begin the process of looking at the information for common meanings between participants. The tape recordings, transcripts and questionnaires will be stored in a locked press. Any information transferred to computer will be password protected. The only people who will have access to these materials are myself and my two supervisors (one from college and one who is also a member of the DBT team), who have assured me confidentiality. Your name will not appear on any materials, instead you will be given an ID number. Myself and my clinical supervisor are the only ones who will know who this ID number indicates and we will not divulge this information. All research information will be destroyed after the research has been completed and written up.

**Are there any consequences if I choose to be a part of the study or I want to opt out during the study?**

There is no obligation on you to participate in this study. If you choose to participate you are free to withdraw at any time. I will give you my contact details so that you can let me know at any time if you choose to opt out of the study.

**Will people know that I took part in the study?**

The DBT team will let me know the names of people who have not completed DBT. However, they will not know whether or not you choose to participate. Participation in the study will not cause harm, however, if you agree to participate I will inform your treatment team or G.P. that you are participating in the research. This is to help monitor that the research is not too much of

a burden for you and in case you need some extra support during the time of the research. While every effort will be made to maintain anonymity, since numbers participating in the research are likely to be small, this cannot be guaranteed.

**Will everything I say be treated in confidence?**

Most things you tell me will be treated confidentially. However, if during the interview you tell me something that gives me cause for concern, then I am obligated to pass on this information, for example if I am concerned about the risk of harm to you or others. In this instance while I will tell you what I intend, I must highlight that I do not require your consent to pass on such information. This is an obligation of everyone who works in the Health Service.

**Is the study being funded?**

The study is being partially funded by St Vincent's Hospital and I am undertaking part of this study to obtain a postgraduate degree.

**Is the study approved?**

The study has received ethics approval from the Ethics Committee, St Vincent's Hospital.

**How can you contact me?**

You can contact me at any time for further information about the research or if you no longer choose to participate. My phone number is 8842404 and my email address is [austinbayley@svhf.ie](mailto:austinbayley@svhf.ie). Should you have any worries about the research, please feel free to contact Maeve Kenny, Principal Clinical Psychologist, St. Vincent's Hospital, Fairview, Dublin 3 by phoning 01) 884 2475 or by email at [maevekenny@svhf.ie](mailto:maevekenny@svhf.ie). Alternatively any concerns about the conduct of this research project can also be directed to the Secretary, Research Ethics Committee, Office of the Vice-President for Research, Dublin City University, ph: 01-7008000; fax 01-7008002

**Thank you for taking the time to read this leaflet and to consider taking part in this research study.**

Austin Bayley,  
Post-graduate Researcher.

**Information Sheet (c)**  
**(For those who have completed DBT – user involvement group)**

**Title of study**

An Evaluation of the Client, Staff and Economic Impact of Dialectical Behaviour Therapy in an Irish Mental Health Setting.

**What is the study about?**

The focus of the study is about exploring the impact that DBT has had on several levels since it was introduced to St Vincent's Hospital. The study will involve interviewing a number of clients who have completed DBT, or who started but did not complete DBT, or who are just about to start in DBT, as well as a number of staff who have worked in St Vincent's Hospital Services before and after the introduction of DBT.

**Who is doing the study?**

Maeve Kenny, Principal Clinical Psychologist and member of the DBT team, St Vincent's Hospital, Fairview and Austin Bayley, Post-graduate Researcher, School of Nursing, DCU are doing the study on behalf of the DBT team.

**What will your participation involve?**

If you are agreeable to be a participant, you will be asked to participate in an interview and to complete some questionnaires. The questionnaires will ask about your symptoms, quality of life and your use of health services. The purpose of this is to test that the questionnaires are easy to understand and use. The interviews will consist of me asking you some questions about your positive and negative experiences of the mental health services, DBT and your expectations about treatment. There are no right or wrong answers. My goal is to hear your opinions and experiences. The purpose of the interviews is to help me generate relevant and detailed questions to ask a group of participants who are about to commence DBT.

