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## **DOCTOR OF PHILOSOPHY**

### **Dialectical behaviour therapists' experience of young people with features of borderline personality disorder : a qualitative analysis**

Rickard, Renee

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**Dialectical Behaviour Therapists' Experience of Young People  
with Features of Borderline Personality Disorder:  
A Qualitative Analysis**

*“these are people who are suffering, whose lives are profoundly blighted and who are viewed in quite a negative way by a significant proportion of the health care professionals meant to be helping... and it kind of nudges you in the direction of wanting to find a way of being genuinely helpful” (Nick)*

**Renee E Rickard**

April 2012

Submitted in part fulfilment of the final degree award: Doctorate in Clinical Psychology

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## **Abstract**

This thesis examines mental health professionals' responses toward patients diagnosed with Borderline Personality Disorder (BPD) and presents a qualitative study of Dialectical Behaviour Therapists' (DBT) experiences in their work with young people with BPD features.

A review of empirical literature regarding emotional, behavioural and attitudinal responses of professionals toward these patients identified a range of negative responses, distinguishable from responses toward patients with other mental health problems. The review highlights the consistency of responses in professionals working in a variety of roles with these patients in countries across the world, and points to the need for further research to understand the precipitants of these negative responses. Controversy surrounds the diagnosis of BPD during adolescence and hence the majority of research in this area focuses upon professionals working with adult patients.

On the basis of evidence regarding the presence of BPD features during adolescence and the application of therapeutic approaches, such as DBT, to young people exhibiting these features, the empirical paper presents an Interpretative Phenomenological Analysis (IPA) of the lived experience of DBT therapists in this context. A super-ordinate theme of '*the impact of the therapy on the therapist*' containing five sub-themes is presented. The emotional responses of the DBT therapists are interpreted as consistent with the literature regarding professionals working with adults with BPD. The findings are also

interpreted in relation to an apparent resonance between the therapists' experiences and that of their patients. This finding is considered from two theoretical perspectives. The third paper considers potential implications of these perspectives in relation to clinical practice. It is argued that the therapists' responses toward these patients may be set within a discourse of normality rather than pathology and that the discourse adopted will have a bearing on the mechanisms of support provided to professionals in clinical practice.



## **Section 1: Literature Review**

## **Author Guidelines**

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Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

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**Responses, attitudes and perceptions of mental health professionals toward patients diagnosed with borderline personality disorder: an empirical review**

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**Abstract**

The present study provides a review of the literature regarding the emotional, behavioural and attitudinal responses of mental health professionals toward patients diagnosed with Borderline Personality Disorder (BPD). Electronic searches of Web of Knowledge, PsychINFO and CINAHL using specific search terms and inclusion criteria identified twenty-two relevant studies. Relevant findings were extracted and analysed. Studies based primarily on vignettes of hypothetical patients and professionals' self-report indicate a range of negative emotional, behavioural and attitudinal responses toward patients with BPD that are distinguishable from responses toward patients with other mental health problems. The consistency of responses across professionals, working in a variety of roles, in different countries across the world, suggests that the reactions and responses elicited are neither culturally dependent nor dependent upon the frequency, intensity or depth of contact with these patients. Qualitative studies in particular, illustrate that attitudes and responses are not exclusively negative. However the analysis yielded inconsistent findings regarding the identification of factors associated with professionals' responses. The review concludes that a greater empirical understanding of what precipitates these responses and what the consequences may be in terms of burnout, stress and well-being is indicated. Investigating sources of support that may help to reduce experiences of negative emotion, attitude and behaviour would also be beneficial for professionals and patients with BPD alike.

**Key Practitioner Message:**

- Negative responses toward hypothetical and actual patients with BPD are frequently reported in mental health professionals cross-culturally.
- Negative emotional, behavioural and attitudinal responses appear to be independent of the frequency, intensity and duration of patient contact.
- Responses of professionals are not exclusively negative and can be counterbalanced by positive attitudes and responses.
- Further research is necessary to understand the precipitants of these negative responses, their consequence for professionals and patients and mechanisms of support for professionals.

**Keywords:** Borderline Personality Disorder, BPD, mental health professionals, emotional responses, attitudes, perceptions, behavioural responses

## **Introduction**

Borderline Personality Disorder (BPD) is a serious psychiatric disorder characterized by affective dysregulation, impulsivity and disturbed relationships (Sanislow et al. 2002). In a review of the literature, Paris (2002) reports that the suicide rate of 10% in individuals diagnosed with BPD is similar to the rates for schizophrenia and depression. Although prevalence rates in the general population have typically been reported as between 1% and 2% (Torgersen, Kringlen & Cramer, 2001), a recent epidemiological study of 34,653 adults conducted in the USA reported a 5.9% lifetime prevalence of BPD in the general population (Grant et al. 2008).

BPD is conceptualised as the result of a combination of temperamental, genetic and environmental factors (Linehan 1993; Gunderson & Lyons-Ruth, 2008) and attention has increasingly turned to the examination of attachment processes in the development and aetiology of BPD (Levy, Beeney & Temes, 2011; Steele & Siever, 2010). A recent longitudinal study found evidence of a link between early maternal separation prior to age five and BPD symptoms in adolescence through to middle adulthood (Crawford, Cohen, Chen, Anglin & Ehrensaft, 2009). A longitudinal, prospective study by Carlson, Egeland and Sroufe (2009) found links between BPD symptoms in adulthood and childhood temperamental and environmental factors including, attachment disorganisation, maltreatment and maternal hostility.

In the context of early disrupted relationships, individuals diagnosed with BPD are described in DSM-IV-TR as forming intense and unstable relationships, often alternating between 'idealization and devaluation' and employing 'frantic efforts to avoid real or imagined abandonment' (American Psychiatric Association, 2000). A recent study by Staebler, Helbing, Rosenback and Renneberg (2011) found that patients with BPD scored higher on a measure of rejection sensitivity than both controls and patients with other mental health problems including social anxiety disorders.

The literature in this area contains numerous reports of the challenges, negative attitudes and experiences of mental health professionals in their work with these patients (Bland, Tudor & Whitehouse, 2007; McHenry, 1994; Westwood & Baker, 2010). According to Aviram, Brodsky and Stanley (2006) there is a stigma associated with BPD within mental health settings evident in clinicians' use of "pejorative terms such as 'difficult', 'treatment resistant', 'manipulative', 'demanding' and 'attention-seeking'" (p. 250). They propose that a self-fulfilling prophecy exists whereby preconceptions regarding patients with BPD and their treatability influence clinicians' behaviours, in turn triggering behaviour on the part of the patient that reinforces the stigma. From the patient's perspective, a recent focus group conducted with 10 in-patients with BPD illustrated that the most salient issue was the negative attitudes and reactions of staff and their perceived lack of understanding regarding the disorder (Rogers & Dunne, 2011).

A greater empirical understanding of the reactions and responses of mental health professionals toward patients with BPD is imperative. In view of the prevalence of the disorder, the high suicide rate in the BPD population, emerging evidence of early-disrupted attachments, and the sensitivity to rejection and abandonment characteristic of BPD, it is vital that professionals are supported to develop and maintain restorative relationships with their patients. This is particularly important in light of Bender et al.'s, (2001) finding that after controlling for axis 1 disorders and demographic variables, patients with BPD had received significantly more psychosocial treatments (including individual therapy, group therapy, day treatment and in-patient treatment) with the exception of family/couples therapy and self-help, than patients diagnosed with either depression or other personality disorders.

The present study aims to review the empirical literature regarding the emotional, behavioural and attitudinal responses of mental health professionals toward patients with BPD. Although a literature review was published recently regarding attitudes toward patients with BPD, the review focused specifically on the views of mental health nurses working in acute mental health settings (Westwood & Baker, 2010). The present review is considered timely given that a sufficient body of evidence exists, examining the responses of a wide range of mental health professionals working in different contexts, toward patients diagnosed with BPD.

## **Method**

### *Inclusion Criteria*

Studies were selected if they included an investigation of emotional responses, behavioural responses and/or attitudes and perceptions of mental health professionals toward patients with BPD. Only empirical studies using quantitative or qualitative methodology published in the English language were included. No limits were placed on the publication date of the study.

### *Identification and Screening*

In October 2011, searches of three electronic databases were carried out: Web of Knowledge, PsychINFO and CINAHL. We searched the terms 'borderline personality disorder' or 'BPD' and 'staff' or 'mental health staff' or 'mental health professional' or 'nursing staff' or 'therapist' or 'psychotherapist' or 'psychotherapist trainee' in singular and plural form. Due to our specific focus on studies investigating the responses of professionals toward patients with BPD we searched for these terms in the category 'title'. This yielded 30 articles. The reference lists of these articles were hand searched for potentially relevant studies yielding an additional 14 articles and an overall total of 44 articles.

Of these articles, six were educational intervention studies aimed at changing the attitudes and perceptions of mental health professionals toward patients with BPD. A further eight were theory/opinion or review articles. Two studies focused on the psychometric evaluation of inventories. A further three studies examined staff feelings and/or responses toward patients based on assessment



of personality organisation (borderline, neurotic or psychotic), a diagnostic model described as 'not directly translatable' to the DSM-IV diagnosis of BPD. Two studies were excluded as they focused on the treatment of BPD using Dialectical Behaviour Therapy (DBT), one focusing on patient and therapist perceptions of the treatment, and one on the relationships between patient-therapist ratings and progress in DBT. Finally, one article was excluded due to a specific focus on patient-therapist attachment in the treatment of BPD. This left a total of 22 articles selected for review.

Findings from single cohort studies will be presented first, followed by studies comparing professionals' responses to mixed cohorts. Studies employing qualitative methodology will then be presented followed by a final section devoted to the consideration of possible factors associated with professionals' responses.

## **Results**

Of the 22 studies identified, eight focused on the emotional responses, attitudes/perceptions and/or physiological responses of professionals to patients with a diagnosis of BPD (See Table 1). A further eight studies compared the differential emotional, behavioural and attitudinal responses of professionals toward patients diagnosed with BPD, schizophrenia and/or depression (See Table 2). In presenting these studies, the term 'significant' is used to refer to findings that achieved statistical significance in the original study unless otherwise specified. A total of five studies employed qualitative

methodology to examine the experiences of professionals in their work with patients with BPD (See Table 3). One of these studies (Hazelton, Rossiter and Milner, 2006) incorporated a mixed methodology, qualitative/quantitative design therefore the results of this study are reported in Tables 1 and 3. Of the 22 studies included, two studies by Rosenkrantz & Morrison (1992a, 1992b) were not discussed in the main body of the review as the theoretical underpinnings and methodology employed made it difficult to directly compare the findings. However, these studies were maintained in the review for their consideration of potential associates of professionals' responses and have therefore been reviewed in the final part of the results section (See p. 41 '*Possible factors associated with the responses of mental health professionals to patients with BPD*').

Mental health nurses (hereafter referred to as nurses) were the most frequently studied professional group. Approximately half studied only nurses and two of these studies combined nurses with unqualified support workers and health-care assistants.<sup>1</sup> The majority of the remaining studies contained a variety of professional groups including psychiatrists, psychologists, psychotherapists and social workers. The mental health professionals studied worked in a variety of settings including in-patient and community settings and several studies focused particularly on professionals practising psychotherapy. The studies took place in ten countries across the world, most frequently in the USA,

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<sup>1</sup> Although these two studies included a proportion of unqualified staff, the vast majority of studies involved qualified staff of various professional groups. Therefore the term 'mental health professional' or 'professional' is used throughout.

Australia and the UK as well as in Canada, Ireland, Greece, Israel, Taiwan, Norway and Sweden. The majority of studies focusing on responses toward actual patients stipulated that patients met DSM-IV criteria for BPD. Exceptions to this were two studies by Miller et al. (2011a, 2011b) whose participants were providing psychotherapy to recently suicidal college students with BPD traits and a study by Rossberg, Karterud, Pedersen and Friis (2007), comparing psychotherapists' responses to in-patients diagnosed with cluster A&B and cluster C Personality Disorders. However, according to Rossberg et al., (2007) most of the patients in the cluster A&B group met DSM-IV diagnostic criteria for BPD.

**Table 1: Responses, attitudes and perceptions of mental health professionals to patients with a diagnosis of BPD**

<i>Authors</i>	<i>Country of Origin</i>	<i>Sample</i>	<i>Design</i>	<i>Key Findings (Emotional responses / attitudes / behavioural / physiological responses)</i>
Cleary, Siegfried & Walter (2002)	Australia	229 - (62%) mental health nurses; (15%) Psychiatrists /Registrars; (8%) social workers; (6%) psychologists working inpatient & community settings mainly with adults, 4% with children /adolescents	Survey of attitudes, experience & knowledge re: BPD	80% perceived working with patients with BPD to be moderately to very difficult  84% perceived patients with BPD to be more difficult to work with than patients with other mental health problems
Deans & Meocevic (2006)	Australia	65 mental health nurses working inpatient & community settings	Survey including emotional reactions toward patients with BPD	89% perceived patients with BPD to be manipulative 51% as engaging in emotional blackmail 38% as nuisances 32% felt anger toward patients with BPD
Hazelton, Rossiter & Milner (2006)	Australia	69 – mental health nurses (66.7%) plus doctors & allied health professionals from inpatient and community mental health, drug & alcohol, pharmacy, psychiatric rehab. & child/family services	Survey of attitudes, experience & knowledge re: BPD prior to DBT training	73.5% perceived working with patients with BPD to be moderately to very difficult  75% perceived patients with BPD to be more difficult to work with than patients with other mental health problems
James & Cowman (2007)	Ireland	65 mental health nurses working inpatient & community mental health settings	Survey of attitudes, experience & knowledge re: BPD	75% perceived working with patients with BPD to be moderately to very difficult  80% perceived patients with BPD to be more difficult to work with than patients with other mental health problems
Giannouli et al. (2009)	Greece	69 mental health nurses working in psychiatric hospitals and psychiatric clinics of general hospitals	Survey of attitudes, experience & knowledge re: BPD	85.5% perceived working with patients with BPD to be moderately to very difficult  65.2% perceived patients with BPD to be more difficult to work with than patients with other mental health problems

## Borderline Personality Disorder & Professionals' Responses

**Table 1 - (Continued)**

Miller et al. (2011a)	USA	6 therapists in training – 3 practising DBT, 3 practising psychodynamic therapy with recently suicidal college students with borderline traits	Pilot Study - Therapist salivary alpha amylase (AA) & cortisol (C) levels measured pre & post therapy sessions with 2 patients over 1 year plus post-session rating of session difficulty & working alliance measure	AA & C levels found to reduce on average from pre to post therapy session Reductions in AA levels associated with greater perceived difficulty of session Greater reductions in C levels associated with stronger working alliance
Bodner, Cohen-Fridel & Iancu (2011)	Israel	57 – mental health nurses (43.9%); psychiatrists (33.3%); psychologists (22.8%) working in several 'psychiatric institutions'	2 Questionnaires developed & factor analysed – Cognitive Attitudes & Treatment Inventory (BPD-CAT) & Emotional Attitudes Inventory (BPD-EA)	BPD-EA – frustration, anger, impatience and agitation experienced by all professional groups in treatment of patients with BPD
Miller et al. (2011b)	USA	6 therapists in training – 3 practising DBT, 3 practising psychodynamic therapy with recently suicidal college students with borderline traits	Pilot study - Salivary cortisol samples and self-report measures of burnout & well-being every 3 months for 1 year	Low levels of burnout and high well-being scores reported by both DBT and psychodynamic therapists throughout the study

**Table 2: Studies comparing responses, attitudes and perceptions of mental health professionals to patients diagnosed with BPD, schizophrenia and/or depression**

<i>Authors</i>	<i>Country of Origin</i>	<i>Sample</i>	<i>Design</i>	<i>Emotional reactions/responses</i>	<i>Attitudes/ attributions / perceptions</i>	<i>Behavioural (inc. Verbal) responses</i>
Gallop, Lancee & Garfinkel (1989)	Canada	113 Mental Health Nurses – working in short-stay psychiatric units	Vignettes –nurses written responses to statements by hypothetical clients - BPD & Schizophrenia			Less empathy expressed - BPD  More affective involvement - Schizophrenia  More likely to belittle / contradict - BPD
Fraser & Gallop (1993)	Canada	17 Mental health nurses – working in inpatient units	Nurses observed facilitating therapeutic groups - confirming / disconfirming responses examined – BPD, Schizophrenia, Affective disorder (AD)	Feelings/emotions more positive toward AD and Schizophrenia than BPD  More negative feelings toward BPD than AD and Schizophrenia		More impervious and indifferent responses toward BPD than AD
McIntyre & Schwartz (1998)	USA	155 Practising Psychotherapists	Audio-taped simulated interviews – BPD & MDD	More hostile and dominant reactions evoked by client with BPD		
Markham (2003)	UK	71 – 50 Mental health nurses 21 Health care assistants working in inpatient units	Questionnaires completed relating to staff views re: BPD, Schizophrenia & MDD		Mental health nurses more socially rejecting & rated BPD more dangerous than MDD & Schiz. More negative experiences & less optimistic re: BPD vs. MDD & Schiz	

Borderline Personality Disorder & Professionals' Responses

**Table 2 – (Continued)**

Markham & Trower (2003)	UK	48 Mental health nurses – working in inpatient facilities	Causal attributions re: challenging behaviours (CB) - imaginary clients – BPD, MDD & Schizophrenia	Greater perceived control - less sympathy- BPD  Less optimism for change - BPD	More stable causes - BPD  Greater perceived control over CB & its causes - BPD	
Forsyth (2007)	UK	26 Mental health nurses & support workers ( <i>proportions not specified</i> ) – working in inpatient settings	Vignettes re: non-completion of therapy task and reason why - BPD & MDD (reasons manipulated – controllability/ stability)			Intended helping behaviour greater for MDD than BPD
Rossberg, Karterud, Pedersen & Friis (2007)	Norway	11 Psychotherapists – providing inpatient group therapy (Psychiatrist/Psychologist/ art therapist/ physiotherapist /social worker/ 5 mental health nurses)	Questionnaire completed re: inpatients 2 weeks after admission and 2 weeks before discharge – Cluster A&B Personality Disorders (most met criteria for BPD) & cluster C Personality Disorders	Less confident toward cluster A&B 2 weeks after admission than toward Cluster C  Less confident, more rejected, on guard, overwhelmed & inadequate than Cluster C		
Bourke & Greenyer (2010)	Australia	20 Clinical psychologists – practising psychotherapy	Interviews re: 2 BPD and 2 MDD clients	Less confident in providing support than to MDD	Client responses to therapist perceived more negative than MDD	Therapist responses to client less positive than MDD

**Table 3: Qualitative studies of mental health professionals' experiences of their work with patients with BPD**

<i>Authors</i>	<i>Country of origin</i>	<i>Sample</i>	<i>Methodology</i>	<i>Core themes</i>	<i>Sub-themes</i>
Bergman & Eckerdal (2000)	Sweden	N = 29 63% licensed nurses; 15% physicians; 11% social counsellors; 11% psychologists working with in-patients and out-patients	Grounded theory	Professional skills of mental health work	<ul style="list-style-type: none"> <li>• Empathy for patients with BPD</li> <li>• Interest in treating BPD</li> <li>• Feelings of professional frustration</li> <li>• Need for a common outlook</li> </ul>
Nehls (2000)	USA	N = 17 – case managers working in units of community mental health centre	Interpretative phenomenological analysis	Monitoring self-involvement	<ul style="list-style-type: none"> <li>• Monitoring concern</li> <li>• Monitoring boundaries</li> </ul>
Hazelton, Rossiter & Milner (2006)	Australia	N = 24 – mental health nurses, doctors & allied health professionals - inpatient & community mental health, drug & alcohol, pharmacy, psychiatric rehab. & child/family services	Discourse analysis of focus groups at pre-training (prior to training in DBT)	'Difficult consumers' Ineffective treatments	<ul style="list-style-type: none"> <li>• 'Staff-splitting'</li> <li>• Manipulative</li> <li>• Attention-seeking</li> <li>• Intimidating</li> <li>• Enmeshed/dysfunctional families</li> <li>• BPD as untreatable</li> <li>• Inconsistent/ineffective treatment</li> </ul>
Woolaston & Hixenbaugh (2008)	UK	N = 6 mental health nurses – 4 acute in-patient; 1 community-based & 1 supported tenancy scheme	Thematic analysis	'Destructive whirlwind'	<ul style="list-style-type: none"> <li>• Care giving</li> <li>• Idealised and demonised</li> <li>• Manipulation</li> <li>• Threatening</li> </ul>
Ma et al. (2009)	Taiwan	N = 15 mental health nurses – psychiatric health centre acute & rehabilitation units	Qualitative content analysis	Shifting from honeymoon to chaos stage Nurses expectations Routine vs. individualised care Adequate or inadequate team support Differences in care outcomes	<ul style="list-style-type: none"> <li>• Positive vs. negative outcomes</li> <li>• Satisfactory experiences / Unsatisfactory experiences / Superficial relationships</li> </ul>



***Studies describing mental health professionals' responses to patients with BPD***

*Emotional reactions/responses*

Deans and Meocevic (2006) reported that just under one third of their sample of nurses felt anger toward patients with BPD. The Emotional Attitudes Inventory (BPD-EA) devised and factor analysed by Bodner, Cohen-Fridel & Iancu (2011) indicated that their sample of 57 nurses, psychiatrists and psychologists experienced anger alongside frustration, impatience and agitation in their work with these patients.

*Perceptions/attitudes*

The perception of patients with BPD as being particularly difficult to work with was illustrated in four surveys using adapted versions of the same 23-item questionnaire, originally devised by Cleary, Siegfried and Walter (2002). From a total pool of 894, the views of 432 mental health professionals (hereafter used interchangeably with the term 'professional') working in both hospital-based and community settings in Australia (Cleary, et al., 2002; Hazelton, et al., 2006), Ireland (James & Cowman, 2007) and Greece (Giannouli, Perogamvros, Berk, Svigos & Vaslamatzis, 2009) were surveyed. In these four surveys, a range of 73.5% (Hazelton, et al., 2006) to 85.5% (Giannouli et al., 2009) of professionals rated patients with BPD as moderately to very difficult to work with. Furthermore, 62.5% (Giannouli et al., 2009) to 84% (Cleary, et al., 2002) of professionals perceived patients with BPD as more difficult to work with than patients with other mental health problems.

Deans and Meocevic (2006) found that the majority of the 65 nurses surveyed, perceived patients with BPD to be manipulative (89%). Over half of the sample believed that these patients engaged in emotional blackmail and over one third perceived them as nuisances.

### *Physiological responses*

Recent pilot studies by Miller et al. (2011a, 2011b) focused on physiological indicators of stress in a group of six psychotherapists in training, three practising DBT and three practising psychodynamic therapy with recently suicidal college students with traits of BPD. The first study examined these responses in the six therapists pre and post therapy sessions with two of their patients over a one-year period. The average reductions in alpha amylase (AA) and cortisol (C) levels from pre to post-therapy sessions was interpreted by the authors as evidence of anticipatory anxiety experienced by the therapists prior to sessions and a reduction in stress afterward. This study also indicated that therapists' perceptions of their work with these patients may have a bearing on their physiological responses in that greater reductions in AA levels pre to post session were associated with perceptions of the session as more difficult and greater reductions in C levels were associated with perceptions of a stronger therapeutic alliance. A second pilot study found that the cortisol awakening responses of the six therapists did not vary during the one-year study period. C levels were measured every three months and indicated that levels at the beginning of the day were relatively stable over time. However, for the purposes

of the present review, it was interesting to note that the therapists self-reported low levels of burnout and high levels of well-being throughout the study period.

***Studies comparing mental health professionals' responses to patients with BPD, schizophrenia and depression***

*Emotional reactions/responses*

Fraser and Gallop (1993) used the staff response sub-scale of Colson's hospital treatment rating scale (Colson et al., 1986) to assess the emotional responses of 17 nurses toward patients with BPD, schizophrenia and affective disorder. More negative emotional responses were experienced toward patients with BPD including anger, frustration, helplessness and confusion.

McIntyre and Schwartz (1998) assessed the reactions of 155 psychotherapists after listening to simulated audio-recorded interviews with a patient diagnosed with BPD or major depressive disorder (MDD). The authors reported that more hostile and dominant reactions were 'evoked' in the therapists by the patient diagnosed with BPD compared to emotional reactions including agreeableness, nurturance, importance and caring, 'evoked' by the patient diagnosed with MDD. The authors reported that hostility reactions included the tendency to criticise, ridicule or punish, doubting others' intentions and emotional detachment and that dominance reactions pointed to perceptions of the patient as exhibitionistic, attention seeking and hungry for approval.

More recently, Rossberg et al., (2007) used the Feeling Words Checklist-58 (Rossberg, Hoffart & Friis, 2003) to compare the reactions/responses of 11 psychotherapists providing group therapy to inpatients diagnosed with cluster A (Paranoid/Schizoid/Schizotypal) and B (Antisocial/Borderline/Histrionic/Narcissistic) personality disorders, most of whom were reported to meet the criteria for BPD, compared to in-patients diagnosed with cluster C (Avoidant/Dependent/Obsessive-Compulsive) personality disorders. Therapists reported being less confident in their work with in-patients labelled with cluster A and B personality disorders two weeks after admission. Subsequently, two weeks before discharge, therapists were found to be less confident, to feel more rejected, on guard and overwhelmed by in-patients with cluster A and B personality disorders. Bourke and Greenyer (2010) also found the 20 clinical psychologists in their study who were interviewed regarding two of their patients with BPD and two with MDD to be less confident in their work with those diagnosed with BPD.

#### *Perceptions/attitudes*

Markham (2003) surveyed 71 nurses and health care assistants regarding their views and experiences of patients diagnosed with BPD, schizophrenia and MDD. They found the nurses in their study to be more socially rejecting of patients with BPD and to rate these patients as more dangerous than patients with either schizophrenia or MDD. Participants in both staff groups described more negative experiences in their work with patients with BPD and reported being less optimistic about working with these patients. In a study examining

causal attributions for challenging behaviour in hypothetical patients diagnosed with BPD, schizophrenia and MDD, Markham and Trower (2003) found the 48 nurses in their study to attribute the challenging behaviour of patients with BPD to more stable causes. Nurses perceived these patients as having greater control over the challenging behaviour and its causes and therefore to be less sympathetic toward them. They were also found to be less optimistic regarding the potential for change in the hypothetical patients with BPD. Additionally, the clinical psychologists in Bourke and Greenyer's (2010) study perceived their patients with BPD as responding to them in a more negative manner than those diagnosed with MDD.

*Behavioural (including verbal) responses*

In 1989, Gallop, Lancee and Garfinkel developed a Staff-Patient Interaction Response Scale (SPIRS), to measure empathy expressed in the written responses of 113 nurses, to statements made by hypothetical patients with a diagnosis of either BPD or schizophrenia. Nurses, working across five acute in-patient units, were found to express more empathy toward patients diagnosed with schizophrenia. More specifically, their responses to patients diagnosed with BPD were more likely to fall into the lowest of three levels of empathic care, categorised 'no care'. This category included responses that belittle or contradict the patient and responses that offer platitudes or clichés. A more detailed examination of the 10 response categories of the SPIRS revealed that, at this level of analysis, the only statistically significant difference was that

nurses were more likely to respond to patients diagnosed with BPD with responses that belittled or contradicted the patient.

The 17 nurses in Fraser and Gallop's (1993) study, as well as completing questionnaires regarding their feelings toward different patient groups, were also observed facilitating therapeutic groups for in-patients. Their responses to patients in the therapeutic groups were rated using a confirmation/disconfirmation rating instrument (Heineken, 1982). Nurses' overall confirming/disconfirming responses were significantly different between diagnostic groups and post hoc analysis found this difference to be evident between patients with BPD and those with affective disorder and between patients with BPD and the diagnostic category 'other'. The comparison between confirming/disconfirming responses toward patients with BPD and those with schizophrenia did not achieve statistical significance. Nurses' responses toward patients with BPD were most likely to be categorised as impervious (defined as a response that "...implies that one knows what is going on inside the other speaker and/or is in a position to judge the correctness of the other's feelings." p.340) and indifferent (defined "...as a response which fails to acknowledge the other individual's attempt to communicate." p.340).

A vignette study by Forsyth (2007) examined the responses of 26 mental health nurses and support workers, working in an inpatient setting, to hypothetical patients diagnosed with BPD and MDD. Patients in each vignette were described as having failed to complete a therapy task with reasons for the non-

compliance also provided. Of relevance to the present review was the significant finding that 'intended helping behaviour' was greater toward patients diagnosed with MDD than toward those diagnosed with BPD. As well as perceiving their patients with BPD as responding more negatively toward them, the 20 clinical psychologists in Bourke and Greenyer's (2010) study judged their own responses to their patients with BPD to be more negative than toward those with MDD.

***Qualitative studies examining mental health professionals' experiences of patients with BPD***

A total of five studies using a range of qualitative methodologies described the experiences of 91 mental health professionals in their work with patients with BPD. The studies took place in different parts of the world with professionals working in both in-patient and community settings. The findings of Hazelton, et al., (2006) and Woollaston & Hixenbaugh (2008) illustrate perceptions of patients with BPD as difficult and destructive and more specifically as manipulative, threatening and intimidating. In these two studies as well as in Bergman & Eckerdal's (2000) study, patients with BPD were seen as causing divisions between professionals. The nurses<sup>2</sup> in Woollaston & Hixenbaugh's (2008) study described the experience of being alternately perceived by patients as either good or bad, the 'sense of injustice' experienced by some when they were 'demonised' and the pleasant experience of being 'idealised' coupled with a sense of discomfort at being perceived in such a positive light.

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<sup>2</sup> The term 'nurses' is used to refer to the findings of studies where the total sample consisted of mental health nurses rather than a mixed professional group.

Similarly, the nurses in Ma, Shih, Hsiao, Shih, and Hayter's (2009) study reported an initial 'honeymoon' stage where relationships between nurses and their patients were peaceful and respectful. This was closely followed by a 'chaos stage' during which patients were perceived as manipulative, and nurses experienced increasingly negative emotions including anger, annoyance, worry and a temptation to 'abandon positive expectations for care outcomes' (p. 444).

Nurses in Woollaston & Hixenbaugh's (2008) study experienced a sense of being unable to help or treat patients with BPD. Similarly, professionals in Hazelton, et al.,'s (2006) focus group perceived patients with BPD as untreatable. Nurses in Ma et al.'s (2009) study varied in this regard with some nurses holding negative expectations based on prior experience, and others believing that positive outcomes were possible, feeling empowered to face challenges and to be encouraging and tolerant toward these patients. Similarly, a sub-theme in Bergman & Eckerdal's (2000) study described professionals' interest in treating patients with BPD that included excitement, curiosity, gladness and a sense of the work as demanding.

The experience of hopelessness and inadequacy described by nurses in Woollaston and Hixenbaugh's (2008) study is consistent with the sub-theme of feelings of professional frustration described by professionals in Bergman and Eckerdal's (2000) study, which included feelings of inadequacy, powerlessness, anger and sorrow. Conversely, Bergman and Eckerdal's (2000) professionals



also talked of empathy, a sub-theme that incorporated the warmth, holding, security and sense of nearness that could be provided for these patients.

Nehls's (2000) study illustrated the degree of monitoring not only of the patient but the self-monitoring that professionals undertook. Professionals were often doubtful that they could adequately monitor their own responses to these patients, spoke of the need to carefully manage boundaries in their work and yet were also aware of the potential impact that setting boundaries might have on their ability to connect with these patients. Nehls (2000) suggested that this process of constant monitoring appeared to be burdensome to professionals.

Ma et al.'s (2009) study illustrated that nurses who held negative expectations regarding treatment outcome were more likely to provide routine care only, with no desire to understand their patients as individuals, leading to the development of 'superficial relationships' with patients with BPD. Nurses holding positive expectations at the outset spoke of utilising individualised care strategies that resulted in satisfactory experiences for some and unsatisfactory experiences for others. The experience of these nurses suggested that adequate support from the wider team was a key factor in influencing those with negative expectations to engage in more individualised patterns of care. Ma et al., (2009) also found that nurses practising individualised care who experienced adequate support from colleagues went on to describe their experiences of caring for these patients as satisfactory. Conversely, those describing unsatisfactory experiences in terms of outcome, spoke of inadequate team support.

***Possible factors associated with the responses of mental health professionals to patients with BPD***

*Age and years of experience*

A number of studies examined the responses of mental health professionals as a function of age and years of experience yielding inconsistent findings.

Whereas Gallop, et al., (1989) found that younger participants were more empathic and used fewer belittling responses than their older counterparts, Markham (2003) found no differences in attitudes and perceptions among his sample based on age. Similarly, Gallop, et al., (1989), Markham, (2003) and Bodner, et al., (2011) found no significant differences in the responses of participants in terms of years of experience/seniority. In post-hoc analyses, McIntyre and Schwartz (1998) reported a non-significant trend whereby emotional reactions and perceptions were inversely related to years of experience. Additionally, although Bodner, et al., (2011) found no significant difference in cognitive and emotional attitudes of professionals on the basis of seniority, after accounting for the effect of other factors such as the perception of suicidal tendencies and the professionals' wish to improve diagnostic skills, an inverse relationship between the experience of negative emotion and seniority was evident. Seniority accounted for 8.2% of the variance in relation to negative emotion.

*Gender*

McIntyre and Schwartz (1998) found no difference in their sample on the basis of gender. However, in post-hoc analyses Bodner, et al., (2011) found that gender accounted for 15.6% of the variance in relation to empathy, with females tending to be more empathic than males toward patients with BPD.

### *Professional Group*

The possibility that responses toward patients with BPD may vary according to professional group was suggested in two of the studies reviewed. Markham (2003) found that unqualified health care assistants were less socially rejecting and perceived patients with BPD as less dangerous than qualified nurses.

Bodner, et al., (2011) found no differences between psychiatrists, psychologists and nurses regarding negative emotions, perceptions of suicidal tendencies and difficulties in the treatment of patients with BPD. However, psychologists were found to make less antagonistic judgements than nurses and psychiatrists.

Additionally, nurses were found to be less empathic toward patients with BPD than either psychiatrists or psychologists.

### *Therapeutic approach*

Bourke and Greenyer (2010) found no difference in emotional response related to the theoretical orientation of the clinical psychologists studied (14 practised cognitive-behavioural therapy and six interpersonal-dynamic therapy). Similarly, Miller et al. (2011a) found no significant differences in pre to post session physiological markers of stress in relation to the therapy practised (three practising DBT and three psychodynamic therapy). However, in a subsequent

examination of cortisol levels over the course of a year, Miller et al., (2011b) found a non-significant trend in the same six therapists. Those practising DBT experienced less stress over the time-period of the study compared to an opposite trend for those practising psychodynamic therapy, to become relatively more stressed over time.

#### *Patient severity and progress*

The severity of patients' problems and their progress in treatment were considered as possible factors affecting professionals' responses in two studies (Bourke & Greenyer, 2010, Rossberg et al., 2007). Rossberg et al. (2007) found that two weeks after admission, professionals felt more inadequate and overwhelmed in their dealings with in-patients who later dropped out of treatment. They also found that emotional reactions toward all in-patients were strongly correlated with client improvement. Similarly, one of the studies not discussed in the main body of the review (Rosenkrantz & Morrison, 1992b), found that a sample of 158 psychotherapists evaluated a patient with BPD described as 'high functioning' more positively, than a patient in another vignette, described as 'low functioning'. Conversely, Bourke and Greenyer, (2010) found that psychologists' responses did not vary according to the severity of the patient's problems assessed at pre-treatment.

#### *Confidence and Training*

Although the descriptive surveys reviewed cannot be analysed statistically, there is a suggestion from studies based on Cleary, et al.,'s (2002)

questionnaire, that the perception of patients with BPD as difficult to work with and more difficult than other patients may not be dependent upon receipt of specific training regarding BPD, nor upon the confidence of professionals in their work with these patients. Respondents in three surveys estimated that they were moderately to very confident in their ability to identify (55.1%, Giannouli et al., 2009 to 77%, Cleary et al., 2002), assess (42%, Giannouli et al., 2009 to 75% James & Cowman, 2007) and manage patients with BPD (47.8% Giannouli et al., 2009, to 75%, James & Cowman, 2007). Although respondents in the Giannouli et al., (2009) study were relatively less confident in their abilities, and respondents in Hazelton et al.'s, (2006) study reported being moderately or 'only a little confident' in these areas (75.3% identification; 75.3% assessment; 84% management), there were few differences in the perceived difficulty of working with patients with BPD.

The consistency of this perception is also notable given that 32% of the respondents in the Cleary et al., (2002) study and 20% in Hazelton et al.'s, (2006) study reported having undertaken specific training regarding BPD, compared to only 4.3% and 3% in the Giannouli et al. (2009) and James and Cowman (2007) studies respectively. Hazelton et al.'s, (2006) study is particularly interesting in this regard in that the percentages summarised in Table 1 are in relation to a survey conducted at baseline, prior to the professionals undertaking training in DBT. The survey was re-administered at one month (N = 38) and again at six months (N = 24) post-DBT training. The perception of patients with BPD as moderately to very difficult to work with was

consistent across the three time points (baseline - 73.5%; 1 month - 77%; 6 months - 77.2%) as was the perception of patients with BPD as more difficult to work with than other patients (baseline - 75%; 1 month - 71.8%; 6 months - 73.9%).

### *Therapist attributes*

Based specifically on an object-relations understanding of BPD (Kernberg, 1975), studies by Rosenkrantz and Morrison (1992a, 1992b) examined the responses of 158 psychotherapists to vignettes of a 'high functioning' and a 'low functioning' patient with BPD who were presented as 'enacting' either a rewarding or a withdrawing 'object relations unit'. According to Rosenkrantz and Morrison (1992a), during enactment of a rewarding object relations unit the therapist may be perceived as 'benevolent' and 'somewhat powerful' and therapists may feel 'needed' and 'useful'. Conversely, the withdrawing object relations unit may be associated with perceptions of the therapist as 'critical' and 'punishing' and therapists 'feeling negatively about themselves' and 'questioning their competence'. One study indicated that overall, the low functioning patient and patients enacting the withdrawing unit were evaluated less positively (Rosenkrantz and Morrison, 1992b). However a second study indicated that 'high boundary' therapists (with a preference for clear boundaries) assessed using an unpublished Personal Boundary Questionnaire (Miller, 1970), evaluated themselves as well as patients enacting the withdrawing unit and the low functioning patient more positively, than 'low boundary' therapists (Rosenkrantz & Morrison, 1992a). Additionally, therapists scoring higher on

'introjective depression' (encompassing issues such as guilt, self-blame and self-criticism) were found to evaluate patients more positively than those scoring higher on 'anaclitic depression' (encompassing issues such as dependency, loneliness and fear of abandonment) assessed using a Depressive Experiences Questionnaire (Blatt, 1974).

### **Discussion**

Across 22 studies based on vignettes of hypothetical patients, professionals' self-reported experiences and one study based upon direct observation, findings suggest that working with patients with BPD elicits negative emotional responses, attitudes/perceptions and behavioural responses in professionals. There is also evidence that these responses are more pronounced in relation to patients with BPD compared to patients with other mental health problems. The most common emotion described was anger alongside feelings and emotions including, frustration, impatience, agitation, helplessness, hostility, hopelessness, inadequacy, feeling overwhelmed, on guard and rejected. Patients with BPD were perceived to be difficult to work with and more difficult than other patients, more dangerous than patients with schizophrenia and depression, to be manipulative, nuisances, attention-seeking, intimidating/threatening and to have the propensity to divide staff groups. Similarly, observed and self-reported behavioural responses were generally negative. Verbal responses categorised as 'impervious' and 'indifferent' and responses that belittled or contradicted the patient were described and some therapists judged their responses to patients with BPD to be more negative than

toward other patients. On a more positive note there was an indication, particularly in some of the qualitative data, that negative emotions and perceptions could co-exist alongside empathy, by expectations of a positive outcome and by an interest in working with these patients that involved a sense of curiosity, excitement and gladness.

These findings need to be considered in the context of the methodological quality of the studies reviewed. The quantitative studies were mainly survey-based. The single cohort surveys based on Clearly et al.'s (2002) questionnaire (Giannouli et al., 2009; Hazelton, et al., 2006; & James & Cowman, 2007) had a broader remit than the present review and hence the relevant information identified lacked specificity. Although more detailed information was gained in the single cohort surveys conducted by Deans & Meocevic (2006) and Bodner et al. (2011), the questionnaires used did not have established psychometric characteristics (Deans & Meocevic, 2006), or analyses were potentially under-powered due to small sample sizes (Bodner et al., 2011). The two pilot studies by Miller et al. (2011a, 2011b) employed a repeated measures design, which yielded much richer data, and also included, for the first time, physiological measurements. However, data came from only six therapists, so the findings should be considered tentative. Additionally, as the studies were designed to examine associations between physiological markers of stress and the provision of psychotherapy to patients with BPD features, no causal inferences can be drawn from these studies.



The mixed cohort studies were also survey-based and generally made use of robust measures. Psychometric characteristics of measures were typically reported, and tended to be at acceptable levels (e.g., Gallop et al., 1989, Markham, 2003, McIntyre & Schwartz, 1998). However, studies tended to rely on small sample sizes (e.g. Bourke & Greenyer, 2010; Fraser & Gallop, 1993; Forsyth, 2007; Rossberg et al., 2007), making it more difficult to gauge the strength of the findings and to extrapolate from the studies. The qualitative studies allow, by design, new and interesting dimensions to emerge, as was the case in the present review. Although methodologically more flexible than quantitative studies, some variation was noted in methodological quality, mainly with respect to the match between sample size and method used. For example, in Nehls's (2000) interpretative phenomenological analysis, the sample of 17 appears rather large to allow the levels of fine-grained analysis typical of the best IPA studies (Smith, 2011). In the case of Bergman and Eckerdal's (2000) grounded theory study, it was difficult to estimate the appropriateness of the sample size as the authors did not discuss how the principle of saturation was applied in their study. In addition, the qualitative studies employed different methodologies in response to different research questions, thus making direct comparisons of methodology and findings more difficult.

However, the consistency of professionals' responses is notable given that the studies reviewed took place in different countries across the world. This consistency is also interesting in view of the varied professional roles of participants. Participants included nurses working in in-patient settings where

contact with patients may be frequent and intense although usually of shorter duration than their counterparts in community settings, through to medical professionals who may have less frequent contact with patients. Other studies focused on the experiences of professionals from a range of backgrounds involved in what might be regarded as a more in-depth psychotherapeutic relationship with patients with BPD. It would appear that the reactions and responses elicited in professionals are not dependent upon the type, duration, depth or intensity of contact with these patients. Although intervention studies report positive attitudinal change following education and training regarding BPD (Krawitz, 2004; Miller & Davenport, 1996; Treloar & Lewis, 2008), the present review would suggest that work with these patients requires an on-going need to manage difficult emotional responses regardless of knowledge and experience of the disorder and of the work context. This finding lends support to Treloar and Lewis's (2008) suggestion that regular access to training is required in order for improvements in attitudes to be maintained. Additionally, although Hazelton et al. (2006) found an overall shift in attitudes, with greater optimism and understanding of clients diagnosed with BPD from pre to post-DBT training, perceptions of the work as difficult were consistent over time.

The studies reviewed provide a mixed picture regarding possible factors associated with the emotional responses, attitudes, and behaviour of professionals toward patients with BPD. Findings are inconsistent in relation to the influence of age, seniority, gender of professionals, therapeutic approach employed and severity of patient problems upon attitudes and responses. Two

studies found some differences on the basis of profession (Bodner, et al., 2011; Markham, 2003) and Rosenkrantz and Morrison's (1992a) study raises the possibility that therapist personal characteristics may influence how they evaluate themselves and their patients with BPD. The lack of consistency in this regard is perhaps unsurprising given the variability in methodologies used.

Although research indicates that working with patients with BPD elicits mostly negative responses and attitudes in professionals, there is a need for a greater empirical understanding regarding what precipitates these responses. Authors of therapeutic approaches to working with patients with BPD have considered this question theoretically from a psychodynamic (Bateman & Fonagy, 2004) and a behavioural (Linehan, 1993) perspective. Qualitative studies also provide insight into particular aspects of the work that might precipitate negative responses. For example, the propensity of patients with BPD to engage in deliberate self-harm, attempt suicide and the requirement for professionals to manage this risk, is often viewed as a particularly difficult aspect of the work, and was mentioned by participants in Bergman and Eckerdal's (2000) and Woollaston and Hixenbaugh's (2008) qualitative studies. Additionally, Bodner, et al., (2011) found that professionals' perception of suicidal tendencies in patients with BPD accounted for 24.5% of the variance in relation to the experience of negative emotions and 27.3% of the variance in relation to perceived difficulties in the treatment of patients with BPD. Additionally, Ma et al.'s, (2009) qualitative study illustrates the key role that support from the wider mental health team has on nursing practices, experiences and expectations

regarding treatment outcome. Further research examining the precipitants to these attitudes and responses is vitally important in improving the care of patients with BPD and in considering how best to support professionals in the challenges of their work.