**How often and how long will you be interviewed for?**

You will be asked to come along on one occasion. The interview will last about 60 minutes. The interviews will be tape recorded, as it would not be possible for me to remember or write all your contributions during the interview.

**What will happen to the information once collected?**

Once the interview is over, the information will be transcribed onto paper so I can read it and begin the process of looking at the information for common meanings between participants. The tape recordings, transcripts and questionnaires will be stored in a locked press. Any information transferred to computer will be password protected. The only people who will have access to these materials are myself and my two supervisors (one from college and one who is also a member of the DBT team), who have assured me confidentiality. Your name will not appear on any materials, instead you will be given an ID number. Myself and my clinical supervisor are the only ones who will know who this ID number indicates and we will not divulge this information. The questionnaires will be destroyed once the pilot phase is complete. The interview material will be destroyed after the research has been completed and written up.

**Are there any consequences if I choose to be a part of the study or I want to opt out during the study?**

There is no obligation on you to participate in this study. If you choose to participate you are free to withdraw at any time. I will give you my contact details so that you can let me know at any time if you choose to opt out of the study. Participation in the study will not cause harm

**Will people know that I took part in the study?**

The DBT team will inform me about people who have completed the DBT programme. Participation in the study will not cause harm, however, if you agree to participate I will inform the DBT team and your treatment team that you are participating in the research. This is to help monitor that the research is not too much of a burden for you and in case you need some extra support during the time of the research. While every effort will be made to maintain anonymity, since numbers participating in the research are likely to be small, this cannot be guaranteed.

**Will everything I say be treated in confidence?**

Most things you tell me will be treated confidentially. However, if during the interview you tell me something that gives me cause for concern, then I am obligated to pass on this information, for example if I am concerned about the risk of harm to you or others. In this instance while I will tell you what I intend, I must highlight that I do not require your consent to pass on such information. This is an obligation of everyone who works in the Health Service.

**Is the study being funded?**

The study is being partially funded by St Vincent's Hospital and I am undertaking part of this study to obtain a postgraduate degree.

**Is the study approved?**

The study has received ethics approval from the Ethics Committee, St Vincent's Hospital.

**How can you contact me?**

You can contact me at any time for further information about the research or if you no longer choose to participate. My phone number is 8842404 and my email address is [austinbayley@svhf.ie](mailto:austinbayley@svhf.ie). Should you have any worries about this research, please feel free to contact Maeve Kenny, Principal Clinical Psychologist, St. Vincent's Hospital, Fairview, Dublin 3 by phoning 01) 884 2475 or by email at [maevekenny@svhf.ie](mailto:maevekenny@svhf.ie). Alternatively any concerns about the conduct of this research project can be directed to the Secretary, Research Ethics Committee, Office of the Vice-President for Research, Dublin City University, ph: 01-7008000; fax 01-7008002

**Thank you for taking the time to read this leaflet and to consider taking part in this research study.**

---

Austin Bayley,  
Post-graduate Researcher.

## Consent Form

Title of the study: **An Evaluation of the Client, Staff and economic impact of Dialectical Behaviour Therapy in an Irish Mental Health Setting.**

Researchers: Maeve Kenny, Principal Clinical Psychologist, St Vincent's Hospital Fairview and Austin Bayley, Post-graduate Researcher, DCU.

Do you understand that you have been asked to participate in a research study?      Yes No

Have you received and read a copy of the Information Sheet?      Yes No

Do you understand the benefits and risks involved in taking part in this study?      Yes No

Would you like further opportunity to ask questions and discuss the study?      Yes No

Do you understand that you are free to refuse to participate or withdraw from the study at any time and that you do not have to give a reason      Yes No

Has the issue of confidentiality and anonymity been explained to you adequately?      Yes No

This study was explained to me by \_\_\_\_\_

I agree to take part in this study

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

\_\_\_\_\_  
Researcher's name (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## APPENDIX E: LETTER TO TREATING TEAM

Date

Name of Consultant/G.P,  
Address 1  
Address 2  
Address 3.