There is also a need to move toward a greater understanding of how the behaviour of patients with BPD and the reactions and responses of professionals inter-relate and impact upon patients and professionals alike. Although some studies focused on behavioural responses, further research examining the influence of negative emotions and attitudes upon the behaviour of professionals in their day-to-day work with patients with BPD is indicated. The literature is also sparse regarding the possible association between negative emotional, attitudinal and behavioural responses, on levels of stress and burnout in professionals. Miller et al.'s (2011a, 2011b) pilot studies suggest that more extensive research measuring physiological markers of stress alongside self-reported well-being and burnout will be a helpful line of enquiry.

Research regarding staff responses to challenging behaviour in the intellectual disability (ID) field may prove useful in guiding future research. In a review, Hastings (2005) reported that staff tend to avoid situations in which high levels of challenging behaviour occur and that the amount of attention staff provide varies according to the function of the challenging behaviour. Staff have been found to provide more attention when challenging behaviour is maintained by attention rather than by escape. Despite differences in the nature of the

'challenge' in working with individuals with ID and patients with BPD, it is likely that behaviours, including verbal behaviours, on the part of patients with BPD are also maintained by factors such as maintaining contact, escape or avoidance. Although psychotherapeutic approaches such as DBT (Linehan, 1993) analyse the behaviour of patients with BPD in this way, a greater understanding of the links between the behaviour of professionals and of patients with BPD would be helpful to staff working in different contexts, and particularly to nursing staff in the frontline of patient care. Research in the ID field has also moved forward in understanding the potential link between negative emotion, staff stress and burnout. For example, a recent study by Mills and Rose (2011) confirmed that negative emotions mediated the relationship between challenging behaviour and burnout in a sample of 78 direct care staff working in residential settings with adults with ID.

In the present review, one study by Rosenkrantz and Morrison (1992a) focused upon therapist personality characteristics and their influence on therapists' perceptions of themselves and of patients with BPD. In the ID field, Chung and Harding (2009) found that after controlling for challenging behaviour, greater neuroticism was associated with greater emotional exhaustion, less personal accomplishment and poorer psychological well-being assessed using the Maslach Burnout Inventory (Maslach & Jackson, 1986). Greater extraversion was associated with less emotional exhaustion and a greater sense of personal accomplishment while conscientiousness was associated with greater depersonalisation. Additionally, Hastings and Brown (2002a) found that

emotion-focused coping strategies were associated with a greater degree of burnout when staff were exposed to high rates of children's challenging behaviour and Hastings and Brown (2002b) found that negative emotional reactions in staff were related to beliefs regarding their ability to deal with challenging behaviour effectively. These studies suggest that examining relationships between the attributes of professionals, their responses to patients with BPD, and levels of stress, burnout and well-being, may be a fruitful area for research.

In summary, this review indicates that working with patients with BPD elicits negative emotional responses, attitudes, perceptions and behavioural responses in mental health professionals working in a variety of professional roles, regardless of the depth of relationship with these patients. Responses are more negative toward patients with BPD in comparison to patients diagnosed with depression and schizophrenia and patients with BPD are consistently perceived as more difficult to work with. However there is also evidence, particularly from qualitative studies, that responses are not exclusively negative and may co-exist alongside empathy, hope and interest in working with these patients. A greater empirical understanding of what precipitates these responses, how they influence the behaviour of professionals, and how the behaviour of professionals and patients with BPD inter-relate is required. Examining characteristics of professionals that may have a bearing on emotional, behavioural and attitudinal responses, well-being and burnout, may also be fruitful. Additionally, given the suggestion that support from colleagues

may be a key factor influencing attitudes and responses, exploration of the experiences of professionals using therapeutic approaches that incorporate mechanisms of support for professionals is indicated.

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Natarajan, R., & Chaturvedi, R. (1983). *Geology of the Indian Ocean* . Hartford, CT: University of Hartford Press. Heslen, J., Carpenter, K., Moriber, H., & Milsop, A. (1983). *Computers in the business world* . Hartford, CT: Capital Press. and so on. The abbreviation *et al.* is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the initial citation, when all are listed) and in all parenthetical citations of material with six or more authors.

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**The experiences of Dialectical Behaviour Therapists in  
their work with young people with features of  
Borderline Personality Disorder: 'A roller coaster ride'**

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## **Abstract**

In the context of research evidence to suggest that working with adult patients with Borderline Personality Disorder (BPD) elicits negative responses in mental health professionals, the present study set out to examine this phenomenon in professionals applying Dialectical Behaviour Therapy (DBT) to young people with BPD features. Interpretative Phenomenological Analysis (IPA) was employed to conduct an in-depth examination of the lived experience of DBT therapists in their work with these young people. Analysis yielded a super-ordinate theme of '*the impact of the therapy on the therapist*' containing five sub-themes: (i) *working at the extremes - the highs and the lows* (ii) *instability, unpredictability and rapidity of change* (iii) *challenges to the therapist's self-efficacy* (iv) *the emotional demands of the work* and (v) *dealing with the turbulence*. The findings suggested that the emotional responses described were consistent with those reported in studies of professionals working with adults with BPD. However, based on current conceptualisations of BPD, the most striking finding was that the emotional responses elicited in the therapists appeared to be resonant with the experience of their patients. This finding was considered theoretically from a behavioural and a psychodynamic perspective. The study concluded that further qualitative analysis of the experience of professionals working with patients with other mental health problems would be helpful in making sense of this apparent resonance and that further research into mechanisms of support for professionals working with young people with BPD features is warranted.

## **Key Practitioner Message**

- DBT therapists working with young people with features of BPD are likely to experience the work as challenging and emotionally demanding.
- The emotional responses of DBT therapists working with young people are consistent with those reported in quantitative and qualitative studies of mental health professionals working with adult patients with BPD.
- The emotional responses elicited in DBT therapists appeared to be resonant with aspects of the experience of their patients.

**Keywords:** Borderline Personality Disorder, BPD, Adolescents, Dialectical Behaviour Therapy, DBT, Interpretative Phenomenological Analysis, Qualitative methodology

## **Introduction**

Mental health professionals perceive their work with adults diagnosed with Borderline Personality Disorder (BPD) to be particularly difficult and more difficult than working with patients with other mental health problems (Cleary, Siegfried & Walter, 2002; Giannouli, Perogamvros, Berk, Svigos & Vaslamatzis, 2009; Hazelton, Rossiter & Milner, 2006; & James & Cowman, 2007). Evidence suggests that working with these patients elicits a range of negative emotional, behavioural and attitudinal responses including anger and frustration (Bodner, Cohen-Fridel & Iancu, 2011), feelings of inadequacy (Woollaston & Hixenbaugh, 2008), a tendency to belittle or contradict patients with BPD (Gallop, Lancee & Garfinkel, 1989) and the perception that they are manipulative (Deans & Meocevic, 2006).

Controversy surrounds the diagnosis of BPD during adolescence and hence the literature is sparse regarding the experiences of professionals working with young people with BPD. Although it is possible to apply most personality disorder categories during childhood or adolescence, DSM-IV describes it as applicable in 'relatively unusual instances' (DSM-IV-TR p.687). However, in the UK, the National Institute for Health and Clinical Excellence (NICE) Guideline (2009) regarding the treatment and management of BPD, reports that prevalence rates in community populations of under 18s range from 0.9% to 3% and when BPD symptoms rather than full diagnostic criteria are used, the rate rises to between 10.8% and 14% (National Collaborating Centre for Mental Health, 2009). The Guideline also reports that considerably higher rates have

been found in adolescent inpatient (49%) and outpatient (11-22%) samples. Additionally, in a longitudinal, prospective study Carlson, Egeland & Sroufe (2009) found that in a group identified as being at high risk for the development of BPD, disturbances in areas including emotion regulation, behaviour, interpersonal relationships and self-representations were evident in early adolescence and were related to borderline personality symptoms assessed in adulthood.

There is on-going debate regarding the validity and stability of the diagnosis of BPD in adolescent populations. According to Tackett, Bagnis, Oltmanns and Krueger (2009) there is evidence to suggest moderate stability of PD symptoms beginning in early adolescence comparable to the stability of symptoms during adulthood. In a review of the empirical literature Miller, Muehlenkamp and Jacobson (2008) conclude that “prevalence, reliability and validity of BPD in adolescent samples is adequate and largely comparable to those found among adult samples” (p.978).

Therefore, irrespective of whether a formal diagnosis is given, it is likely that mental health professionals will encounter young people with difficulties consistent with BPD. Given the evidence of negative responses in mental health professionals toward adults with BPD, concerns regarding possible stigmatisation of these patients by professionals (Aviram, Brodsky & Stanley, 2006) and patient reports of negative experiences of mental health care (Rogers & Dunne, 2011), it is important to understand the responses of

professionals to young people with BPD features including deliberate self-harm (DSH). When Law, Rostill-Brookes and Goodman (2009) presented a group of final-year health-care and non-health-care students with case vignettes describing DSH in an adolescent female, they found that perceived responsibility for the self-harm was associated with anger and perceptions of risk were associated with anxiety in the students studied. Anger was associated with the self-harm being viewed as manipulative and both anger and anxiety were associated with less willingness to help. However, in contrast to the adult literature, one questionnaire survey found low levels of negativity overall among different professional groups toward DSH in adolescents (Crawford, Geraghty, Street & Simonoff, 2003). This finding was interpreted in relation to the close liaison between the paediatric and Child and Adolescent Mental Health Services (CAMHS) in the geographical area studied.

One of the concluding recommendations of the NICE Guideline report is that young people diagnosed with BPD or presenting with BPD features should be provided with the same range of treatments recommended for adults with BPD albeit in a CAMHS setting (National Collaborating Centre for Mental Health, 2009, p. 377). Dialectical Behaviour Therapy (DBT; Linehan, 1993) is one such empirically supported treatment for adults with BPD that has begun to be applied to young people with BPD features. Preliminary studies of the application of DBT to adolescent in-patients (Katz, Cox, Gunasekara, & Miller, 2004; McDonnell et al., 2008) and outpatients (James, Taylor, Winmill & Alfoadari, 2008; Woodberry & Popenoe, 2008) report promising results.



Therefore, in light of the evidence of negative emotional, behavioural and attitudinal responses in mental health professionals toward adults with BPD and the lack of research relating to responses toward young people with similar problems, the present study investigates this phenomenon in DBT therapists working with young people with BPD features. The study reported here, employing qualitative methodology, focuses specifically on the lived experience of DBT therapists within the therapeutic relationship. The therapists' experience of practising DBT and its application to young people with BPD features is the focus of an article in preparation.

## **Method**

### *Qualitative Perspective*

Interpretative phenomenological analysis (IPA: Smith, Flowers & Larkin, 2009)

was chosen as the most appropriate qualitative methodology given that an in-depth exploration of the personal experience of DBT therapists was required.

IPA is idiographic in its detailed consideration of individual accounts of a given phenomenon in a particular context. The depth of analysis required means that

IPA studies are conducted on small, homogenous purposively-drawn samples.

IPA is grounded in participants' descriptions of their experience and

interpretative in the researcher's engagement in a "double hermeneutic"

whereby "the researcher is trying to make sense of the participant trying to make sense of their personal and social world" (Smith, 2004, p. 40).

*Participants*

A total of eight DBT therapists (six women and two men) took part in the study.

To be eligible to participate in the study participants were required to have at least two years experience of practicing DBT in their work with young people with BPD features as part of a DBT team. DBT is a structured therapy with clear guidelines regarding therapist practice, and adherence to the model is facilitated through a regular consultation group. As a result, no upper limit was placed on the years of experience participants had as DBT practitioners.

Participants had a range of two to 13 years experience of using DBT as part of a DBT team. All participants had undertaken the same foundational training in DBT and all regularly attended an on-going DBT networking event on a quarterly basis. All participants worked for the same service provider in the UK, seven within Child and Adolescent Mental Health Services and one in an in-patient adolescent service. Participants were asked to estimate the percentage of young people with BPD features on their caseload at any one time and estimates ranged from 20-70%.

Once ethical approval for the study had been granted by the relevant National Health Service Research Ethics Committee, participants were recruited from those attending a local DBT networking event at a British University. The first author attended the commencement of two networking events to outline the study and provide information sheets (See Appendix I, p. 198) and consent forms (See Appendix II, p. 205). Participants opted-in to the study by returning a consent form together with contact details in a pre-paid envelope to the first

author (RR). Following the first networking event, six participants were recruited and two were recruited following the second.

*Procedure*

Individual interviews with each participant were conducted at the participant's place of work by the first author (RR) using a semi-structured schedule designed by the first author in consultation with the third author (JH) (See Appendix III, p. 208). IPA interviews are usually structured to ask general questions followed by gentle probing. However in the present study, the interview schedule was designed to begin with a specific focus. Participants were first asked to describe a rewarding or positive experience they had encountered in their work with one of their patients; subsequently they were asked to describe a difficult or challenging experience. Follow up questions focused on how these experiences made the participant feel and the ways in which DBT had been helpful and/or unhelpful to them in these particular situations. This structure was chosen to maximise participants' reconnection at an affective and cognitive level with their experiences within the therapeutic relationship. It also ensured that accounts were less likely to concentrate on conceptual and theoretical aspects of DBT so that resulting narratives were more 'alive', and as close to the participant's lived experience as possible. Subsequent questions were more general in focus and participants were asked to reflect on the sense they made of the problems of these young people and their experiences of using DBT in this context. The interviews ranged from 28-54 minutes.

*Reflexivity*

The first author (RR) identified herself at interview as someone with considerable clinical experience working with adults presenting with BPD and BPD features, who had some knowledge of, but who had not undertaken formal training in DBT. Although the first author did not work in the same service as any of the participants, she was known to some of them professionally in relation to her work within clinical psychology training. The first author's experience of conducting the interviews was that there was little to discriminate those conducted with known versus previously unknown participants and that all participants were open and reflective in their answers to the interview questions.

As the second author (MS) is a UK national DBT trainer and had been involved in the training of many of the participants, the first author remained the only researcher aware of the identity of the participants. Participants were informed of this aspect of the protocol in the information sheet given at recruitment. No aspect of the study involved evaluating DBT training provided by the second author and as all interviews and primary analysis were conducted by the first author, the potential for bias was considered to be low. The third author (JH) had no connections with the participants or with the local DBT training community and worked in a separate University department.

*Data Analysis*

Interviews were transcribed and analysed by the first author (RR) based on the recommendations outlined in Smith, Flowers and Larkin (2009). Transcribed

interviews were read several times highlighting significant points, summarising responses, making connections and identifying emerging themes. In an iterative process, themes that emerged from the first transcripts analysed were used to guide the analysis and interpretation of subsequent transcripts (See Appendix IV, p. 210 – excerpt sample analysis). A summary of the findings was sent to the first, fourth and eighth participant interviewed who were invited to comment on the credibility of the analysis as recommended by Bradbury-Jones, Irvine and Sambrook, (2010) (See Appendix V, p. 223). Comments were received from two of these participants both of whom reported that the findings strongly resonated with their personal experience (See Appendix VI, p. 230). The interpretations offered by the first author were also checked by the second author (MS) who has particular expertise in DBT and by the third author (JH) who has particular expertise in qualitative methodology.

## **Findings**

A number of themes emerged from the analysis relating to DBT therapists' experiences of their work with young people with BPD features and their experience of practising DBT in this context. The present article focuses on the themes connected to the super-ordinate theme of '*the impact of the therapy on the therapist*'. This super-ordinate theme contained five themes: (i) *working at the extremes - the highs and the lows* (ii) *instability, unpredictability and rapidity of change* (iii) *challenges to the therapist's self-efficacy* (iv) *the emotional demands of the work* and (v) *dealing with the turbulence*. The themes are described and illustrated with excerpts from the transcribed interviews (See

Appendix VII, p. 233, - complete quotes per theme). The names of participants have been changed to maintain anonymity. The excerpts have been grammatically corrected to enhance readability, and the following transcription conventions are used:

*Italicised text* = words emphasised by the speaker

(...) = words omitted to shorten the quote

[text] = explanatory information included by the author

The super-ordinate theme of '*the impact of the therapy on the therapist*' was illustrated vividly by metaphors used by Nick and Beth:

“Ahmm you know this thing about setting a tent up in a hurricane (...) it's very much that way.”

“So yeh, I could have some sort of feelings of bafflement and (...) actually it would be a bit bizarre if I didn't because it was chaotic and whirlpoolly and messy.”

These metaphors provided an insight into the powerful way that these patients impacted upon the therapist. A hurricane and a whirlpool are metaphors of our frailty and the likely fear, instability, disorientation, and powerlessness that may arise in any who encounter such a force.

In addition, having just reflected on some of the ways in which DBT helped him in his work with these young people, Tom indicated that his experience with them was qualitatively different to his work with other patients. He also illustrated the depth to which these patients entered his internal world by describing his experience at a visceral level and linking his experience to that of the patient:

“but *all* of that still doesn’t take away from the fact that to sit in a room with some of these patients sometimes *is* really, really difficult and it’s difficult in a *different* way to how it is to sit in a room with someone that’s quite low. Very often, *even now*, I will leave a session with a DBT patient *feeling* like a bit jiggled up inside, feeling a little bit like someone’s just got inside me and kind of (...) messed it up a bit and then it’ll take me a little bit of time to just kind of come back down and obviously, you know, that’s an example of their experiences, it’s just a transference thing.”

Illustrative of the overarching, super-ordinate theme, these excerpts provide a useful backdrop from which to consider the associated themes below.

**(i) Working at the extremes – the highs and the lows**

This theme is best encapsulated by Nick’s description of his work with a young woman as “a real roller coaster ride”. The metaphor of the roller coaster brings to mind intense swings of emotion from exhilaration and excitement to fear, and vividly portrays the highs and lows of the work. The language used by

participants when asked to reflect on positive or rewarding experiences illustrated the high points of the work. Megan spoke about her enjoyment of the challenges inherent in her work and of a clinical session when she and her patient were able to “celebrate” the patient’s success in averting an episode of self-harm. Roz described feeling “touched” during an emotional moment with a patient and her carer and “in touch” with their feelings, while Nick described an experience with a patient as “a joy” and his work more generally as “edifying” and “fascinating” as well as “challenging”. The high points were evident in the following excerpts from Tom and Kate:

“I felt (...) I did feel a sense of achievement. I felt, happy isn’t the right word. It was, yeh (...) it was a relief and it was an achievement I suppose.”

“I suppose just really kind of proud, kind of proud of her, proud of some of the work we’ve done.”

In contrast, the low points of the work were evident across participants in emotions including, frustration, anger, annoyance and irritation. The range of difficult emotions experienced by the DBT therapists in their work with these young people is consistent with the literature on mental health professionals’ responses toward adults diagnosed with BPD (Bodner, et al., 2011; Bourke & Grenyer, 2010; Deans & Meocevic, 2006; Woollaston & Hixenbaugh, 2008). Kate indicated that difficult feelings could arise from the outset:



“I think to begin with I was quite pessimistic about what we would be able to give this young person (...) She was presenting in a worse position than when she had first come.”

In the following quotation, Megan illustrated the low points during the therapy process:

“So I feel a little bit sort of ahmm powerless to repair or to work out with her what’s gone wrong really which feels a bit uncomfortable.”

Nick illustrated the movement between the extremes in his work with these patients most powerfully when he juxtaposed the highs and the lows:

“you can go from a sense of exhilaration and great satisfaction in the work that you’re doing and feeling positive (...) at the one end, and then at the other end it can be overwhelming and confusing and profoundly disheartening.”

Consistent with studies reporting negative attitudes and perceptions toward this patient group (Hazelton et. al. 2006 & Markham, 2003), Emma reflected on experiences from earlier in her career where young people with these difficulties were blamed for their problems or were “written off” by the professionals caring

for them. However, she indicated that amidst the challenges of the work, this remained a possibility for her as a DBT therapist:

“Well I guess there’s still temptation to slip into that sometimes. You can [think] well we’re not getting anywhere.”

**(ii) Instability, unpredictability and rapidity of change**

Participant accounts indicated that the work with these young people was unpredictable and changed rapidly. Roz highlighted this when she spoke of the transient nature of the therapy. This transient or momentary nature of their experience suggested that therapists had nothing solid or stable to hold onto in the midst of the highs and lows of the work. Becky also spoke of the momentary nature of her experience and together with Roz and Megan gave insight into the rapid shifts in the therapeutic relationship:

“with moments, I mean that’s the thing you know, moments of them saying that’s been really helpful (...) you’re the only person that’s understood me, but then the complete opposite in the next session.”

“I know that she cared about me and she liked me and she would alternate from sending me cards full of gratitude and how much I’d changed her life to telling me to fuck off and slamming a door in my face. And I’d think well which is it? And telling me none of it works anyway.”

“they’re a patient group for reasons in relation to their history (...) they split, they love you one minute, they hate you the next. They’re very punishing.”

For Roz in particular this experience of uncertainty and instability led to a lack of trust in her experience of her patients’ progress:

“I wonder whether working with these patients sometimes because progress often seems slow or steps are few and far between that it’s a bit like you’re (...) *starved* of it aren’t you, you’ve got a real hunger for *something* and then you get a peanut thrown and you think “Oh thank God something’s happened, something’s worked” (...) and you’ve got to kind of cling on to those moments (...) but then again when it goes backwards and you think oh was it just a, not a real peanut was it, just a false peanut.”

“that’s the thing when I say you get the good bits, peanuts, (...) but you don’t trust them anymore either. You start to think well what’s, what’s going on?”

While reflecting on the rapid changes that occur during therapy, Nick made sense of this in relation to the experience of his patients:

“and within, you know, a relatively short space of time and I think that that, that in a way replicates the experience of the emerging borderline individual of their own lives. It’s almost that kind of pattern.”

**(iii) Challenges to the therapist’s self-efficacy**

Faced with the on-going highs and lows and the instability and uncertainty inherent in their work with these patients, a theme across participants was the questioning of themselves and their efficacy as DBT therapists. This finding is consistent with studies reporting that therapists feel less confident in their work with adults with BPD (Bourke & Grenyer, 2010; Rossberg et al., 2007). The consistency of this theme across participants was particularly interesting given the range of experience practising DBT (range 2-13 years). For example, two participants at opposing ends of the continuum of professional and DBT experience reported feelings of failure. The powerful descriptors in the following quotations by Roz and Becky illustrated the depth to which belief in their efficacy as therapists was challenged:

“Useless (...) sometimes you think am I just rubbish at being a therapist (...) should I just do assessments instead (...) just give up trying to be a therapist because I don’t seem to be getting anywhere with people. Self-doubt, a lot of self-doubt and frustration.”

“really worried and really (...) inadequate (...). I wasn’t necessarily, doubting the model but I was doubting my own ability to do it (...) definitely reflecting on myself as inadequate or incompetent.”

Given that self-doubt and worries regarding effectiveness could be attributable to the personal characteristics of the therapist, Kate’s reflections were particularly interesting as she identified herself as someone who generally worried that she had not got things right. However she experienced this as being more prominent in her practice of DBT and pondered on whether it had something to do with the patient group:

“I worry that I haven’t got it right all the time (...) I think I’m naturally the sort of person that worries that I haven’t got it right (...) and I don’t know what it is about DBT but DBT seems to raise more of that in me (...) or perhaps it’s something about the patients...that kind of, they’re up and down (...) but I do feel it more with DBT.”

**(iv) The emotional demands of the work**

This theme was closely related to the low points of the work identified in the theme ‘*working at the extremes*’. However, in addition to the range of difficult emotions experienced, this theme illustrated the significant demands placed upon the therapists in their work with these patients. Consistent with literature indicating that professionals find their work with adult BPD patients to be more challenging than their work with other patients (Cleary et. al., 2002; James &

Cowman, 2007), participants stressed that the work was “taxing”, “emotionally challenging”, “really hard work” and that these patients “are probably one of the most difficult patient groups to work with.” Participants spoke of experiences including, “anxiety”, “worry”, “pressure”, “feeling conflicted” and “inclined toward hopelessness”. Although Kate had experienced stress in relation to learning DBT as a therapy, she specifically referred to the stress associated with her direct clinical work:

“I think initially there were frustrations with DBT (... ) I find it a hard model to get my head around (...) so I find that stressful but the thing I find more stressful now is the patients.”

Nick illustrated the emotional demands of the work vividly in the language used in the following excerpt:

“occasions when you’re feeling quite overwhelmed (...) just so much to deal with and frankly, trying to keep pace and (...) when she was very low, it was ooaahh, it was quite draining.

DBT places difficulties with emotion regulation at the centre of its understanding of the behaviour of individuals diagnosed with BPD. It was therefore of particular interest to hear Tom and Megan reflect on the challenge in regulating their own emotions in relation to their work with these young people:

“I got really dysregulated myself about all this (...) they weren’t kind of giving her a break and I (...) *struggled* to not get angry in meetings very often.”

“I felt really dysregulated myself and really sort of churned up you know, in terms of what went on (...) I felt a bit helpless and a bit powerless and a bit ahmm useless, the truth be known (...) yeh in terms of, you know, total rejection I suppose.”

**(v) Dealing with the turbulence**

In the context of the extremes of emotion experienced, the uncertainty and rapid shifts in the therapy and the significant emotional demands of the work, this theme centred on the different ways in which participants responded to the challenges of their work. Roz spoke of the amount of time after sessions that these patients pervaded her thinking, “trying to make sense of them”. Perhaps because of these demands, not just within the therapy but afterwards, Beth emphasised the need for self-care and not having too many of these young people on her caseload “because they’re a high need group defined”. Megan spoke of needing a team of people around to help her consider her own responses to her patients due to the “very strong issues of transference that these young people bring to the therapeutic experience”. Nick and Megan spoke of the degree of effort they put into their work with these young people:

“knowing that I’m going to have to (...) use a great deal of myself in that session, perhaps more than I would ordinarily because of the challenges I’m being presented with.”

“you’re pulling at all (...) your resources in order to help them.”

Tom talked about the importance of being able to communicate to the patient that he could “contain” what they might bring to therapy and of:

“being able to instill a sense of strength in me so that they can kind of lean on you a little bit or not try and protect you I guess, from how destructive they think that they are.”

Emma admitted to a conflict due to the demands of the work with a part of her looking forward to therapy ending:

“I was torn between wanting to (...) really stick with it (...) but also feeling like actually part of you (...) is looking forward to an ending because it’s difficult to carry this all the time *and* that has to happen at some point.”

Roz indicated that therapists have limits in the context of the demanding nature of the work when she described feeling “quite selfish” when others spoke of “caring too much” and being “worried” about patients and when she explained that for her sometimes:



“it boils down to self-preservation, preservation of self-worth so if I’m worried about them I get to the point where I’m worried that I’ve done everything I should have done and I’m not going to (...) get found out to have been unprofessional (...) I wouldn’t say, it’s not that I *don’t* care about them but actually maybe you can’t care about them all, *that* much.”

### **Discussion**

The present study set out to explore the lived experience of DBT therapists working with young people with BPD features including DSH. Adopting an interpretative phenomenological approach permitted us to gain a deep insight into the therapists’ experience of their work. The findings highlight the extent of *the impact of the therapy on the therapist*. One of the most salient findings from this study is the considerable overlap between the emotional responses of the DBT therapists in their work with young people with BPD features and those of professionals working with adults diagnosed with BPD. Therefore, despite the controversy regarding the appropriateness of the diagnosis of BPD during adolescence, this study suggests that the work is as emotionally demanding for professionals working therapeutically with young people with BPD features, as it is for their counterparts in adult services.

However, what is perhaps most striking about the DBT therapists’ accounts of their work is the apparent similarity between their experiences and what the young people they are working with might be predicted to experience on the

basis of current conceptualisations of BPD. One participant's metaphor of a roller coaster ride represented the rapid swings of emotion that the therapists experienced in their work with these young people. Positive feelings and emotions including joy, a sense of achievement, fascination and pride were experienced alongside more difficult emotions including anger, irritation, frustration, pessimism, powerlessness and hopelessness. Therapists reported feeling overwhelmed and finding it difficult to regulate their emotional experience. There was an inherent instability, unpredictability and experience of transience in the therapeutic relationship that led one participant to find it difficult to trust her experience. Therapists described self-doubt, and experienced feelings including worry, failure, inadequacy, incompetency and uselessness that resulted in one participant sometimes contemplating giving up her work as a DBT therapist. There are interesting parallels between these experiences and the patterns of instability in affect, interpersonal relationships and sense of self that characterise BPD (American Psychiatric Association, 2000). Two participants specifically, made sense of their experience as similar to or in the words of one participant, as "replicating" the experience of the patient.

There are parallels between participant experiences in this study and those reported in a qualitative study examining BPD patients' perceptions of their suffering (Perseius, Ekdahl, Åsberg, & Samuelsson, 2005). Interviews with 10 women diagnosed with BPD were analysed alongside biographical material provided by five of the participants. The emotional experience of the women

studied bears striking resemblance to the difficult emotional experiences of the DBT therapists in this study. These women experienced "...anxiety, feelings of emptiness, hopelessness, meaninglessness, anger and powerlessness..." (p. 163). Additionally, the metaphors in the present study of a whirlpool and "putting up a tent in a hurricane" are resonant with the imagery of "climbing this narrow path with precipices on either side" (p. 163) and "a balance act on a slack wire over a volcano" (p. 164) reported by the women in the Perseus et al., (2005) study.

Interestingly, in making sense of their experiences, two participants made reference to the concept of transference, which has been traditionally viewed as the patient's projections onto the therapist. From a psychodynamic perspective individuals with BPD are believed to use defense mechanisms including projective identification and splitting (McHenry, 1994; Rosenkrantz & Morrison, 1992; Zanarini, Weingeroff & Frankenburg, 2009). Recent conceptualisations of projective identification emphasise its communicative function and according to Maroda (1995) "...most therapists believe that a patient tries to communicate disavowed affect so that the therapist can experience it, understand it, and find a way to live with it..."(p. 234). Fonagy and Luyten (2009) argue that borderline personality functioning is in part a consequence of "...the constant pressure for externalization of internal states (projective identification), which we conceive of as the reexternalization of disorganized intolerably painful self-states..." (p. 1357). From this theoretical perspective, the intense and rapidly shifting emotional experience of the DBT therapists studied may be understood in

relation to the propensity of their patients to “communicate disavowed affect”. Their experiences may therefore be seen as illustrative of the emotional turmoil of their patients.

The concept of splitting was mentioned explicitly by one participant (Megan) who spoke of being loved one minute and hated the next. A second participant (Roz) received expressions of gratitude closely followed by rejection and a third (Becky) reported being told that the therapy was helpful, that she was the only person who understood the patient, only to hear the opposite expressed in the next therapy session. It has been suggested that splitting is experienced by the therapist as being, “alternately praised as all good or attacked as all bad” (McHenry, 1994. p. 559). From this theoretical perspective the experiences of the therapists may be viewed as related to the tendency of their patients to vacillate between polarised views of others.

On the other hand, DBT has its roots in radical behaviourism, which classifies thoughts, feelings and emotions as ‘behaviours’ and as subject to the same governing principles as more overt behaviours. From this perspective, the emotional highs and lows and the transience and instability experienced by the therapists may be viewed as the consequences of relating to another person whose affective state and perception of events, others and themselves is subject to continual change. The resulting lack of trust described by one participant could be viewed as having been reinforced by repeated exposure to experiences that are contrary to her expectation. Similarly, the consistent

experience of self-doubt and the therapists' questioning of their self-efficacy could be regarded as consequences of the direct and/or indirect communication from the patient that the therapy does not appear to be beneficial.

Although DBT emphasises the therapist's role in shaping the behaviour of the patient it also recognises that the patient has a role in shaping the behaviour of the therapist and that therapists as well as their patients can engage in "therapy-interfering behaviours". According to Swales and Heard (2009) "...these behaviours may result from some combination of the therapist's personal issues, clinical skills deficits, strong emotions or cognitive distortions during the session, or contingencies imposed by the system" (p. 147).

Therapists are therefore encouraged to apply the principles of the treatment to themselves as well as to their patients via a DBT consultation team. (Linehan, 1993; Swales & Heard, 2009).

Therefore, although both psychodynamic and behavioural perspectives would suggest that the experiences of the DBT therapists studied could be attributable in part to the therapist and the therapists' life experience and in part to the patient, the behavioural interpretation would not assume the involvement of unconscious mental processes on the part of the patient. Indeed even psychoanalytic writers have questioned the view "...that the analyst's emotional reactions are a *mirror* of some aspect of the patient's inner world, namely of internal objects, rather than reactions *elicited* by the patient" (Eagle, 2000, p. 33). Concern has been expressed that this interpretation may result in too much

emphasis being placed on the patient and not enough on the therapist's reactions as potential barriers to therapeutic progress (Eagle, 2000; Hayes, 2004).

The literature suggests that professionals respond differently to patients diagnosed with BPD than to those with depression and/or schizophrenia (Bourke & Greenyer, 2010; Fraser & Gallop, 1993; Markham, 2003; McIntyre & Schwartz, 1998). Therefore further qualitative research examining therapists' experiences of their work with patients suffering from problems such as depression and anxiety, could help to shed light on whether there is something specific to working with patients with BPD features that challenges therapists' self-efficacy and elicits feelings and emotions that are resonant with the experience of the patient.

The experiences of the DBT therapists in this study, illustrate how demanding the therapy can be for the therapist. Therapists reacted in different ways to these demands by trying to become stronger internally, trying harder and using more of their own resources, spending time attempting to make sense of their patients, looking forward to the ending of therapy, and ultimately for one therapist, a focus on self-preservation. The experiences of the participants in this study suggest that DBT therapists are just as likely as other professionals to experience their work with this patient group as challenging and demanding. The range of therapist experience, from two to 13 years, in practising DBT would suggest that the experience of the work as demanding and challenging to

the therapist's self-efficacy is not dependent upon years of experience. Further qualitative analysis of DBT therapists' experiences of practising DBT will be useful in exploring its potential to support therapists in dealing with the demands of the work. The DBT therapists interviewed in this study were also questioned regarding their experience of practising DBT, the analysis of which is the focus of an article in preparation.

Further qualitative research examining the experiences of DBT therapists working with young people and with adults with BPD would be helpful in considering the commonality of the experiences described. It would also be useful to ask therapists who work with patients with BPD as well as patients with other mental health problems to reflect on areas of convergence and divergence in their experience of working therapeutically with a broader range of their patients. Additionally, quantitative studies of inexperienced and experienced DBT therapists utilising standardised measures of constructs such as stress, burnout, well-being and job satisfaction would provide a different perspective on the demands of the therapy on the therapist.

In summary, the present study examined the lived experience of DBT therapists in their work with young people with BPD features including DSH. The emotional experiences described by the therapists were consistent with those reported in studies of professionals working with adults with BPD. The most striking finding was the apparent similarity between aspects of the emotional experience of the therapists and what the young people they are working with

may be predicted to experience based on our understanding of BPD. The study also suggests that DBT therapists are as likely as other professionals working with patients with BPD to experience their work as challenging and demanding. Further investigation into mechanisms of support for professionals working with young people with BPD features is warranted. Additionally, further qualitative analysis of professionals working with patients with other mental health problems would be helpful in ascertaining whether there is something specific to working with patients with BPD that elicits emotional responses in the therapist that are resonant with the experience of the patient.

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## **Section 3: Contributions to Theory and Clinical Practice**

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## **Introduction**

*“And also [its] about finding compassion...there are times...where you’re feeling worn out and you’re inclined towards hopelessness and maybe...judgements are creeping in...and just trying to...re-attach to the compassion.” (Nick)*

In consolidating the information gleaned from an examination of the existing literature together with information obtained from participants in my own study, I found myself to be rather alarmed by the array of negative responses to adults and young people with BPD/BPD features. Although the qualitative studies in the literature review and my own qualitative analysis of DBT therapists’ experiences indicated that the negative responses of professionals could co-exist with positive responses such as joy, fascination, empathy and interest, this did not detract from the rather shocking experience of seeing the range of negative responses listed in the text. Working in adult mental health for nearly 20 years, bearing witness to negative responses in other professionals and having experienced a range of both positive and negative responses in myself, I had not anticipated being shocked or surprised by what I might find. This reaction highlights for me, the vital importance of understanding the mechanisms by which these responses are elicited and supporting professionals to manage their responses in order to minimise harm to patients and professionals alike.

In the literature review I suggest that not much progress has been made in understanding what factors may contribute to the negative responses toward

these patients. For example, given the risk issues that professionals are required to manage in their work with these patients and the high suicide rates reported in this clinical population, it would be helpful to examine the extent to which negative responses may be related to this aspect of clinical practice.

Bodner, Cohen-Fridel and Iancu's (2011) finding that the perception of suicidal tendencies accounted for 24.5% of the variance in relation to negative emotion and 27.3% of the variance in relation to perceived difficulties in the treatment of patients with BPD, suggests that it would be profitable to explore this area further. In considering the research regarding staff responses to challenging behaviour in individuals with an ID, I also suggest that an examination of therapists' attributes that could have a bearing on responses to these patients may be helpful in moving the research in this area forward. However in this paper I would like to explore the possible interpretations of the findings of the empirical paper in greater depth and consider the implications for clinical practice.

### **Theoretical Considerations**

In the discussion section of the empirical paper I suggest that the seeming resonance between the therapists' experiences and aspects of their patients' experiences may be interpreted from two theoretical standpoints. At one level this may seem to be a rather academic point, lacking in practical relevance. However in this section, by conducting a more in-depth exploration of these two theoretical perspectives, I hope to lay the foundations for an argument that the theoretical interpretation of the findings, together with the language used to

describe the phenomenon observed, may have an important bearing on clinical and professional practice.

### **Psychodynamic Theory Divided**

*“...and obviously you know...that’s an example of their experience, it’s just a transference thing” (Tom)*

The terms transference and countertransference were used by Freud to describe particular processes within a particular context that is, between psychoanalyst and analysand in the process of psychoanalysis. Since then the terms have been used more widely by therapists of different persuasions to describe the processes that unfold between therapist and patient, and even to describe processes unfolding between professionals and patients outside a psychotherapy context. For example, in a study by Holmqvist and Armelius (2006) examining the associations between staff members’ feelings toward their patients and treatment outcome, the study participants (psychiatric nurses and nursing ‘aides’) were reported to rarely conduct formal psychotherapy. Yet, the findings of the study were conceptualised in terms of countertransference, and the authors concluded that they could ‘tentatively describe a general model for the clinical use of counter-transference based on the findings of this study’ (p. 581).

In view of its long history and varied usage, it is perhaps hardly surprising that the concept of countertransference continues to be difficult to define. The

classical view of countertransference as an 'impediment' to therapy in the form of the therapist's unresolved, unconscious conflicts, activated by the patient's transference, can be contrasted with later re-conceptualisations as the therapist's complete emotional response to the patient. In this latter 'totalistic' definition of countertransference the therapist's response is seen as an invaluable source of information about the patient, and the communicative nature of the phenomenon is emphasised (Eagle 2000; Hayes 2004).

Empirical studies do not appear to have helped clarify the defining features of countertransference. For example, Betan, Heim, Conklin and Westen (2005) factor analysed a Countertransference Questionnaire based on the cognitive, emotional and behavioural responses of 181 psychiatrists and psychologists, of differing theoretical persuasions, toward one of their patients. On the basis of their findings the authors conclude, "...patients not only elicit idiosyncratic responses from particular clinicians (based on the clinician's history and the interaction of the patient's and the clinician's dynamics) but also elicit what we might call average expectable countertransference responses, which likely resemble responses by other significant people in the patient's life" (p. 895). This study appears to support a totalistic definition of countertransference and emphasises its communicative function. Conversely, in a paper summarising a series of empirical studies of countertransference, some of which included assessment of therapist 'blind-spots' and their responses when patients touched on these areas of conflict, Hayes (2004) proposes "...that countertransference be conceptualized as therapist reactions that stem from areas of

personal conflict within the therapist” (p. 31). Although more akin to Freud’s original conceptualisation of countertransference, Hayes (2004) suggests, “[t]his definition...does not require that therapist conflicts be unresolved. Rather, it allows for the possibility that countertransference might also arise from therapist issues or conflicts that are partially resolved” (p. 31). Psychodynamic theorists therefore appear to be divided as to whether the reactions and responses of the therapist within the therapeutic relationship have their origins in the clinical material of the patient or in the conflicts of the therapist.

### **Therapist responses and patient communication: A Behavioural Perspective**

*“oftentimes you don’t...get the full reality of how profoundly dysfunctional some of these families are. And then gradually over time it becomes increasingly apparent...and you think to yourself, Christ, Christ, Christ! I mean the truth is, you’re [the patient] remarkably intact and remarkably resilient the more that I come to understand and know your family...well I mean...severe borderline parents, basically, on occasion...” (Nick)*

At first sight it might appear that psychodynamic and behavioural theories have little in common. However I would like to suggest that on closer inspection, the conceptualisation of countertransference as a communicative device, in which the patient unconsciously illustrates something to the therapist regarding their relational history, might be compatible with behavioural theory, albeit phrased using different terminology.

At a philosophical level, behavioural theory appears to be consistent with psychological determinism. According to Bray (2003) “[p]sychological determinism is the theory of determinism applied to human experience. The theory states that all of one’s choices are determined by one’s beliefs and desires, which are in turn determined by one’s inborn temperament and the experiences that one encounters in life” (p. 270). An individual’s behaviour (and from a radical behaviourist perspective this includes thoughts, feelings and emotions as well as overt behaviour), has been shaped over time through classical and operant conditioning. On this basis, the behaviour of an individual in the present is based on their previous learning history, and hence patterns of behaviour are repeated in the present in predictable ways. It is likely that many of these repetitive patterns of thought and behaviour will be outside the conscious awareness of the individual and in this sense could be described as unconscious. Although this use of the term ‘unconscious’ is rather different from its conceptualisation in Freudian theory, it is still the case that psychodynamic therapists attempt to make ‘unconscious conflicts’ conscious to the patient in order that they can be resolved.

More recently, relational frame theorists (RFT) have proposed that language and cognition enables humans to derive relations between stimuli and events that have not been directly learned or experienced (Hayes, Strosahl, Bunting, Twohig, and Wilson, 2004). Relational frames are built up in vast arrays over time including for example, frames of co-ordination or similarity, opposition, distinction or discrimination, time, cause and perspective (including a

perspective or sense of self). Relational framing is considered to be important in the clinical arena because of the ways in which relations in a network can affect or alter the functions of others. To illustrate this point, Hayes et al. (2004) use the example of an adult who experienced fear and anxiety as a result of having been trapped in a confined space as a child. Years later, some of this fear could transform the functions of other situations where entrapment could be experienced (for example within an intimate relationship or within a lecture or tutorial), leading to the experience of fear and anxiety in these settings.

In this way behavioural theory would suggest that the reactions and responses of the patient within the therapeutic relationship contain important clinical information for the therapist regarding the patient's past relational experiences. In summarising evidence examining the perceptions of self and others in patients with BPD, Scott, Levy and Pincus (2009) state that "[s]everal studies show that individuals with BPD tend to view others as malevolent...and to describe themselves as unlovable, inherently evil or bad, dependent, and helpless" (p.259). From a behavioural perspective, these perceptions have been shaped by the individual's experiences within relationships with others and, as a result of relational framing, may transform the functions of other relational situations including the therapeutic relationship. Particular words, tone of voice, gestures and body language on the part of the therapist may trigger, through a vast network of associations rooted in prior experience, particular assumptions, thoughts, beliefs and behaviour on the part of the patient. Evidence in support of this perspective can be found in studies reporting the

prevalence of experiences of trauma, abuse and neglect in the histories of patients with BPD. For example, Crawford, Cohen, Chen, Anglin and Ehrensaft (2009) in a longitudinal prospective study report “[a] recorded history of child abuse had the expected very large association with BPD symptoms mean over the trajectory” (p. 1025). In another longitudinal study, Carlson, Egeland and Sroufe (2009) found that, “borderline personality symptoms were significantly related to early relational experiences previously reported in retrospective studies. These included attachment disorganization (12–18 months) and maltreatment (12– 18 months), maternal hostility and boundary dissolution (42 months), family disruption related to father presence (12 – 64), and family life stress (3 – 42 months)” (p. 1328). Interestingly, it was found that analyses “did not consistently support the endogenous contributions to adult disorder” (p. 1328).

Behavioural and psychodynamic theory therefore, appear to concur that the therapist’s observation and experience of the patient within the therapeutic relationship can provide important clinically relevant information regarding the patient’s relational history. What then of the alternative conceptualisation of countertransference as an impediment to therapy in form of the therapist’s unresolved conflicts? Might there also be areas of overlap between psychodynamic and behavioural perspectives when the focus is on the therapist rather than the patient in the therapeutic relationship? In the next section I argue that the behavioural and psychodynamic positions regarding the



therapist's role in the relationship differ as a result of the underlying assumptions upon which the theories rest.