Re: Client Name, Address 1, Address 2, Address3 DOB: xx/xx/xxxx.

Dear Dr. XXXXXX,

I am writing to inform you that above client has kindly agreed to take part in a research study investigating the impact of DBT. This client will be part of the XXXX group who will be seen on XX occasions for the research study. I have enclosed an Information Sheet on the research for you information.

As this research will ask clients about their quality of life and about positive and negative experiences of health services in general and DBT in particular, there may be occasions when clients become upset or distressed. If the client still attends DBT I have an arrangement with the DBT therapists that the client will be seen. In the event that the client no longer attends the DBT programme a therapist will see the client and will follow-up with you as appropriate. The DBT team are also aware that this client is participating in this research. In the event that the client discloses information about risk of harm to him/herself I will contact you directly. If it becomes apparent in the course of your usual contact with the client that the research is becoming unduly burdensome, please let me know.

This research study is being run through the Psychology Department at St. Vincent's Hospital, under the supervision of Maeve Kenny, Principal Clinical Psychologist and part of it will form the basis of a post-graduate research degree in conjunction with Dublin City University.

Please do not hesitate to contact either myself or Maeve Kenny (8842475) if you have further questions or other issues you would like clarified.

Yours sincerely,

---

Austin Bayley, Post-graduate Researcher, Tel: 884 2404.

**APPENDIX F: EXAMPLE OF CONTENT ANALYSIS PROCESS –  
A TRANSCRIPT OF INTERVIEW WITH PARTICIPANT**

Could you explain how your previous difficulties impacted upon your life?  
Getting from that point to being referred for DBT?

LIFE CRISIS –  
LEADING TO  
SEVERAL OTHER  
PROBLEMS AND  
CONTACT WITH  
MHS

How many words! Alright ok, I suppose my problems started in 1995, when I qualified as an accountant and got this huge promotion for quite a well known company. My new boss, we didn't get on, and he hadn't approved of the promotion. It was sanctioned by the owner of the company. Anyway a year down the line I was dismissed, I took it really badly. It was a long way to fall because I'd this fantastic job, loved the company, loved the people and I took it really badly. I ended up with a bad eating disorder and was very depressed. Ending up in the psychiatrist's chair on a lot of medication, in and out of the hospital, in and out, in and out. Eventually one night I took another OD and ended up in the [REDACTED], and it was just my luck to have met a doctor in there this time that said it was the aftercare treatment and not the hospital that was important and put me in contact with [REDACTED]. And that's where my recovery started. I saw her for five years, on the fourth year she suggested the DBT. For the last year I saw her, I did the DBT for a year.

RELATES TIME IN DBT TO RECOVERY

Very good, and that's where you are now.

In a nutshell.

So that was a long process.

It was, it was 7 years altogether.

From that period, from being made unemployed, so much of it must have been awful for you. Trying to cope with such big changes in your life.

Well it wasn't that I had no job all of a sudden, because the company didn't want in disgrace. Because of unfair dismissals, they didn't want me to take proceedings against them, which I could have done. So they agreed they would pay me a lot amount of money and give me a great reference, they would give me three months to look for a job, no pressure. So I did, I found an even better job with more money, but inside I felt so hurt, I couldn't cope, I lasted six months in the new job. I had to leave.

You weren't happy there?

INNER  
TURMOIL

I couldn't do it. Inside I'd fallen apart altogether and this eating disorder was eating away at me. I was eating nothing, and lost a huge amount of weight. I just felt hurt. I had a breakdown completely, you know. So I couldn't hold down the job, and could never hold down another one for the years that followed.

It must have been very scary for you? To be so successful and so in control of your life, to losing that control in some ways.

Yeah.

How did you overcome these difficulties, you said that [REDACTED] was the first port of call for recovery?

She was.

RANGE OF PREVIOUS CARE

LITTLE CONSISTENCY OF CARE – DBT OFFERED THAT

Did you see a psychiatrist before that? Did you?