**Therapist responses as normality or pathology**

*"I also think we're all a bit borderline here and there aren't we...to a [greater] or lesser extent." (Roz)*

As a medical practitioner, Freud's theories are likely to have been influenced by a Western medical perspective of health and illness. Use of the terms 'conflict', 'unresolved' or even Hayes's (2004) description of 'partially resolved conflicts' is predicated on the assumption that it is possible for conflicts to be resolved and hence presumably, to disappear. The theory therefore seems to be based on a discourse of pathology rather than normality. From this viewpoint, disorder or mental ill health is based upon underlying conflicts of which the patient is unaware and it is the task of the psychotherapist to help the patient end the conflict. Freud's concept of countertransference suggests that therapists can also have conflicts of which they too may be unaware. There is therefore an expectation for psychoanalytic psychotherapists to undergo therapy themselves in order for their own conflicts to be resolved, and hence to minimise potential harm to the patient. From this perspective, the reactions and responses described in the previous literature review and empirical paper may be seen as evidence of unresolved conflicts on the part of the therapists and professionals studied, necessitating resolution through psychotherapy.

This can be contrasted with the assumptions underpinning the so-called ‘3<sup>rd</sup> wave therapies’, including DBT and Acceptance and Commitment Therapy (ACT). The prevalence of depression, anxiety problems, alcoholism, suicidal behaviour and other psychological and emotional problems has led ACT theorists to question the ‘assumption of healthy normality’, that is, that psychological health is the default position for most human beings. ACT is based on the premise that language is central to human suffering and that, as a result, suffering is ubiquitous and inextricably linked to being human. In relation to the concept of personality disorder, proponents of DBT suggest that “from a behavioural perspective, personality and hence personality disorder, *is* only a series of overt and covert behaviours” and that “[o]nce the behaviours change and the client neither displays the overt behaviours, nor experiences the covert behaviours (other than to a degree and intensity similar to the rest of the community) then the personality disorder is gone” (Swales & Heard, 2009, p. 39-40). From the perspective of these behavioural theories, we are all a product of our learning histories and tend to react to situations in habitual ways, much as do our patients. These approaches appear therefore, to be based upon a discourse of normality rather than pathology.

### **Clinical Implications**

As the name implies, DBT rests upon a dialectical perspective. One of the fundamental principles of dialectics is the principle of interrelatedness and wholeness. According to Swales and Heard (2009) “[d]ialectics specifically directs the therapist’s attention toward transactions that occur between the

therapist and client and accepts that the therapist is part of and, therefore, influenced by the therapeutic context. The DBT therapist views therapy as a system in which the therapist and client reciprocally influence each other” (p. 17). From a dialectical perspective, the negative emotional, behavioural and attitudinal responses of professionals and therapists toward patients with BPD would not be seen as dependent solely on either the patient or the therapist, but as occurring within the system that the two create together, influenced by their respective learning histories.

### **Patients’ Responses**

*“So it isn’t personal to me but sometimes...you’re left with feelings that you think, hang on a minute...where’s this coming from...” (Megan)*

The idea that therapists’ experiences of the patient can be seen as a source of important information that may be clinically useful in understanding and working with a patient with BPD seems uncontroversial. The main concern in this regard is that too much emphasis on the patient as the source of the therapists’ responses can result in therapists minimising their own contributions to the relationship and perhaps at worst, blaming the patient for their own negative reactions and responses. Outside a psychotherapy context, psychoeducational interventions for mental health professionals that provide information regarding the development and aetiology of BPD and the problems faced by these patients have been found to be helpful in reducing negative attitudes and perceptions (Krawitz, 2004; Treloar & Lewis, 2008). These interventions may be

seen as providing a context in which professionals can consider their responses to patients from a different vantage point.

### **Therapists' Responses as Pathology**

*“you know I said before about being competent, so...is my self-esteem too dependent on this person's well-being and my self-esteem as a psychologist?”*

*(Roz)*

In the previous section I suggest that depending on the underlying theoretical assumptions and language used, the therapist's reactions and responses, when viewed as related to their own personal history, can be set within a discourse of normality or pathology. Within a perceived pathological discourse, therapists may be less open to examining their contribution to the unfolding therapeutic relationship and resistant to the suggestion that they may be in need of psychotherapy to deal with conflicts that remain unresolved. At worst, a pathological discourse may make it more difficult for therapists to discuss negative emotional, behavioural and attitudinal responses within clinical supervision, perhaps even inducing feelings of shame and guilt. This could result in negative effects for both therapist and patient in terms of insufficient support for the therapist in dealing with the emotional demands of the work and for the patient, if the therapist is struggling to manage their own responses.

### **Therapists' Responses as Normality**

*“...so you can...mindfully let it go...mindfully accept it and let it go...you use some of the principles of the model to manage your own stuff.” (Beth)*

The idea of suffering as a fundamental part of being human and not simply the province of those diagnosed with mental health problems, has brought with it an emphasis within the '3<sup>rd</sup> wave therapies', on the importance of the therapists' own practice of the therapeutic principles employed in the therapy. Therapists are seen as human and subject to the same causes of suffering as their patients by virtue of language, cognition and the development of a sense of self in the context of their learning history. From this perspective, it is inevitable that difficult thoughts, feelings and emotions will arise especially when relating to another whose suffering is intense, who has difficulty regulating emotion, a tendency toward impulsive behaviour and a heightened sensitivity to rejection in the context of disrupted and often abusive past relationships. However, whilst these responses may be viewed as normal, it is incumbent upon professionals to find ways to manage their reactions and responses in order to minimise harm to an already vulnerable group of people.

Common to all '3<sup>rd</sup> wave therapies' is the idea that awareness is the key to helping our patients and ourselves, to step out of habitual patterns of behaviour. Mindfulness practice, with its emphasis on present moment awareness, is a fundamental part of approaches such as DBT and ACT. The concept of resolution is absent from these therapies. Rather, it is envisaged that as a result of our prior learning, we will be drawn at times into repetitive patterns of thought, feeling and behaviour. This can be contrasted with times of greater present moment awareness, providing us with the opportunity to choose how

we might respond to a given situation. It is in becoming aware of our conditioning or our programming, if you will, that freedom lies.

### **Helping the helpers**

*“I feel really hopeful...privileged actually...I feel like I’ve learnt so much about everything really... it’s helped me grow myself...so I feel that even though it’s heavy end work, it’s actually kind of lighter because the way to perceive is clear.” (Beth re: DBT)*

Set within a discourse of normality, the responses of both professionals and their patients are seen as part of what it is to be human. From this perspective, it is of little surprise that the responses observed toward these patients are observable cross-culturally both within and outside a psychotherapy context. It also indicates that professionals need to be encouraged firstly, to be able to voice their thoughts, feelings and reactions to these patients in a supportive environment. Secondly, professionals will need the help of others to take a step back from their experience, to observe their responses and hence to heighten their awareness of judgements, assumptions and habitual reactive patterns of behaviour.

DBT is a therapy that has been specifically designed to support professionals in precisely these ways. The findings of the empirical paper indicate that although DBT therapists are trained in a model that sets the problems of patients with BPD in a biopsychosocial framework, this knowledge in and of itself does not

render the therapists immune from intense and difficult experiences in their work. Therefore, although educational interventions for professionals have been shown to improve attitudes toward these patients, they cannot be seen as sufficient and need to be supplemented with on-going support in the work environment.

Alongside individual supervision, DBT therapists attend a consultation group where their experiences may be validated and normalised by colleagues. However, normalising their experience does not equate to justifying negative responses that may prove harmful to the patient. Therefore the consultation group (helped by designation of an observer who attends to the group process), functions to help identify the therapists' narrative in relation to their patients and to deconstruct this narrative. In this way, judgements and assumptions are identified and examined with a focus on a patient's observed behaviours rather than on inferences regarding the patient's intentions. Therapists are encouraged to make use of the skills they teach to their patients to help them as therapists to manage their own emotions. Within the consultation group, therapists may undertake mindfulness practices to help them step back from and observe, habitual patterns of thought, emotion and behaviour.

In a paper examining moral responsibility in patients with BPD, Bray (2003) concludes, "...most BPD features, such as impulsivity, acting out and the milder forms of dissociation do not vitiate responsibility" (p. 275). Therefore, if patients with BPD (despite fundamental difficulties in emotion regulation, impulsivity and

within interpersonal relationships), are held to be responsible for their actions, then to an even greater extent, professionals employed to work with these patients have a responsibility to manage their responses. However, in a work context where the professionals themselves are the 'tool' used to help others, it is the employer's responsibility to ensure that adequate provision is made to support employees in the work they undertake. A second paper (in preparation) regarding the therapists' experience of practicing DBT discusses various supportive aspects of the therapy. On basis of the findings in this thesis, I would argue that robust forms of support are a necessity for professionals working in any professional context with these patients. The range of negative emotions reported when considered alongside Mills and Rose's (2001) finding that negative emotion mediated the relationship between challenging behavior and burnout in direct care staff, suggests that this should be a matter of priority for employers.



## **Personal Reflections**

### *Trapped by Language*

At a philosophical level, I am in complete agreement with proponents of the various 3<sup>rd</sup> wave therapies that human suffering is an inevitable part of being human. By virtue of having a mind, capable of logical reasoning, self-awareness and reflection, the achievements of human beings over time have been remarkable. And yet conversely and for the same reason, they also continue to behave in regrettable ways causing suffering to themselves, others and the earth. The more I have worked with adults suffering from various mental health problems and the more I have attempted to work with the vagaries of my own mind, the more convinced I am that the processes of mind in the patients I work with, are different in severity and intensity rather than in kind, to the processes in the minds of everyone. I therefore struggle with the dominant medical perspective within mental health and particularly with diagnostic labels such as BPD. And yet in writing this thesis I could see no way around the use of the term BPD. Attempting to describe the types of suffering endured by these patients in a succinct way without the shorthand label BPD seemed to be impossible. Additionally, in writing the literature review and empirical paper for an academic journal, making reference to existing literature in this area, I again experienced a sense of having no alternative but to use the terminology based on the concept of 'disorder'.

Equally difficult was the decision to use the term patient or client. In the first instance, I tried to write individual or person and found it impossible to use either word consistently without it becoming cumbersome to write and to read. I strongly dislike the term 'service user' and also dislike the term 'client', even though it is the term I have traditionally used in clinical practice. Surveys have indicated that people in receipt of mental health services prefer the term patient although the preference is less marked when consulting non-medical professionals (Simmons, Hawley, Gale & Sivakumaran, 2010; Vohora & Close, 2011). Despite my discomfort therefore, I opted for the word 'patient' throughout.

*The Impact of the Research Process on the Researcher*

Setting up a tent in a hurricane, a roller coaster ride, swings of emotion and challenges to self-efficacy all seem to be as applicable to my experience of researching and writing up this thesis as they did to the participants I interviewed. I began my CPD doctorate in clinical psychology having set aside the rigours of research and absorbing myself in clinical practice immediately after my qualification in 1992. Despite having been told that I could write by the then director of the NWCPP, I began my extended essay nearly three years ago, spending roughly three hours one evening writing two paragraphs, one of which largely comprised a quotation. At this point I was absolutely convinced that I could no longer write academically.

Having overcome this first hurdle and enduring the anxiety of having an extended 'report of clinical activity' assessed after some eighteen years working as a clinical psychologist, I began the hugely cumbersome task of applying for NHS research ethics committee approval. At this point I was probably the most empathic training co-ordinator for NWCPP trainees on the programme team. The whole process from the development of the proposal to gaining ethical approval took months to complete and I finished the process thinking it was of little surprise that pressured NHS clinical psychologists find little time for research.

#### *The Demands of Qualitative Research*

Although I knew that my statistical knowledge had waned and a quantitative project would be helpful in reminding me of what I'd forgotten, I was drawn to learning something completely new and attracted to qualitative research as a result of its philosophical and epistemological basis. I was warned by several people about the amount of work required to transcribe and analyse qualitative data and I recall the phrase 'drowning in the data' being used on more than one occasion. However, a little like the experience of childbirth, in the context of many peoples' vivid descriptions of their own experiences, it required me to be faced with the actual experience itself to properly understand. Setting up a tent in a hurricane is a good metaphor for the point at which, having asked far too many questions in the interview, I attempted to reduce the information into a more coherent and manageable unit. The advice of my qualitative research supervisor, when she came to find me on the floor with sheets of quotations

strewn all around me, was invaluable. At this point I realised that I had data for at least two, possibly three research papers contained within the interviews.

This experience has made me aware of the need to define a research question as tightly as possible and perhaps to ask fewer questions at interview.

However, the experience of gaining NHS ethical approval has also made me aware of the potential benefits of asking a broader range of questions that may be analysed separately in order to answer more than one research question.

I found the interviews themselves to be absorbing and although a significant amount of time was required to transcribe and analyse the interviews, I was engaged, interested and fascinated by the material. The process of IPA seemed to come quite naturally to me. My qualitative research supervisor and I reflected on the possible similarities between IPA and my therapeutic work whereby I am often listening to the patient with an ear for emerging themes and the sense the patient is making of their life experience. Rather more difficult was the process of listening with an objective ear and 'bracketing' any assumptions, beliefs and theoretical perspectives. This was particularly marked when the resonance between the therapists' experience and that of their patients began to emerge. Although I do not practice psychodynamic psychotherapy, I found myself immediately labelling what I was hearing as projective identification and countertransference. This culminated in my presentation of the first draft of the empirical paper to my supervisor, a national trainer and expert in DBT, having totally neglected to even consider the phenomenon from a behavioural perspective. Having diplomatically pointed out that it might be helpful to

## Personal Reflections

consider more than one theoretical interpretation of the findings, I was able to consider the differing perspectives and hopefully conduct a more in-depth examination of the implications of theory upon clinical and professional practice. This experience together with an exploration of some of the available literature, has led me to speculate that the concepts of transference and countertransference have become the dominant discourse within a therapy context in relation to the therapists' responses to the patient.

Although admittedly labour intensive and notwithstanding the problems of generalisability in qualitative research, I think that research approaches such as IPA have a lot to offer in relation to examining both theory and clinical practice by providing such depth of insight into the lived experience of participants.

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## **Section 4: Ethics Proposal**

## Research Study Protocol

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(Research to be submitted in part-fulfilment of the final award of doctorate in clinical  
psychology)

### Project Title

Dialectical behaviour therapists' experience of working with people who deliberately self-harm, exhibiting borderline personality symptoms.

### Supervision

Dr Michaela Swales (Consultant Clinical Psychologist; Betsi Cadwaladr University Health Board & Lecturer/Practitioner; Bangor University) & Dr Jaci Huws (Lecturer and Research Fellow; Bangor University)

### Background

It is recognised that mental health professionals find it particularly difficult to work with people who engage in deliberate self-harm (DSH). Given that recurrent suicidal behaviour or repeated self-mutilation is one of the DSM-IV criteria for Borderline Personality Disorder (BPD) there is an allied literature describing similar difficulties in staff working with clients diagnosed with BPD. Attitudes of staff toward these clients have been found to be overwhelmingly negative.

#### *Deliberate Self-Harm*

In a review of the literature on the attitudes of professionals toward self-injury, Bosman & Van Meijel (2008) described nurses as "...feeling uncertain, helpless, frustrated, or angry. Nurses even feel personally rejected, manipulated, looked down on, envied, idealized or maligned and reviled" (p.184). Two qualitative studies described the experience of stress and a range of difficult feelings and emotions in nursing staff working with clients who deliberately self-harm (Wilstrand et. al. 2007; Thompson et. al. 2008). In both studies, staff described difficulties in understanding the behaviour of their clients. The CPN's in the Thompson et.al. (2008) study experienced emotional demands in relation to risk assessment/management, feelings of responsibility and difficulties in the establishment and maintenance of a positive therapeutic alliance. Wilstrand et. al. (2007) outlined two overarching themes of 'being burdened with feelings' and 'balancing professional boundaries' in the experiences of psychiatric nurses working with people who self-harm,

#### *Borderline Personality Disorder*

Three surveys of mental health staff, two in Australia and one in Ireland, found that the majority of respondents estimated working with BPD clients to be moderately to very difficult and more difficult than working with clients with other mental health problems (Cleary et. al., 2002; Hazelton et. al. 2006; & James &

Cowman, 2007). In the Hazelton et. al. (2006) study, analysis of focus group data from some of the survey participants indicated that clients with BPD were commonly perceived as untreatable and difficult, with "...connotations of...manipulative, attention-seeking, intimidating..." (p.126). In a survey of nursing staff Deans & Meocevic (2006) found that clients with BPD were perceived to be manipulative.

Markham (2003) found that psychiatric nurses were more socially rejecting of patients labelled as having BPD and rated them as more dangerous than those with a label of schizophrenia or depression. Nurses in this study were less optimistic about those with a BPD label and described more negative experiences in their work with this client group.

### *Theoretical Considerations*

Attribution theory, in particular Weiner's attributional theory of motivation and emotion (Weiner 1980, 1985), has been used as a means to understand the responses of staff to clients who self-harm and those labelled with BPD. According to Weiner, causal explanations regarding events directly influence emotion and hence behaviour. In the area of helping behaviour, perceptions of control are thought to be particularly important. When help is required, if the prospective helper perceives the cause of the need to be uncontrollable, sympathy is likely to be elicited with a greater likelihood of help being offered. Conversely when the cause of the need is perceived to be controllable, anger is more likely to be elicited and help is less likely to be offered.

Huband & Tantam (2000), in a factor analysis of surveyed attitudes of mental health professionals toward a female client with a history of repeated self-injury, found perceived control to be the dominant factor influencing staff attitudes. Markham & Trower (2003) found that when a client was labelled as having BPD as opposed to either schizophrenia or depression, staff attributed the client's challenging behaviour to more stable causes and the client was perceived to have more control over both their challenging behaviour and its causes. Greater attributions of control and stability were associated with less sympathy and less optimism toward this client group. In a similar study examining the attitudes of A&E medical and nursing staff to DSH, Mackay & Barrowclough (2005) found that attributions of control regarding the causes of the DSH were associated with more negative attitudes and less willingness to help. Additionally, greater perceptions of stability regarding the causes of the DSH were associated with less optimism and less willingness to help.

Findings in these studies were mixed as to whether gender, professional group and receipt of specific training in relation to BPD and DSH influence staff attributions and experiences. Huband & Tantam (2000) found that perceptions of control in mental health professionals were not related to gender, profession or specific training in self-injury but were found to be less for staff working in the community, those with 10+ years of clinical experience and those in possession of a qualification in counselling and/or psychotherapy. One hypothesis proposed to

explain this latter finding was that counselling and psychotherapy training may help professionals in dealing with anxieties raised by their work with these clients, resulting in less propensity "...to attribute responsibility and blame away from themselves and onto the patient" (p.501). Mackay & Barrowclough (2005) found that male A&E staff were less sympathetic, experienced more irritation and frustration, and were less optimistic and less willing to help than the females in their study. Additionally they found that medical staff experienced greater irritation, less optimism and were less willing to help than nurses.

### *Addressing the problem*

From this brief review it can be seen that methods to support staff in their work with DSH and with clients diagnosed with BPD is crucial in order to reduce staff stress and potential burnout. However it is also crucial from the clients' perspective as negative experiences of health care have been described by clients who self-harm (McAllister et. al. 2002; Broadhurst & Gill; 2007) and those diagnosed with BPD (Perseus et. al. 2005). Additionally, Huband & Tantam, (2004) found that client perceptions of staff members delivering an intervention had a bearing on its effectiveness.

In a review of the literature, Paris (2002) reported that the suicide rate of 10% in people diagnosed with BPD was similar to that found in schizophrenia and depression. The review also indicated that most suicides in the BPD client group take place in the context of multiple previous suicide attempts and with some evidence that the number of previous attempts is predictive of completed suicide. In the context of the differential responses of staff to clients diagnosed with BPD, schizophrenia and depression these suicide rates give cause for concern.

Commons Treloar & Lewis (2008) found that providing education on BPD and DSH improved the attitudes of both A&E and mental health staff from a variety of professional backgrounds as assessed using the Attitudes Towards Deliberate Self-Harm Questionnaire.

Dialectical Behaviour Therapy (DBT) (Linehan, 1993) is an approach to working with BPD, which purports to recognise the stresses inherent for professionals in working with this client group and which provides a coherent framework for the management of DSH. In addition to providing education on a psychosocial theory of BPD the therapy also has a mechanism of support for therapists in the form of a regular consultation group for DBT therapists (Swales & Heard, 2009).

There is some evidence emerging from studies of professionals undertaking training in DBT that the training has a positive effect on the attitudes and perceptions of professionals to clients diagnosed with BPD. Perseus et al. (2003) interviewed two female and two male DBT therapists all of whom had prior experience in cognitive psychotherapy. Therapists described DBT as altering their perceptions of patients diagnosed with BPD and their attitudes toward them. Therapists described a shift from ".....regarding patients as troublesome and

manipulative to regarding them ‘as doing their best under tough circumstances.’ ” (p.224).

Hazelton et al. (2006) employed a mixed quantitative/qualitative design to examine the knowledge and attitudes of mental health staff undertaking training in DBT at pre-training and again at one month and six months post-training. Most staff completed a two-day DBT training with some going on to complete more advanced training. DBT training did not influence staff perceptions of the difficulty inherent in working with BPD clients with similar numbers of staff rating this client group as moderately to very difficult to work with and more difficult than other client groups at each time point in the study. However, discourse analysis of focus groups conducted at each stage illustrated an overall shift in attitudes with greater optimism and understanding of clients diagnosed with BPD.

Another mixed quantitative/qualitative study by Perseus et al. (2007) examined levels of stress and burnout in nineteen professionals involved in a project to set up a DBT service for young women engaging in DSH. No significant changes in burnout were found over the 18 month period of the study. Qualitative content analysis confirmed the findings of previous studies that therapists experienced their work with this client group to be stressful and demanding. Although DBT was experienced as increasing stress while participants were being trained in the approach, it was experienced as decreasing stress in subsequent direct clinical work with this client group. Following DBT training, professionals described greater confidence in their work with these clients, more optimism and satisfaction.

The proposed study aims to build on the emerging evidence regarding the potential for DBT to positively impact upon staff attitudes and perceptions of their clients. A detailed examination of the lived experience of DBT therapists working with clients engaging in DSH with symptoms of BPD will be carried out. Attention will be paid to how experienced DBT therapists make sense of the behaviour of their clients, particularly in the area of causal attributions. In addition, the discourse of DBT therapists regarding their clients will be examined. It is hoped that the study will provide more detailed information regarding the potential for DBT to support therapists in their work with this challenging group of clients, and the mechanisms by which this may take place.

### **Research question**

How do DBT therapists experience their work with people who deliberately self-harm, exhibiting symptoms of BPD and how do they make sense of their client’s behaviour? What can be learned about the attitudes and perceptions of DBT therapists toward this client group from their discourse regarding these clients?

### **Participant recruitment**

8-10 DBT therapists with two or more year’s experience of using DBT clinically as part of a DBT team will be eligible to participate in the study. The first 1-2 interviews will be transcribed immediately following completion in order for the

richness of the data to be evaluated and for the interview schedule to be amended as necessary.

Participants will be recruited from a group of 20-25 DBT therapists attending quarterly DBT consultation and training days with Dr Michaela Swales at Bangor University. Ideally, the chief investigator will attend one of the DBT consultation and training days to outline the proposed study. Participants will be asked to volunteer to take part in the study and information sheets, consent forms and pre-paid envelopes for returning the consent forms will be distributed.

Approval has been gained from Dr Michaela Swales to attend the DBT consultation and training days in order to access potential participants. In the event that initial contact with the therapists is necessary before the next scheduled training day, Dr Michaela Swales will be asked to contact potential participants by e-mail to introduce the chief investigator, attach an outline of the study and ask those interested in taking part to indicate their willingness to be contacted by the chief investigator.

### **Design and Procedures**

A mixed methodology qualitative design will be used. An Interpretative Phenomenological Analysis will be undertaken to examine DBT therapists' experiences of working with clients who deliberately self-harm, exhibiting symptoms of BPD and depending on the suitability of the data, Discourse Analysis (DA) will be used to examine the language used when discussing this client group. Participants will be interviewed for up to 1-1.5 hours using a semi-structured interview. The interviews will be conducted at the participant's place of work or at Bangor University, depending upon preference.

At interview, all participants will be asked for their consent to be contacted following preliminary analysis of their interview transcript. A random sub-sample of consenting participants will be sent a copy of the analysis of their transcript and contacted subsequently by telephone to discuss their views on the credibility of the analysis. Dr Jaci Huws will be consulted regarding the proportion of the sample to be contacted in this regard.

### **Measures**

Demographic Information will be collected as follows:

Age; gender; work environment (CAMHS/Adult services); profession; years of clinical experience post-professional qualification; level of DBT training; years of experience using DBT clinically; other counselling/psychotherapy qualifications; estimated proportion of caseload consisting of identified client group.

Under the guidance of Dr Jaci Huws, an in-depth semi-structured interview was devised to explore participant experiences of working with the identified client group. Questions will be included to provide insight into the meanings ascribed by DBT therapists to understand the behaviour of their clients.

### **Data management and analysis**

Audio files of interviews and Word files of transcribed interviews will be stored electronically on a secure (PIN protected) pen drive and on the chief investigator's password-protected laptop. IPA of the interview transcripts will be undertaken as outlined by Smith, Flowers & Larkin (2009). As part of the interview, participants will be asked to describe critical incidents in their work with particular clients to illustrate a challenging and a rewarding/positive experience. A Discourse Analysis based upon the work of either Parker (1992) or Potter & Wetherell (1987) will be carried out primarily on the critical incidents described, to examine the ways in which the participants discourse positions them in relation to their clients.

### **Diversity**

As recommended by Smith, Flowers & Larkin (2009) the purposive sample of participants selected will be relatively homogenous. However as IPA is concerned with the way in which individuals make sense of a particular phenomena, the data will be analysed examining both points of convergence and divergence within the accounts of participants.

The study indirectly focuses on clients who are vulnerable to social exclusion and stigma. Given the difficulties experienced by staff in working with these clients, they are also at risk of exclusion from mental health services and of receiving inadequate care. It is hoped that the study will contribute to an understanding of how mental health staff can be supported to develop more positive attitudes toward and maintain positive therapeutic relationships with this client group, thus minimising the risk of exclusion and experiences of mental health care that are detrimental to an already vulnerable group of people.

### **Proposed journals**

Consideration is being given to the following journals:

- Psychology and Psychotherapy: Theory, Research and Practice
- Journal of Consulting and Clinical Psychology
- Behavioural and Cognitive Psychotherapy

### **Ethical/Registration issues**

Participants will be informed that their participation in the study is entirely voluntary and that only the chief investigator will be aware of the identities of those who have agreed to participate. At the beginning of the interview they will be reminded that they have the right to withdraw consent without consequence at any time and the interview will be terminated. As the chief investigator works in the local area it is possible that she will be known to prospective participants and this may influence decisions to participate.

Participants will be informed that interviews will be transcribed with pseudonyms and that no excerpts used in the thesis will be tied to particular participants. No-one reading the thesis will be able to identify participants. The chief investigator will keep a separate file on a password-protected laptop linking specific participants to their pseudonyms until the thesis has been examined.

Participants will be requested not to use the names of particular clients and will be assured that they will not be asked for any identifying details of the clients discussed during the course of the interview. Any names accidentally mentioned at interview will not be included in the transcription.

Personal information will be stored securely for 6-12 months after completion of the study. Anonymised data will be stored for up to 10 years on the laptop computer and password protected pen drive of the chief investigator. Only the chief investigator and research supervisor will have access to the data.

Ethical approval will be sought initially from the School of Psychology, Bangor University and subsequently from one of the ethics committees of Betsi Cadwaladr University Local Health Board.

It is likely that the interviews will take place during the working time of participants and at their places of work therefore approval will be sought from the relevant R&D committees of the employing NHS Trust/Health Board. The majority of participants attending the DBT consultation and training days with Dr Michaela Swales come from the North Wales area.

### **Feedback**

Participants will be asked to indicate whether they would like to receive a copy of the results of the study. A copy of the empirical paper of the thesis will be forwarded to all interested participants.

### **Risk Assessment**

It is envisaged that risk to both participants and the chief investigator will be minimal. It is likely that most interviews will take place at the clinical base of the participant, during working hours and no home visits are planned, thus minimising risks associated with lone working.

Although there is the potential for some distress for participants in discussing the self-harming behaviour of their clients, these experiences will be discussed in retrospect and all DBT therapists will have already had and will continue to have access to the support of a DBT consultation group to discuss any difficulties arising in relation to their clinical work.

### **Data storage**

Data will be stored as outlined earlier under 'data management and analysis'. Following examination of the thesis, the audio files of the interviews will be destroyed and transcripts will be stored securely at the North Wales Clinical Psychology Programme, Bangor University, for up to 10 years.

### **Financial information**

It is anticipated that the costs of the study will be minimal especially if most of the participants are agreeable to being contacted by e-mail and receiving documents



## Research Protocol

electronically. The table below includes estimated costs in the event that participants elect to receive paper copies of all documentation by post. The chief investigator will require access to a digital voice recorder from NWCPP. There will be no transcription costs as the interviews will be transcribed by the chief investigator.

Item & Estimated Quantity	Cost per unit	Estimated total cost
Travel – up to 600 miles	@ 40p / mile	£240.00
Digital Voice Recorder	@ max £260	£260.00
Printing x 500 (double sided) sheets	@ 5p / sheet	£25.00
Postage 20 x large letter	@ 61p	£12.20
A4 envelopes x 1 pk	@ 4.09	£4.09
A4 White Paper x 2 pks	@ 2.99 / 500 sheets	£5.98
		<b>Total: £ 547.27</b>

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## School Of Psychology Ethical Approval Form

### Ethics Checklist

**Before submitting this form, please check that you have:**

- Read and followed the advice provided in the *Ethics Guidance & Procedures* (provided in the ethics folder online)
- Provided names and email addresses for **all** investigators (as this is the means we will use to contact you regarding the outcome of your ethics review)
- In Part One of these forms, ticked **either** Box A **or** Box B and provided the further information required
- In Part Two of these forms, provided on a separate sheet further information on any risks likely to be incurred in conducting the study
- Attached consent forms and information sheets
- Attached any questionnaires to be used in the study

And, additionally:

- If working with children or other vulnerable populations, ensured that all investigators working directly with participants have arranged for a CRB check to be conducted.
- If your proposal is to be submitted to an NHS LREC, attached the NRES and R&D forms (and followed the information provided in the *Ethics Guidance & Procedures* on completing certain questions)

School of Psychology Ethics Application

**SCHOOL OF PSYCHOLOGY ETHICAL APPROVAL FORM**

Please complete all parts to this form.

Please attach consent and information/debriefing sheets to all applications.

Date: 05/07/2010

Tick one box:  STAFF PROJECT  MASTERS PROJECT  PHD PROJECT

CLINICAL PSYCHOLOGY PROJECT  UNDERGRADUATE PROJECT  
 CLASS DEMONSTRATION

What is the broad research area?  Vision and the Brain  Clinical & Health  
 Language and Development  Other

Who is the funder of the research? North Wales Clinical Psychology Programme

Title of project: Dialectical behaviour therapists' experience of working with people who deliberately self-harm, exhibiting borderline personality symptoms.

Name and email address(es) of all researcher(s): Renee E Rickard – [r.rickard@bangor.ac.uk](mailto:r.rickard@bangor.ac.uk)

Name and email address of supervisor (for student research):

Dr Michaela A Swales – [m.swales@bangor.ac.uk](mailto:m.swales@bangor.ac.uk); Dr Jaci C Huws – [j.huws@bangor.ac.uk](mailto:j.huws@bangor.ac.uk)

**Study Start Date:- 01/09/10 Study End Date:- 31/12/11**

	YES	NO
Is your project in the area of Health and Social Care requiring sponsorship by the University of Wales, Bangor? If yes, please <b>complete your ethics application in NRES format and submit an NHS R&amp;D form</b> alongside it. <b>You should still complete all sections to this form, but do not need to supply the additional information requested in boxes A or B of Part 1.</b>	√	
Does your project require scrutiny from an outside body that has its own forms? If yes, please <b>complete your ethics application using the forms required by that outside body. You should still complete all sections to this form, but do not need to supply the additional information requested in boxes A or B of Part 1.</b>	√	
If a student project, is this part of the supervisor's ongoing research that has been previously reviewed and approved? If yes, please <b>give the proposal number of the approved research project, and complete all sections of this form.</b>	Proposal no.	√

**PART ONE: ETHICAL CONSIDERATIONS**

		YES	NO	N/A
1	Will you describe the main experimental procedures to participants <sup>3</sup> in advance, so that they are informed about what to expect?	√		
2	Will you tell participants that their participation is voluntary?	√		

<sup>3</sup> In questions 1-9, if participants are children, please consider the information that you will supply to the legal guardian in each case.

## School of Psychology Ethics Application

3	Will you obtain written consent for participation?	√		
4	If the research is observational, will you ask participants for their consent to being observed?			√
5	Will you tell participants that they may withdraw from the research at any time and for any reason?	√		
6	With questionnaires, will you give participants the option of omitting questions they do not want to answer?			√
7	Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	√		
8	Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)?	√		

If you have ticked **No** to any of Q1-8, but have **ticked box A** overleaf, please give an explanation on a separate sheet.

[Note: N/A = not applicable]

		YES	NO	N/A
9	Will your project involve deliberately misleading participants in any way?		√	
10a	Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort? If <b>Yes</b> , give details on a separate sheet and state what you will tell them to do if they should experience any problems (e.g., who they can contact for help)		√	
<b>10b</b>	<b>Is there any realistic risk of any participants experiencing discomfort or risk to health, subsequent illness or injury that might require medical or psychological treatment as a result of the procedures?</b>		√	

If you have ticked **Yes** to 9 or 10 you should normally **tick box B** overleaf; if not, please give a full explanation on a separate sheet.

11	Does your project involve work with animals? If yes, please <b>tick box B</b> overleaf.		√	
12	Does your project involve payment of participants that differs from the standard rates? Is there a significant concern that the levels of payment you offer for this study will unduly influence participants to agree to procedures that they may otherwise find unacceptable? If yes to either, please tick box B and explain in point 5 of the full protocol.		√	
13	Do participants fall into any of the following special groups? If they do, please refer to BPS guidelines, and <b>tick box B</b> overleaf.  <b>Note that you may also need to obtain satisfactory CRB clearance.</b>	<b>Children (under 18 years of age)</b> N.B. You must ensure that you have made adequate provision for child protection issues in your protocol	√	
		<b>People with learning or communication difficulties</b> N.B. You must ensure that you have provided adequate provision to manage distress	√	
		<b>Participants covered by the Mental Capacity Act:</b> i.e. Adults over 16 years of age who lack the mental capacity to make specific decisions for themselves. You must ensure that you have appropriate consent procedures in	√	

## School of Psychology Ethics Application

		place (See guidance notes below) Some research involving participants who lack capacity will require review by an NHS REC. If you are unsure about whether this applies to your study, please contact the Ethics Administrator in the first instance			
		<b>Patients</b> N.B. You must ensure that you have provided adequate provision to manage distress.		√	
		People in custody		√	
		<b>People engaged in illegal activities</b> (e.g. drug-taking)		√	
		<b>Participants recruited from one of the Neurology Patient Panels or the Psychiatry Patient Panel and, if so, has the protocol been reviewed by the appropriate expert/safety panel?</b>		√	
		<b>Physically vulnerable adults</b> N.B. You must ensure that there is a person trained in CPR and seizure management on hand at all times during testing.		√	
14 Does your project require use of any of the following facilities and, if so, has the protocol been reviewed by the appropriate expert/safety panel? If yes, tick <b>Box B overleaf and supply evidence that the appropriate panel have endorsed your study.</b>		<b>MRI</b>		√	
		<b>TMS</b>		√	

### Mental Capacity Act 2005

The act provides a comprehensive legal framework for decision making adults, aged 16 or over, when, because of specific mental disability (defined as an impairment of or disturbance in the functioning of a person's mind or brain), they lack the mental capacity to make specific decisions for themselves.

The Act enshrines several key principles:

- A person must be assumed to have capacity unless it is established that he/she lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him/her do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.
- Any decision made under this Act on behalf of a person who lacks capacity must be made in her/his best interests.

Intrusive research on people lacking capacity to consent is unlawful unless:

- The research is approved by specified body (LREC/MREC etc)
- It relates to the person's condition or treatment, and has negligible risks
- It cannot be done as effectively on people who have capacity to consent

## School of Psychology Ethics Application

- Stringent safeguards are put in place, including consultation with carers.

Researchers conducting studies involving individuals lacking capacity must familiarise themselves with their responsibilities under the law and ensure proper approval mechanisms and appropriate consent procedures are in place.

There is an obligation on the lead researcher to bring to the attention of the School Ethics and Research Governance Committee any ethical implications not clearly covered by the above checklist.

PLEASE TICK **EITHER** BOX A **OR** BOX B OVERLEAF AND **PROVIDE THE DETAILS REQUIRED IN SUPPORT OF YOUR APPLICATION.**

Please tick

A. I consider that this project has <b>no</b> significant ethical implications to be brought before the Departmental Ethics Committee.	√
<b>Give a brief description of participants and procedure, including information on (1) hypotheses, (2) participants &amp; recruitment, (3) research methodology, and (4) Estimated start date and duration of the study. Please attach consent and debrief forms.(5) For studies recruiting via SONA please provide the summary of the study that will appear in SONA to inform participants about the study. N.B. This should be a brief factual description of the study and what participants will be required to do.</b>	



## School of Psychology Ethics Application

Please tick

<p><b>B.</b> I consider that this project <b>may</b> have ethical implications that should be brought before the Departmental Ethics Committee, and/or it will be carried out with children or other vulnerable populations.</p>	
<p>Please provide all the further information listed below in a separate attachment, in this order.</p> <ol style="list-style-type: none"> <li>1. Title of project</li> <li>2. The potential value of addressing this issue</li> <li>3. Brief background to the study</li> <li>4. The hypotheses</li> <li>5. Participants: recruitment methods, age, gender, exclusion/inclusion criteria</li> <li>6. Research design</li> <li>7. Procedures employed</li> <li>8. Measures employed</li> <li>9. Qualifications of the investigators to use the measures (Where working with children or vulnerable adults, please include information on investigators' CRB disclosures here.)</li> <li>10. Venue for investigation</li> <li>11. Estimated start date and duration of the study (N.B. If you know that the research is likely to continue for more than three years, please indicate this here).</li> <li>12. Data analysis</li> <li>13. Potential offence/distress to participants</li> <li>14. Procedures to ensure confidentiality and data protection</li> <li>15. *How consent is to be obtained (See BPS Guidelines and ensure consent forms are expressed bilingually where appropriate. The University has its own Welsh translations facilities on extension 2036)</li> <li>16. Information for participants (provide actual consent forms and information sheets) including if appropriate, the summary of the study that will appear on SONA to inform participants about the study. N.B. This should be a brief factual description of the study and what participants will be required to do.</li> <li>17. Approval of relevant professionals (e.g., GPs, Consultants, Teachers, parents etc.)</li> <li>18. Payment to: participants, investigators, departments/institutions</li> <li>19. Equipment required and its availability</li> <li>20. If students will be engaged a project involving children, vulnerable adults, one of the neurology patient panels or the psychiatric patient panel, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)</li> <li>21. If students will be engaged in a project involving use of MRI or TMS, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)</li> <li>22. What arrangements are you making to give feedback to participants? The responsibility is yours to provide it, not participants' to request it.</li> <li>23. Finally, check your proposal conforms to BPS Guidelines on Ethical Standards in research and sign the declaration. If you have any doubts about this, please outline them.</li> </ol>	

PLEASE COMPLETE PART TWO OVERLEAF.

School of Psychology Ethics Application

PART TWO: RISK ASSESSMENT

If you tick “yes” to any of the questions in the table below, please outline on a separate sheet the probability and significance of the risks involved and the means proposed for the management of those risks. **Where relevant, please also describe the procedures to be followed in the event of an adverse event or emergency.**

		YES	NO	N/A
1	Is there significant potential risk to <b>participants</b> in any of the following ways?	Potential adverse effects		√
		Potential distress		√
		<b>Potential for persisting or subsequent illness or injury that might require medical or psychological treatment</b>		
2	Is there significant potential risk to <b>investigator(s)</b> in any of the following ways?	Potential risk of violence or other harm to the investigator(s) (e.g., through work with particular populations or through context of research).		√
		Potential risk of allegations being made against the investigator(s). (e.g., through work with vulnerable populations or context of research).		√
3	Is there significant potential risk to the <b>institution</b> in any way? (e.g., controversiality or potential for misuse of research findings.)		√	
4	Is there significant potential risk to other members of staff or students at the institution? (e.g., reception or other staff required to deal with violent or vulnerable populations.)		√	

The following questions address specific situations that can carry risks to the investigators and/or participants. If you tick “yes” to any of the questions below, please refer to the guidance given (See *Ethics Guidance and Procedures*) on procedures for dealing with these risks and, **on a separate sheet, outline how these risks will be dealt with in your project.**

5	Does the research involve the investigator(s) working under any of the following conditions: alone; away from the School; after-hours; or on weekends?		√	
6	Does the experimental procedure involve touching participants?		√	
7	Does the research involve disabled participants or children visiting the School?		√	

There is an obligation on the lead researcher to bring to the attention of the School Ethics and research Governance Committee any risk implications of the research not clearly covered by the above checklist.

**PLEASE COMPLETE PART THREE OVERLEAF.**

School of Psychology Ethics Application

PART THREE: RESEARCH INSURANCE

**The purpose of this section is to decide whether the University requires additional insurance cover for a research project. In the case of student research, this section should be completed by the supervisor.**

		YES	NO	N/A
1	Is the research to be conducted in the UK?	√		
2	Is the research based <b>solely</b> upon the following methodologies? <ul style="list-style-type: none"><li>▪ Psychological activity</li><li>▪ Questionnaires</li><li>▪ Measurements of physiological processes</li><li>▪ Venepuncture</li><li>▪ Collections of body secretions by non-invasive methods</li><li>▪ The administration by mouth of foods or nutrients or variation of diet other than the administration of drugs or other food supplements</li></ul>	√		

If you have ticked “Yes” to the questions above, then insurance cover is automatic for your research, once your study has been approved by the school Ethics and Research governance Committee and there is no need to do anything further.

If the answer to either of the above questions is “No,” we will supply you with a further questionnaire to complete and return to the Insurance Officer; in these cases **the research should not commence until it has been established that appropriate insurance cover is in place. Please request this questionnaire from the Ethics Administrator.**

**PLEASE SIGN AND DATE THE DECLARATIONS ON THE FINAL PAGE OF THIS FORM OVERLEAF.**

School of Psychology Ethics Application

**Declaration of ethical compliance**

This research project will be carried out in accordance with the guidelines laid down by the British Psychological Society and the procedures determined by the School of Psychology at Bangor. I understand that I am responsible for the ethical conduct of the research. I confirm that I am aware of the requirements of the Data Protection Act and the University’s Data Protection Handbook, and that this research will comply with them.

**Declaration of risk assessment**

The potential risks to the investigator(s) for this research project have been fully reviewed and discussed. As an investigator, I understand that I am responsible for managing my safety and that of participants throughout this research. I will immediately report any adverse events that occur as a consequence of this research.

**Declaration of conflicts of interest**

To my knowledge, there is no conflict of interest on my part in carrying out this research.

***Declaration of data ownership and IPR (for students)***

I understand that any data produced through this project are owned by the University and must be made available to my supervisor on request or at the end of the project. I confirm that I am aware of the University’s Intellectual Property Policy and that this research will comply with it.

*For Undergraduate and Masters projects, I understand that in signing this form I am certifying that the study described meets appropriate scientific standards AND that I have reviewed the procedures described to ensure that they comply with ethical guidelines as published by the BPS and described in the School of Psychology’s Ethical Guidance Procedures.*

**(Chief investigator/supervisor) Dr Michaela A Swales**

**Signed:**

Date:

**(Associate investigator(s)/student(s) Dr Jaci C Huws**

**Mrs Renee E Rickard**

**Signed:**

**Date:**

---

For School Use Only

Reviewer 1 Name..... Approved Signature.....Date

Reviewer 2 Name..... Approved Signature.....Date

Proposal No. ....