Oh yeah I've been to psychiatrists before, I'd seen a lot of doctors. I've been in a lot of different hospitals. And there was a stint in a day therapy or whatever. But it was all, nothing was every followed through, I never saw anyone on a continual basis. So Maria was the first person, the first therapist I saw. The first person, where we actually sat down and we started to work on something, where before it was doctors.

How do you feel about the previous situation before [REDACTED]? With the professionals you were with?

Looking back on it, it's scary! At the time I was in a fog, I was confused. So I just thought they were going to make me better, they were going to make the situation better, somehow it was going to work. But yeah looking back on it now it was scary.

Really?

TREATMENT RECEIVED BEFORE DBT – SCARY AND NOT TALKING

Because I don't think I would have recovered.

That it was so disorganised, and you didn't have any consistency?

Well all it was doctors and medication. There was no real talking to me. There was no therapy. It was just drug therapy, that was it, which is not what I needed.

And how did that make you feel that you were just drugged practically?

At the time I believed them that this was the solution.

So it is only in retrospect now that you see a broader picture?

Yeah, yeah. I think oh my god.

RETROSPECT+RECOVERY FACILITATES REFLECTION

That there are options available.

...I said in my head all those drugs they've given me. You know and it was just increasing and increasing. You know I was ending up doing crazy things.

DRUG TREATMENT

And were they changing your medication regularly?

All the time, yeah.

Each time having a different effect on you.

Oh yeah.

Would you say there are big differences with the attitudes of the mental health professionals in the understanding of your problems and the sympathy levels. Would you say there are differences in terms of a nurse, psychiatrist in ways they are sympathetic to you?

Well I suppose the nurses have more time so they are going to get to know you  
This is just general, I can't think of anything in particular. The doctors, you see them for 5/10 minutes maybe, they're prescribing drugs, they are just treating symptoms, which I don't agree with.

NURSES:  
SPENT MORE  
TIME

LITTLE TIME GIVEN  
BY PSYCHIATRIST

There are more than just symptoms there is the actual person.

Well there is an underlying and in my experience I don't think the doctors were treating the underlying problem they were just treating the symptoms. You're depressed, you get antidepressants, if you can't sleep you get sleeping tablets. If you're gone a bit high you get something, gone a bit low you get something else. That's all they were treating.

A sea-saw effect

Well they didn't treat the underlying problem. What was really wrong, and that's when Maria came in.

So you did see a lot of different attitudes?

Yeah I was in a lot of different hospitals, I think I was in every psychiatric ward in Dublin over those years. Yeah so I saw that, a lot of differences.

Was it easy to get professional help? I know it took some time to get it.

FEELS FORTUNATE TO  
HAVE GOTTEN DBT

To get the right professional help it did take some time. I think I was extremely lucky because I saw and met so many people a long the way that weren't as lucky as me, I know they're still in that whole system, they're still there. I thought they would have similar stories to me, they had similar attitudes, they were doing similar things. But they're still there, so I felt I was extremely lucky.

So they're still caught in the system.

Yeah I found the right help. That's why I mentioned the doctor in the Mater that night, I was really lucky to have met him.

Because if you met a different doctor they may not have referred you on?

They would have said 'Here we go again, you know, patch her up and send her home in a couple of days time and I would have been back a couple of months later.'

A revolving door for you really.

COMMON ATTITUDE  
OF DOCTORS

Totally

## APPENDIX G: ETHICAL APPROVAL FROM ST. VINCENT'S HOSPITAL, FAIRVIEW

-----Original Message-----

**From:** Ned Byrne  
**Sent:** 13 October 2005 11:24  
**To:** Maeve Kenny  
**Subject:** An evaluation of the client and economic impact of Dialectical Behaviour Therapy ion an Irish Mental Health Setting

Dear Maeve

The Ethics Committee of the hospital considered the above study at its meeting on 10 October 2005.

The committee would make the following observations:

- 1 The Information Sheet for patients needs to be written in simpler language and it should provide for a signature by the subject patient
- 2 The patient's treating team should be informed about this study.
- 3 It is suggested that a control group from outside the hospital would give greater objectivity to the study.