**National Health Service Research Ethics Committee Application**

# NHS REC Application

NHS REC Form

Reference:  
10/WNo/54

IRAS Version 3.0

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

**Please enter a short title for this project** (maximum 70 characters)  
Deliberate self-harm: dialectical behaviour therapist's experience-1

**1. Is your project research?**

Yes  No

**2. Select one category from the list below:**

- Clinical trial of an investigational medicinal product
- Clinical investigation or other study of a medical device
- Combined trial of an investigational medicinal product and an investigational medical device
- Other clinical trial or clinical investigation
- Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- Study involving qualitative methods only
- Study limited to working with human tissue samples, other human biological samples and/or data (*specific project only*)
- Research tissue bank
- Research database

**If your work does not fit any of these categories, select the option below:**

Other study

**2a. Please answer the following question(s):**

- a) Does the study involve the use of any ionising radiation?  Yes  No
- b) Will you be taking new human tissue samples (or other human biological samples)?  Yes  No
- c) Will you be using existing human tissue samples (or other human biological samples)?  Yes  No

**3. In which countries of the UK will the research sites be located?** (*Tick all that apply*)

- England
- Scotland
- Wales
- Northern Ireland

**3a. In which country of the UK will the lead NHS R&D office be located:**

- England
- Scotland

Date: 06/09/2010

1

56623/147275/1/965

# NHS REC Application

NHS REC Form

Reference:  
10/WNo/54

IRAS Version 3.0

- Wales  
 Northern Ireland  
 This study does not involve the NHS

**4. Which review bodies are you applying to?**

- NHS/HSC Research and Development offices  
 Social Care Research Ethics Committee  
 Research Ethics Committee  
 National Information Governance Board for Health and Social Care (NIGB)  
 Ministry of Justice (MoJ)

**5. Will any research sites in this study be NHS organisations?**

- Yes  No

**6. Do you plan to include any participants who are children?**

- Yes  No

**7. Do you plan to include any participants who are adults unable to consent for themselves through physical or mental incapacity?** *The guidance notes explain how an adult is defined for this purpose.*

- Yes  No

**8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service in England or Wales?**

- Yes  No

**9. Is the study, or any part of the study, being undertaken as an educational project?**

- Yes  No

**9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?**

- Yes  No

**10. Is this project financially supported by the United States Department for Health and Human Services?**

- Yes  No

**11. Will identifiable patient data be accessed outside the clinical care team without prior consent at any stage of the project (including identification of potential participants)?**

- Yes  No

Date: 06/09/2010

2

56623/147275/1/965

# NHS REC Application

NHS REC Form

Reference:  
10/WNo/54

IRAS Version 3.0

## Integrated Research Application System Application Form for Research involving qualitative methods only



### Application to NHS/HSC Research Ethics Committee

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting [Help](#).

**Short title and version number:** (maximum 70 characters - this will be inserted as header on all forms)  
Deliberate self-harm: dialectical behaviour therapist's experience-1

*Please complete these details after you have booked the REC application for review.*

**REC Name:**  
North Wales-West

**REC Reference Number:**  
10/WNo/54

**Submission date:**  
06/09/2010

### PART A: Core study information

#### 1. ADMINISTRATIVE DETAILS

##### A1. Full title of the research:

Dialectical behaviour therapist's experience of working with people who deliberately self-harm, exhibiting borderline personality symptoms.

##### A2-1. Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:  
Doctorate in Clinical Psychology

Name of educational establishment:  
Bangor University

Name and contact details of academic supervisor:

	Title	Forename/Initials	Surname
	Dr	Michaela A	Swales
Address	School of Psychology Bangor University Bangor, Gwynedd		
Post Code	LL57 2DG		

Date: 06/09/2010

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56623/147275/1/965



# NHS REC Application

NHS REC Form

Reference:  
10/WNo/54

IRAS Version 3.0

E-mail m.swales@bangor.ac.uk  
Telephone 01248382552  
Fax

Name and contact details of student:

	Title	Forename/Initials	Surname
Address	Mrs	Renee E	Rickard
	NWCPP, School of Psychology Bangor University, Bangor Gwynedd		
Post Code	LL57 2DG		
E-mail	r.rickard@bangor.ac.uk		
Telephone	01248383778		
Fax	01248383718		

*A copy of a current CV for the student (maximum 2 pages of A4) must be submitted with the application.*

## A2-2. Who will act as Chief Investigator for this study?

- Student  
 Academic supervisor  
 Other

## A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
Post	Mrs	Renee E	Rickard
Qualifications	Senior Clinical Tutor/Principal Clinical Psychologist Bsc (Hons) Psychology Diploma Clinical Psychology		
Employer	North Wales Clinical Psychology Programme & Betsi Cadwaladr University Health Board		
Work Address	NWCPP, School of Psychology Bangor University Bangor, Gwynedd		
Post Code	LL57 2DG		
Work E-mail	r.rickard@bangor.ac.uk		
* Personal E-mail	r.rickard@bangor.ac.uk		
Work Telephone	01248383778		
* Personal Telephone/Mobile	07871770240		
Fax	01248383718		

*\* This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*

*A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.*

## A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?

*This contact will receive copies of all correspondence from REC and R&D reviewers that is sent to the CI.*

Date: 06/09/2010

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56623/147275/1/965

# NHS REC Application

NHS REC Form

Reference:  
10/WNo/54

IRAS Version 3.0

	Title Forename/Initials Surname
	Dr Oliver Turnbull
Address	School of Psychology Bangor University Bangor, Gwynedd
Post Code	LL57 2DG
E-mail	o.turnbull@bangor.ac.uk
Telephone	01248383670
Fax	01248382599

## A5-1. Research reference numbers. Please give any relevant references for your study:

Applicant's/organisation's own reference number, e.g. R & D (if available):

Sponsor's/protocol number:

Protocol Version:

Protocol Date:

Funder's reference number:

International Standard Randomised Controlled Trial Number (ISRCTN):

ClinicalTrials.gov Identifier (NCT number):

European Clinical Trials Database (EudraCT) number:

Project website:

Ref.Number	Description	Reference Number
------------	-------------	------------------

## A5-2. Is this application linked to a previous study or another current application?

Yes  No

Please give brief details and reference numbers.

## 2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

### A6-1. Summary of the study. Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. This summary will be published on the website of the National Research Ethics Service following the ethical review.

It is recognised that mental health professionals find it particularly difficult to work with people who deliberately self-harm and those diagnosed as having a borderline personality disorder. Attitudes of staff toward these clients have been found to be overwhelmingly negative. Nursing staff are reported to experience stress and a range of difficult feelings and emotions in working with these clients. Some studies have found that staff estimate working with BPD clients to be moderately to very difficult and more difficult than working with clients with other mental health problems.

Supporting staff in their work with DSH and with clients diagnosed with BPD is crucial in order to reduce staff stress and potential burnout. This is also crucial from the client's perspective, as these clients have described negative experiences of health care.

Dialectical Behaviour Therapy (DBT) is a therapy for clients diagnosed with BPD, which recognises the stresses professionals experience in working with these clients and which provides a framework to help staff in working with clients who self-harm. There is some evidence that DBT training has a positive effect on the attitudes and perceptions of professionals to clients diagnosed with BPD.

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The study aims to find out more about how Dialectical Behaviour Therapists experience their work with people who deliberately self-harm (DSH), with symptoms of Borderline Personality Disorder (BPD) and how the therapists make sense of their client's behaviour. The study also aims to learn more about the attitudes and perceptions of DBT therapists toward these clients by studying how they speak about their clients during interview. Experienced DBT therapists will be invited to take part in an interview about their work with these clients, which will be recorded and later analysed using qualitative research methods.

**A6-2. Summary of main issues.** *Please summarise the main ethical and design issues arising from the study and say how you have addressed them.*

1. Participants will be recruited from a group of 20-25 DBT therapists attending quarterly DBT consultation and training days at Bangor University with Dr Michaela Swales, Consultant Clinical Psychologist and academic supervisor for this project. In order to minimise the likelihood of therapists feeling obliged to participate, it is planned that the chief investigator will attend one of the training days to outline the proposed study and to ask for contact details and permission to contact the therapists subsequently to invite them to participate. However, in the event that initial contact with the therapists is necessary before the next scheduled training day, Dr Michaela Swales will be asked to contact potential participants by e-mail to introduce the chief investigator, attach an outline of the study and ask those interested in taking part to e-mail the chief investigator for further details.
2. As Dr Michaela Swales will be in a training/supervision role with prospective participants, only the chief investigator will be aware of the identities of those who have agreed to participate. Participants will be informed of this and that participation in the study is entirely voluntary. The chief investigator will keep a separate file on a password-protected laptop linking specific participants to their pseudonyms until the thesis has been examined.
3. As the chief investigator works in the local area it is possible that she will be known to prospective participants and this may unavoidably influence decisions to participate.
4. Participants of the study will be NHS professionals with busy schedules. It is therefore anticipated that the main burden will be in terms of the time required for participation. This dilemma needs to be balanced with the requirements of qualitative methodology to obtain rich data from a small number of participants. The interviews will take around 60 minutes and up to a maximum of 90 minutes. In order to reduce the time taken to participate in the study, the Chief Investigator will arrange to visit participants at their work base and at a time most convenient for the participant.
5. At the beginning of the interview participants will be reminded that they have the right to withdraw consent without consequence at any time and the interview will be terminated.
6. Participants will be requested not to use the names of particular clients and will be assured that they will not be asked for any identifying details of the clients discussed during the course of the interview. Any names accidentally mentioned at interview will not be included in the transcription.
7. Participants will be informed that interviews will be transcribed with pseudonyms and that no excerpts used in the thesis or in any publications will be tied to particular participants. No-one reading the thesis will be able to identify participants.

**A10. What is the principal research question/objective?** *Please put this in language comprehensible to a lay person.*

How do DBT (Dialectical Behaviour Therapy) therapists experience their work with people who deliberately self-harm, exhibiting symptoms of BPD and how do they make sense of their client's behaviour?

**A11. What are the secondary research questions/objectives if applicable?** *Please put this in language comprehensible to a lay person.*

What can be learned about the attitudes and perceptions of DBT therapists toward this client group from their discourse regarding these clients?

**A12. What is the scientific justification for the research?** *Please put this in language comprehensible to a lay person.*

This study aims to build on the emerging evidence regarding the potential for Dialectical Behaviour Therapy to positively impact upon staff attitudes and perceptions of clients who deliberately self-harm (DSH) with symptoms of Borderline Personality Disorder (BPD).

Evidence suggests that staff find it particularly difficult to work with clients who deliberately self-harm (e.g. Bosman &

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Van Meijel, 2008; Wilstrand et al., 2007; Thompson et al., 2008) and those diagnosed with BPD (e.g. Cleary et al., 2002; Hazelton et al., 2006; & James & Cowman, 2007) and that staff attitudes and perceptions toward these clients are overwhelmingly negative.

Attribution theory has been used as a means to understand the responses of staff to these clients. Studies have found that staff perceive clients who self-harm and those with BPD, as opposed to those diagnosed with either schizophrenia or depression, to have more control over both their challenging behaviour and its causes, to perceive the causes as more stable and that these attributions are associated with less sympathy and less optimism toward these clients (Huband & Tantam, 2000; Mackay & Barrowclough, 2005; Markham & Trower, 2003).

Methods to support staff in their work with DSH and with clients diagnosed with BPD is crucial in order to reduce staff stress and potential burnout. However it is also crucial from the clients' perspective as the suicide rate in people diagnosed with BPD is reportedly similar to that found in schizophrenia and depression (Paris, 2002). Additionally, negative experiences of health care have been described by clients who self-harm (McAllister et al. 2002; Broadhurst & Gill; 2007) and those diagnosed with BPD (Perseus et al. 2005) and Huband & Tantam, (2004) found that client perceptions of staff members delivering an intervention had a bearing on its effectiveness.

Three studies using qualitative (Perseus et al., 2003) and mixed qualitative/quantitative methods (Hazelton et al., 2006; Perseus et al., 2007) have found training in DBT to have a positive effect on the attitudes and perceptions of professionals to clients diagnosed with BPD who engage in DSH. Although staff still experienced their work with these clients as challenging, there was a positive shift in attitudes, more understanding and optimism and greater confidence and satisfaction in their work with these clients.

A detailed examination of the lived experience of DBT therapists with two or more years experience using DBT clinically with clients engaging in DSH with symptoms of BPD will be carried out. Attention will be paid to how experienced DBT therapists make sense of the behaviour of their clients, particularly in the area of causal attributions. In addition, the discourse of DBT therapists regarding their clients will be examined. It is hoped that the study will provide more detailed information regarding the potential for DBT to support therapists in their work with this group of clients, and the mechanisms by which this may take place.

**A13. Please give a full summary of your design and methodology.** *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

Previous research has examined the effects of training in Dialectical Behaviour Therapy on the experiences, attitudes and perceptions of staff working with clients who self-harm with BPD. The level of training in DBT varied across participants with one study examining staff receiving a 2-day training in DBT with some going on to receive more advanced training.

In order to find out more about the potential of DBT to support more experienced therapists in their work with this client group and the mechanisms by which this may take place, an in-depth study of the lived experience of DBT therapists has been planned.

A mixed methodology qualitative design will be used. An Interpretative Phenomenological Analysis will be undertaken to examine DBT therapists' experiences of working with these clients. An in-depth semi-structured interview will be used to explore participant experiences and questions will be included to provide insight into how DBT therapists make sense of their client's behaviour. As part of the interview, participants will be asked to describe critical incidents in their work with particular clients to illustrate a challenging and a rewarding/positive experience. A Discourse Analysis will be carried out primarily on the critical incidents described, to examine the ways in which the participant's discourse positions them in relation to their clients.

8-10 DBT therapists with two or more years experience of using DBT clinically as part of a DBT team will be eligible to participate in the study. Participants will be recruited from a group of 20-25 DBT therapists attending quarterly DBT consultation and training days with Dr Michaela Swales at Bangor University.

Demographic Information will be collected as follows:

Age; gender; work environment (CAMHS/Adult services); profession; years of clinical experience post-professional qualification; level of DBT training; years of experience using DBT clinically; other counselling/psychotherapy qualifications; estimated proportion of caseload consisting of identified client group.

Participants will be interviewed for up to 1-1.5 hours using a semi-structured interview. The interviews will be conducted at the participant's place of work or at Bangor University, depending upon preference.

At interview, all participants will be asked for their consent to be contacted following preliminary analysis of their

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interview transcript. A random sub-sample of consenting participants will be sent a copy of the analysis of their transcript and contacted subsequently by telephone to discuss their views on the credibility of the analysis.

Participants will be asked to indicate whether they would like to receive a summary of the results of the study. A summary will be forwarded to all interested participants.

**A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?**

- Design of the research
- Management of the research
- Undertaking the research
- Analysis of results
- Dissemination of findings
- None of the above

*Give details of involvement, or if none please justify the absence of involvement.*

Centering as it does on the experiences of mental health professionals, this study only indirectly focuses on service users. It is hoped that the study will contribute to an understanding of how mental health staff can be supported to develop more positive attitudes toward and maintain positive therapeutic relationships with this client group, thus minimising the risk of exclusion and experiences of mental health care that are detrimental to an already vulnerable group of people.

As DBT therapists are the focus for the study, Dr Michaela Swales (academic supervisor) who is an experienced DBT therapist and trainer in DBT has been closely involved in the design of the research. Additionally, some participants will contribute to the analysis of the data by giving their views on the credibility of the analysis of their particular interview transcripts.

## 4. RISKS AND ETHICAL ISSUES

### RESEARCH PARTICIPANTS

**A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).**

Trained DBT therapists with two or more years experience of using DBT clinically as part of a DBT team will be eligible to participate in the study.

**A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).**

Therapists who have completed DBT training but are not currently using the therapy as part of a DBT team with the identified client group will be excluded.

### RESEARCH PROCEDURES, RISKS AND BENEFITS

**A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. These include seeking consent, interviews, non-clinical observations and use of questionnaires.**

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

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Intervention or procedure	1	2	3	4
Completing consent form	4	0	5 mins	With chief investigator prior to interview
Interview	4	0	60-90 mins	With chief investigator at participant's place of work or at Bangor University
Reading preliminary analysis of interview transcript	4	0	approx 45 mins	Sub-sample of participants will read the analysis privately at a location of choice.
Telephone call to discuss views on credibility of analysis	4	0	approx 30 mins	Chief investigator will contact relevant participants at a time and telephone number of choice.

## A21. How long do you expect each participant to be in the study in total?

Participants who are being interviewed but are not contributing their views on the credibility of the analysis will leave the study as soon as the interview has ended.

Those who are to receive the preliminary analysis of their interview and a telephone call subsequently to discuss the analysis are anticipated to be in the study for up to 3 months to enable sufficient time for interview transcription, analysis and to arrange a convenient time to discuss the analysis.

## A22. What are the potential risks and burdens for research participants and how will you minimise them?

*For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.*

It is envisaged that the risk to participants will be minimal. It is likely that most interviews will take place at the clinical base of the participant, during working hours or at Bangor University, thus minimising risks associated with lone working.

It is anticipated that the main burden will be in terms of the time required for participation. This dilemma needs to be balanced with the requirements of qualitative methodology to obtain rich data from a small number of participants. The interviews will take 60-90 minutes and in order to reduce the time taken to participate in the study, the chief investigator will arrange to visit participants at their work base or at Bangor University depending on their choice and at a time most convenient for the participant.

Additional time will be required for those participants invited to give their views on the credibility of the analysis. It is envisaged that out of 8-10 participants a sub-sample of 2-3 will be contacted to discuss the analysis. Participants will be asked to consent to this part of the project before the interviews commence. They will be informed that their participation in this part of the study is entirely voluntary and refusal to consent will not exclude them from the study.

## A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

Yes  No

*If Yes, please give details of procedures in place to deal with these issues:*

There is the potential for some distress to participants in discussing the self-harming behaviour of their clients. However these experiences will be discussed in retrospect and all DBT therapists will have already had and will continue to have access to the support of a DBT consultation group and clinical supervision to discuss any difficulties arising in relation to their clinical work.

## A24. What is the potential for benefit to research participants?

No material benefit will be gained by participating in the study. However, it is hoped that the information gained will help in the understanding of the mechanisms by which staff can best be supported to work with this client group.

## A26. What are the potential risks for the researchers themselves? (if any)

No home visits are planned and interviews are to be scheduled during working hours at the work base of the

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participants or the chief investigator, thus minimising risks of lone working.

Although there will be the potential for distress in hearing accounts of self-harm and the stresses of staff in their clinical work, the chief investigator is a Clinical Psychologist with experience working with the identified client group and with regular clinical and research supervision.

## RECRUITMENT AND INFORMED CONSENT

*In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.*

**A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?** For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).

Participants will be recruited from a group of 20-25 DBT therapists attending quarterly DBT consultation and training days with Dr Michaela Swales (academic supervisor) at Bangor University.

**A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?**

Yes  No

Please give details below:

**A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?**

Yes  No

**A29. How and by whom will potential participants first be approached?**

Ideally, the chief investigator will attend one of the DBT consultation and training days to outline the proposed study. Participants will be asked to volunteer to take part in the study and information sheets, consent forms and pre-paid envelopes for returning the consent forms will be distributed.

Approval has been gained from Dr Swales to attend the DBT consultation and training days in order to access potential participants. In the event that initial contact with the therapists is necessary before the next scheduled training day, Dr Swales will be asked to contact potential participants by e-mail to introduce the chief investigator, attach an outline of the study and ask those interested in taking part to indicate their willingness to be contacted.

**A30-1. Will you obtain informed consent from or on behalf of research participants?**

Yes  No

*If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.*

*If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.*

All prospective participants will be given an information sheet and consent form. Information sheets will include contact details of the researcher and will identify the supervisors should participants have any questions or concerns. Participants will be asked to complete the consent form indicating which aspects of the study they agree to participate in i.e. interview, analysis, receipt of study summary. They will be provided with a pre-paid envelope so that consent forms can be returned to the chief investigator.

*If you are not obtaining consent, please explain why not.*

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Please enclose a copy of the information sheet(s) and consent form(s).

**A30-2. Will you record informed consent (or advice from consultees) in writing?**

Yes  No

**A31. How long will you allow potential participants to decide whether or not to take part?**

Participants will be asked to indicate their willingness to participate within two weeks of receiving the study information. However if insufficient numbers have been obtained, participants will be accepted into the study at any time during data collection, which is anticipated to take place over a 3-4 month period.

**A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?(e.g. translation, use of interpreters)**

As participants in this study will have received training in English in Dialectical Behaviour Therapy it is not anticipated that participants will have difficulty understanding verbal explanations or written information in English.

**A33-2. What arrangements will you make to comply with the principles of the Welsh Language Act in the provision of information to participants in Wales?**

Information sheets and consent forms will be translated and presented bilingually in English and Welsh. Once the study has gained ethical approval, information sheets and consent forms will be translated by the relevant department at Bangor University.

**A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? Tick one option only.**

- The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- The participant would continue to be included in the study.
- Not applicable – informed consent will not be sought from any participants in this research.

Further details:

## CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

### Storage and use of personal data during the study

**A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?(Tick as appropriate)**

- Access to medical records by those outside the direct healthcare team
- Electronic transfer by magnetic or optical media, email or computer networks
- Sharing of personal data with other organisations
- Export of personal data outside the EEA

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- Use of personal addresses, postcodes, faxes, emails or telephone numbers
- Publication of direct quotations from respondents
- Publication of data that might allow identification of individuals
- Use of audio/visual recording devices
- Storage of personal data on any of the following:
  - Manual files including X-rays
  - NHS computers
  - Home or other personal computers
  - University computers
  - Private company computers
  - Laptop computers

*Further details:*

Contact details of all prospective participants will be kept securely on the password-protected laptop of the chief investigator, which is the property of the North Wales Clinical Psychology Programme, Bangor University.

Audio files of interviews and Word files of transcribed interviews will be stored electronically on a secure (PIN protected) pen drive and on the chief investigator's password-protected laptop.

The chief investigator will keep a separate file on a password-protected laptop linking specific participants to their pseudonyms until the thesis has been examined.

**A38. How will you ensure the confidentiality of personal data?** Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.

Participants will be informed that interviews will be transcribed with pseudonyms and that no direct quotations used in the thesis or subsequent publications will be tied to particular participants. No-one reading the thesis or publications will be able to identify participants.

**A40. Who will have access to participants' personal data during the study?** Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.

Participants will be informed that only the chief investigator will be aware of the identities of those who have agreed to participate and contact details will be kept securely for the duration of the study.

### Storage and use of data after the end of the study

**A43. How long will personal data be stored or accessed after the study has ended?**

- Less than 3 months
- 3 – 6 months
- 6 – 12 months
- 12 months – 3 years
- Over 3 years

### INCENTIVES AND PAYMENTS

**A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?**

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Yes  No

**A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?**

Yes  No

**A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?**

Yes  No

## NOTIFICATION OF OTHER PROFESSIONALS

**A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?**

Yes  No

*If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.*

## PUBLICATION AND DISSEMINATION

**A50. Will the research be registered on a public database?**

Yes  No

*Please give details, or justify if not registering the research.*

The project is being undertaken as part fulfillment of a Doctorate in Clinical Psychology.

**A51. How do you intend to report and disseminate the results of the study? Tick as appropriate:**

- Peer reviewed scientific journals
- Internal report
- Conference presentation
- Publication on website
- Other publication
- Submission to regulatory authorities
- Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- No plans to report or disseminate the results
- Other (please specify)

**A53. Will you inform participants of the results?**

Yes  No

*Please give details of how you will inform participants or justify if not doing so.*

Participants will be asked to indicate whether they would like to receive a summary of the results of the study. A summary will be forwarded to all interested participants.