I am pleased to advise that the study is approved subject to the receipt of a revised Application Form incorporating these suggestions.

Kind regards

Ned

Edward Byrne  
Chief Executive  
St Vincent's Hospital  
Fairview, Dublin 3  
Telephone 00 353 1 884 2436  
Mobile 00 353 87 222 4440  
E-mail: [nedbyrne@svhf.ie](mailto:nedbyrne@svhf.ie)

## APPENDIX H: DCU ETHICAL APPROVAL

March 15, 2006

Mr. Austin Bayley  
St Vincent's Hospital  
Fairview  
Dublin 3

Dear Austin,

The DCU School of Nursing committee that reviews ethics proposals has met to discuss your project:

An evaluation of the client impact of Dialectical Behaviour Therapy in an Irish Mental Health Setting

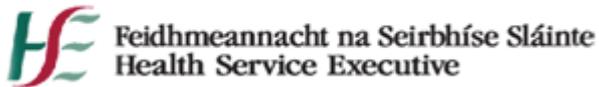
The committee has approved your project. However, we would like you to make some small changes in the documents you plan to give potential participants and participants. A number of typographical errors are pointed out in the enclosed document. More substantially, the committee would like the documents to be more explicit that a patient's decision not to participate in the research will not limit the therapy they will be able to receive. Please then send a copy of the revised documents to me.

The committee is impressed by your project and sees it as very important. We wish you all the best with your research. Please contact me if I can be of any further help.

Yours truly,

Dónal O'Mathúna, Ph.D.  
Chair, School of Nursing Research & Teaching Ethics Committee  
School of Nursing  
Dublin City University  
Glasnevin, Dublin 9

## APPENDIX I: ETHICAL APPROVAL FROM ST. ITA'S HOSPITAL, PORTRANE



St. Ita's Hospital,  
Portrane, Donabate,  
Co. Dublin.  
Ospideal Naomh Ide,  
Port Reachrann,  
Domhnach Bat,  
Co. Atha Cliath.

13<sup>th</sup> March 2007

Tel: (01) 843 6337  
Fax: (01) 843 6315

Dr. Paul Lyons,  
Clinical Psychologist,  
Castlebrook Mental Health Centre,  
Swords Health Centre,  
Bridge St,  
Swords,  
Co. Dublin.

Re: An evaluation of the client, staff, and economic impact of Dialectical Behaviour Therapy in an Irish Mental Health setting.

Dear Paul,

Thank you for the proposal on this study supported by the Ethics Committee of St. Vincent's Hospital, Fairview and the DCU School of Nursing. The aim of the study, namely the exploration of Dialectical Behaviour Therapy on the treatment of Borderline Personality Disorder in an Irish setting is very relevant to patient care. I would support the inclusion of patients participating in the DBT programme in North Co. Dublin in this research project.

Yours sincerely,

---

R. Blennerhassett.  
Clinical Director.

**APPENDIX J: ETHICAL APPROVAL FROM ST. COLUMBA'S DAY SERVICE,  
CRUMLIN**



**THE ADELAIDE & MEATH  
HOSPITAL, DUBLIN**  
INCORPORATING  
THE NATIONAL CHILDREN'S HOSPITAL

Dr. Beth O'Riordan,  
Senior Clinical Psychologist/DBT Team Leader,  
Crumlin Adult Mental Health Services,  
St. Columba's Day Hospital,  
Armagh Rd,  
Crumlin,  
Dublin 12.

June 5<sup>th</sup> 2007

Re: Crumlin Team DBT Feasibility study

Dear Dr. O'Riordan,

Thank you for your recent submission of the above proposal to the SJH/AMHCH Research Ethics. The Chairman, having reviewed your proposal has, on behalf of the Committee, given ethical approval to the proposed study.

Yours sincerely,

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Daniel R. Lynch.  
Secretary,  
SJH/AMNCH Research Ethics Committee.