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5. Scientific and Statistical Review

**A54. How has the scientific quality of the research been assessed? Tick as appropriate:**

- Independent external review
- Review within a company
- Review within a multi-centre research group
- Review within the Chief Investigator's institution or host organisation
- Review within the research team
- Review by educational supervisor
- Other

*Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:*

The study has been approved by the Senior Research Tutor at the North Wales Clinical Psychology Programme and subsequently by the School of Psychology ethics committee, Bangor University.

*For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.*

*For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.*

**A59. What is the sample size for the research? How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.**

Total UK sample size: 10  
 Total international sample size (including UK):  
 Total in European Economic Area:

*Further details:*

**A60. How was the sample size decided upon? If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.**

As recommended by Smith, Flowers & Larkin (2009) a small, relatively homogenous, purposive sample of participants will be selected. The first 1-2 interviews will be transcribed immediately following completion in order for the richness of the data to be evaluated and for the interview schedule to be amended as necessary.

**A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.**

Under the guidance of Dr Jaci Huws, second supervisor for the project, an Interpretative Phenomenological Analysis of the interview transcripts will be undertaken as outlined by Smith, Flowers & Larkin (2009).

As part of the interview, participants will be asked to describe critical incidents in their work with particular clients to illustrate a challenging and a rewarding/positive experience. A Discourse Analysis based upon the work of Parker (1992) and Potter & Wetherell (1987) will be carried out primarily on the critical incidents described, to examine the ways in which the participant's discourse positions them in relation to their clients.

6. MANAGEMENT OF THE RESEARCH

**A63. Other key investigators/collaborators. Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.**

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	Title Forename/Initials Surname
	Dr Jacqueline Celia Huws
Post	Lecturer and Research Fellow
Qualifications	PhD
Employer	Bangor University
Work Address	School of Healthcare Sciences College Health/Behavioural Science Bangor University, Gwynedd
Post Code	LL57 2EF
Telephone	01248383155
Fax	01248383192
Mobile	
Work Email	j.huws@bangor.ac.uk

## A64. Details of research sponsor(s)

### A64-1. Sponsor

#### Lead Sponsor

- Status:  NHS or HSC care organisation Commercial status:  
 Academic  
 Pharmaceutical industry  
 Medical device industry  
 Local Authority  
 Other social care provider (including voluntary sector or private organisation)  
 Other

*If Other, please specify:*

#### Contact person

Name of organisation Bangor University  
Given name Oliver  
Family name Turnbull  
Address School of Psychology, Bangor University  
Town/city Bangor, Gwynedd  
Post code LL572DG  
Country UNITED KINGDOM  
Telephone 01248383670  
Fax 01248382599  
E-mail o.turnbull@bangor.ac.uk

#### Is the sponsor based outside the UK?

- Yes  No

*Where the lead sponsor is not established within the UK, a legal representative in the UK may need to be appointed. Please consult the guidance notes.*

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**A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?**

Yes  No

*Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.*

**A69-1. How long do you expect the study to last in the UK?**

Planned start date: 01/09/2010

Planned end date: 31/12/2011

Total duration:

Years: 1 Months: 3 Days:

**A71-1. Is this study?**

Single centre  
 Multicentre

**A71-2. Where will the research take place? (Tick as appropriate)**

- England  
 Scotland  
 Wales  
 Northern Ireland  
 Other countries in European Economic Area

Total UK sites in study

**Does this trial involve countries outside the EU?**

Yes  No

**A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:**

- NHS organisations in England  
 NHS organisations in Wales  
 NHS organisations in Scotland  
 HSC organisations in Northern Ireland  
 GP practices in England  
 GP practices in Wales  
 GP practices in Scotland  
 GP practices in Northern Ireland  
 Social care organisations  
 Phase 1 trial units  
 Prison establishments  
 Probation areas  
 Independent hospitals

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- |  |   |
|--|---|
| <input checked="" type="checkbox"/> Educational establishments | 1 |
| <input type="checkbox"/> Independent research units            |   |
| <input type="checkbox"/> Other (give details)                  |   |

Total UK sites in study: 1

## A76. Insurance/ indemnity to meet potential legal liabilities

*Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland*

### A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? Please tick box(es) as applicable.

*Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.*

- NHS indemnity scheme will apply (NHS sponsors only)  
 Other insurance or indemnity arrangements will apply (give details below)

The study will be insured by Bangor University - see indemnity certificate enclosed.

*Please enclose a copy of relevant documents.*

### A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? Please tick box(es) as applicable.

*Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.*

- NHS indemnity scheme will apply (protocol authors with NHS contracts only)  
 Other insurance or indemnity arrangements will apply (give details below)

As above, Bangor University will provide indemnity.

*Please enclose a copy of relevant documents.*

### A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

*Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.*

- NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)  
 Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

As above, Bangor University will provide indemnity.

*Please enclose a copy of relevant documents.*

Date: 06/09/2010

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56623/147275/1/965

# NHS REC Application

NHS REC Form

Reference:  
10/WNo/54

IRAS Version 3.0

## PART C: Overview of research sites

**Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites.** For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.

Research site		Investigator/ Collaborator/ Contact	
Institution name	Bangor University	Title	Mrs
Department name	North Wales Clinical Psychology Programme	First name/ Initials	Renee E
Street address	43 College Road	Surname	Rickard
Town/city	Bangor		
Post Code	LL57 2DG		

Date: 06/09/2010

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56623/147275/1/965

## PART D: Declarations

### D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
  - Will be held by the main REC or the GTAC (as applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
  - May be disclosed to the operational managers of review bodies, or the appointing authority for the main REC, in order to check that the application has been processed correctly or to investigate any complaint.
  - May be seen by auditors appointed to undertake accreditation of RECs.
  - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
11. I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

**Contact point for publication***(Not applicable for R&D Forms)*

*NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.*

- Chief Investigator  
 Sponsor  
 Study co-ordinator



# NHS REC Application

NHS REC Form

Reference:  
10/WNo/54

IRAS Version 3.0

- Student
- Other – please give details
- None

**Access to application for training purposes** *(Not applicable for R&D Forms)*

*Optional – please tick as appropriate:*

I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

Signature: .....

Print Name: Renee E Rickard

Date: (dd/mm/yyyy)

# NHS REC Application

NHS REC Form

Reference:  
10/WNo/54

IRAS Version 3.0

## D2. Declaration by the sponsor's representative

*If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.*

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Signature: .....

Print Name: Dr Oliver Turnbull

Post: Head of School, School of Psychology

Organisation: Bangor University

Date: (dd/mm/yyyy)

# NHS REC Application

NHS REC Form

Reference:  
10/WNo/54

IRAS Version 3.0

## D3. Declaration for student projects by academic supervisor

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.
2. I undertake to fulfil the responsibilities of the Chief Investigator and the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.
3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.
4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Signature: .....

Print Name: Dr Michaela A Swales

Post: Consultant Clinical Psychologist/Lecturer/Practitioner

Organisation: Betsi Cadwaladr University Health Board & Bangor University

Date: (dd/mm/yyyy)

**NHS REC Invitation letter to attend for review**

## File Copy



Pwyllgor Moegeg Ymchwil Gogledd Cymru (Y Orllewin)  
North Wales Research Ethics Committee (West)

**PRIVATE & CONFIDENTIAL**

Mrs Renee E Rickard  
Senior Clinical Tutor  
NWCPP, School of Psychology  
Bangor University  
Bangor, Gwynedd  
LL57 2DG

Betsi Cadwaladr University Health Board  
Ysbyty Gwynedd  
Clinical Academic Office  
Bangor, Gwynedd  
LL57 2PW

Telephone/Facsimile: 01248 - 384.877  
Email: Rossela.Roberts@wales.nhs.uk

02 September 2010

Dear Mrs Rickard,

**Full title of study:** Dialectical behaviour therapist's experience of working with people who deliberately self-harm, exhibiting borderline personality symptoms  
**REC reference number:** 10/WNo01/54

Thank you for your application for ethical review, which was received on 02 September 2010. I can confirm that the application is valid and will be reviewed by the Committee at the meeting on 16 September 2010.

### Meeting arrangements

The meeting will be held in the Llewelyn Room, Ysbyty Gwynedd Hospital, Bangor, LL57 2PW on 16 September 2010. The Committee would find it helpful if you could attend the meeting to respond to any questions from members. Other key investigators and a representative of the sponsor are also welcome to attend. This may avoid the need to request further information after the meeting and enable the Committee to make a decision on the application more quickly.

If you have a disability and need any practical support when attending the REC meeting you may wish to contact the REC office so appropriate arrangements can be made if necessary.

If you are unable to attend the meeting the Committee will review the application in your absence.

The review of the application has been scheduled for 7:30pm. Would you please let me know whether or not you would be available to attend at this time. Please note that it is difficult to be precise about the timing as it will depend on the progress of the meeting. We would kindly ask you to be prepared to wait beyond the allocated time if necessary.

If you cannot attend, it would be helpful if you could be available on the telephone at the time of the review.

Committee meetings are occasionally attended by observers, who will have no vested interest in the applications under review or take any part in discussion. All observers are required to sign a confidentiality agreement.

**Documents received**

The documents to be reviewed are as follows:

Document	Version	Date
REC application 56623/147275/1/965		06 September 2010
Protocol	1	17 May 2010
Interview Schedules/Topic Guides	1	17 May 2010
Participant Information Sheet	1	17 May 2010
Participant Consent Form	1	17 May 2010
Evidence of insurance or indemnity	UMAL	01 August 2010
Investigator CV		01 September 2010
Academic supervisor CV (Dr Jaci Huws)		
Academic supervisor CV (Dr Michaela Swales)		02 July 2010

No changes may be made to the application before the meeting.

If you envisage that changes might be required, we would advise you to withdraw the application and re-submit it.

**Notification of the Committee's decision**

You will receive written notification of the outcome of the review within 10 working days of the meeting. The Committee will issue a final ethical opinion on the application within a maximum of 60 days from the date of receipt, excluding any time taken by you to respond fully to one request for further information or clarification after the meeting.

**R&D approval**

All researchers and local research collaborators who intend to participate in this study at sites in the National Health Service (NHS) or Health and Social Care (HSC) in Northern Ireland should apply to the R&D office for the relevant care organisation. A copy of the Site-Specific Information (SSI) Form should be included with the application for R&D approval. You should advise researchers and local collaborators accordingly.

The R&D approval process may take place at the same time as the ethical review. Final R&D approval will not be confirmed until after a favourable ethical opinion has been given by this Committee.

Guidance on applying for R&D approval is available at <http://www.rdforum.nhs.uk/rdform>.

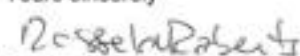
There is no requirement for separate Site-Specific Assessment as part of the ethical review of this research. The SSI Form should not be submitted to local RECs.

**Communication with other bodies**

All correspondence from the REC about the application will be copied to the research sponsor and to the R&D office for Betsi Cadwaladr University Health Board (West). It will be your responsibility to ensure that other investigators, research collaborators and NHS care organisation(s) involved in the study are kept informed of the progress of the review, as necessary.

10/WNo01/54	Please quote this number on all correspondence
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Yours sincerely



**Dr Rossela Roberts**  
Committee Co-ordinator

Email: [rossela.roberts@wales.nhs.uk](mailto:rossela.roberts@wales.nhs.uk)

Enclosure: *Further information about REC membership and meeting arrangements*

Copy to: Sponsor's Representative: Prof Oliver Turnbull, Bangor University  
R&D office for Betsi Cadwaladr University Health Board (West)

**NHS REC Ethical Approval Confirmation**

## File Copy



Pwyllgor Moseg Ymchwil Gogledd Cymru (Y Orllewin)  
North Wales Research Ethics Committee (West)

**PRIVATE & CONFIDENTIAL**  
Mrs Renee E Rickard  
Senior Clinical Tutor  
NWCPP, School of Psychology  
Bangor University  
Bangor, Gwynedd  
LL57 2DG

Bethel Cadwaladr University Health Board  
Ysbyty Gwynedd  
Clinical Academic Office  
Bangor, Gwynedd  
LL57 2PW

Telephone/Facsimile: 01248 - 384.677  
Email: [Rosalea.Roberts@wales.nhs.uk](mailto:Rosalea.Roberts@wales.nhs.uk)

17 September 2010

Dear Mrs Rickard,

**Full title of study:** Dialectical behaviour therapist's experience of working with people who deliberately self-harm, exhibiting borderline personality symptoms  
**REC reference number:** 10/WNo01/54  
**Protocol number:** Version 1 dated 18/06/2010

The Research Ethics Committee reviewed the above application at the meeting held on 16 September 2010. Thank you for attending to discuss the study.

### Ethical opinion

**In discussion, the Committee noted the following ethical issues:**

The Committee queried the answer to question A12 in the application form: the study aims to recruit participants with deliberate self-harm (DSH) and symptoms of Borderline Personality Disorder (BPD) or participant with DSH or BPD. The Chief Investigator clarified that DSH is the defining criteria -with or without a formal diagnosis of BPD.

The committee queried if the recruitment e-mails send by Dr Swales would not amount to coercion? The Chief Investigator clarified that her academic supervisor, Dr Swales, will e-mail potential participants with the request to answer to the student - thus avoiding incentive or coercion.

The Committee noted that the Consent Form has no designated space for Researcher's signature. Mrs Rickard clarified that participants will be given the information Sheet and Consent Form and will have time to consider the information and return the signed Consent Form at a later date - therefore the researcher will not witness the signature.

**On the basis of the information provided, the Committee was satisfied with the following aspects of the research:**

- Social or scientific value
- Scientific validity
- Fair participant selection
- Favourable risk benefit ratio
- Independent review
- Informed consent
- Respect for potential and enrolled participants
- Suitability of the Applicant and Supporting Staff



The members of the Committee present gave a **favourable ethical opinion** of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

#### **Ethical review of research sites**

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

#### **Conditions of the favourable opinion**

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

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

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

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

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

#### **Approved documents**

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
REC application 56623/147275/1/965		06 September 2010
Protocol	1	17 May 2010
Interview Schedules/Topic Guides	1	17 May 2010
Participant Information Sheet	1	17 May 2010
Participant Consent Form	1	17 May 2010
Evidence of insurance or indemnity		01 August 2010
Investigator CV		01 September 2010
Academic supervisor CV (Dr Jaci Huws)		
Academic supervisor CV (Dr Michaela Swales)		02 July 2010

#### **Membership of the Committee**

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

No conflicts of interest were declared in relation to this application.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**After ethical review**

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

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

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

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study


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

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk)

10/WNo01/54	Please quote this number on all correspondence
-------------	--

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

Yours sincerely



**Mr David Owen**  
Chairman

Email: [rossela.roberts@wales.nhs.uk](mailto:rossela.roberts@wales.nhs.uk)

*Enclosure: List of names and professions of members who were present at the meeting and those who submitted written comments*

*"After ethical review – guidance for researchers"*

*Copy to: Sponsor: Prof. Oliver Turnbull, School of Psychology, Bangor University  
R&D office for Betsi Cadwaladr University Health Board*

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Chairman/Cadeirydd – Mr David Owen, CBE, QPM

## North Wales Research Ethics Committee - West

## Attendance at Committee meeting on 16 September 2010

## Committee Members

<i>Name</i>	<i>Profession</i>	<i>Capacity</i>	<i>Present</i>
Dr. Swapna Alexander	Consultant Physician	Expert	Yes
Mr. John Kevan Blomeley	Teacher (retired)	Lay +	No
Mrs. Kathryn Chester	Research Nurse	Expert	Yes
Dr. Christine Clark	Consultant Obstetrician & Gynaecologist	Expert	No
Dr. Derek James Crawford	Consultant Surgeon (Vice-Chairman)	Expert	No
Mrs. Gwen Dale-Jones	PA (retired)	Lay +	No
Mr. Hywel Lloyd Davies	Solicitor (Alternate Vice-Chairman)	Lay +	No
Mr. Henry Alan Owen Hughes	Pharmacy Professional Services Lead	Expert	Yes
Dr. Mike C Jackson	Consultant Clinical Psychologist	Expert	No
Mr. Clive Robert Jenkins	Consultant GCP Auditor	Lay	Yes
Ms. Gillian Jones	Information Governance Manager	Lay	No
Dr. Mark Lord	Consultant Pathologist	Expert	Yes
Mr. David Owen	Retired Chief Constable (Chairman)	Lay +	Yes
Mr. Paramasivam Sathyamoorthy	Consultant Orthopaedic Surgeon	Expert	Yes
Dr. Thanthullu Vasu	Consultant Anaesthetist	Expert	Yes
Mr. Christopher John Whitaker	Statistician	Lay	Yes
Dr. Philip Wayman White	General Practitioner	Expert	Yes

## Deputy Members

<i>Name</i>	<i>Profession</i>	<i>Capacity</i>	<i>Present</i>
Mrs. Rebecca Burns	Research Nurse (deputy to Mrs. Chester)	Expert	No
Dr. Michael Cronin	Consultant Paediatrician (deputy to Dr. Clark)	Expert	No
Mrs. Mair Martin	Pharmacist (deputy to Mr. Hughes)	Expert	No

## In attendance

<i>Name</i>	<i>Position (or reason for attending)</i>
Dr. Rossela Roberts	Committee Coordinator

**NHS Research & Development Committee Approval**



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

Ysbyty Glan Clwyd Hospital, Ysbyty Maelor Wrexham  
Hospital

Adran Ymchwil a Datblygu,  
Ysbyty H M Stanley, Llanelwly,  
Sir Ddinbych, LL17 0RS

Research and Development Department,  
H M Stanley Hospital, St Asaph LL17 0RS

Mrs Renee Rickard  
Senior Clinical Tutor/Principle Clinical  
Psychologist  
School of Psychology  
Bangor University  
Bangor  
Gwynedd  
LL57 2DG

Ein cyf / Our ref: LTJ

Eich cyf / Your ref:

Rhif Ysbyty / Hospital Number:

Rhif GIG / NHS Number:

☎: 01745 589624

Gofynnwch am / Ask for: Lona Tudor Jones

Ffacs / Fax: 01745 589717

E-bost / Email:

Lona.TudorJones@wales.nhs.uk

Dyddiad / Date: 15.10.2010

PRIVATE & CONFIDENTIAL

Dear Mrs Renee Rickard

**Re: Deliberate self-harm: dialectical behaviour therapist's experience-1**

**Ref: RICKARD10/WNo01/54**

The above research project was reviewed at the meeting of the Research Governance Committee / Internal Review Panel held on 15/10/2010 at Wrexham Maelor Hospital.

I have pleasure in confirming that the Internal Review Panel has approved to proceed at Ysbyty Maelor Wrexham Hospital and Ysbyty Glan Clwyd Hospital, however it would be a requirement that the Laptop used for the study be encrypted.

The study should not commence until the Ethics Committee reviewing the research has confirmed final ethical approval (favorable opinion and no objection to site specific assessment).

As part of the regular monitoring undertaken by the Research Governance Committee you will be required to complete a short progress report. This will be requested on a six monthly basis. However, please contact me sooner should you need to report any particular successes or problems concerning your research. Whilst the Health Board is keen to reduce the burden of paperwork for researchers failure to produce a report may result on withdrawal of approval.

All research conducted at Betsi Cadwaladr University Health Board must comply with the Research Governance Framework for Health and Social Care in Wales (November 2001). An electronic link to this document is provided on the Trust's R&D WebPages. Alternatively, you may obtain a paper copy of this document via the R&D Office.

Attached you will find a set of approval conditions outlining your responsibilities during the course of this research. Failure to comply with the approval conditions will result in the withdrawal of the approval to conduct this research at the Betsi Cadwaladr University Health Board.

If you would like further information on any other points covered by this letter please do not hesitate to contact me. On behalf of the Committee, may I take this opportunity to wish you every success with your research.

---

Cyfeiriad Gohebiaeth ar gyfer y Cadeirydd a'r Prif Weithredwr / Correspondence address for Chairman and Chief Executive:  
Swyddfa'r Gweithredwyr / Executives' Office,  
Ysbyty Gwynedd, Penrhosgarnedd  
Bangor, Gwynedd LL57 2PW

Gwefan: [www.pbc.cymru.nhs.uk](http://www.pbc.cymru.nhs.uk) / Web: [www.bcu.wales.nhs.uk](http://www.bcu.wales.nhs.uk)



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NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

Yours Sincerely

*Laura Tudor Jones*

Dr D A Parker  
Director R&D

Cc Copy to R&D



Email: rossela.roberts@wales.nhs.uk

Mrs Renee Rickard  
c/o: Dr Michaela Swales  
NWCPP  
School of Psychology  
Bangor University  
Bangor, Gwynedd  
LL57 2DG

18 October 2010

Dear Mrs Rickard,

**Re: Research Project Review**

**[Rickard 10/WNo01/54](#)**

Dialectical behaviour therapist's experience of working with people who deliberately self-harm, exhibiting borderline personality symptoms

The above research project was reviewed at the meeting of the R&D Internal Review Panel held on 14 October 2010.

**Documents reviewed:**

	Version	Date
Protocol	1.0	17/05/2010
NHS R&D Form - 56623/147285/14/690	-	-
Checklist	-	06/09/2010
Patient Information Sheet	1.0	17/05/2010
Consent Form	1.0	17/05/2010
CV of CI (Renee Rickard)	-	-
CV (Michaela Swales)	1.0	02/07/2010
CV (Jaci Huws)	1.0	02/07/2010

**Comments:** The Committee discussed the study and is satisfied with the scientific validity of the project. The following issues were raised:

- a Data Protection query was raised in relation to storing personal information on a pen drive Page 2 of the patient information sheet – Upon completion of the study, personal details will be stored for up to 12 months electronically on a password-protected pen drive” Pen drive, the Committee assumed is another term for memory stick is only really appropriate for the safe transfer of data, and although encrypted (password protected) it was felt that it’s inappropriate to store information on it for 12 months, especially personal details

**Decision:** Provisional opinion, pending clarifications requested above



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

**Panel Arolygu Mewnol Y&D (Y Gorllewin)**  
**R&D Internal Review Panel (West)**

Betsi Cadwaladr University Health Board  
Ysbyty Gwynedd  
Clinical Academic Office  
Bangor, Gwynedd  
LL57 2PW

Telephone/Facsimile: 01248 - 384.877

Email: rossela.roberts@wales.nhs.uk

I have pleasure in confirming that the Internal Review Panel has considered the above proposal, and would be pleased to grant approval to proceed at the Betsi Cadwaladr University Health Board – West Division sites, subject to resolving the above issues.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chairman.

The Committee will issue a final opinion on the application within a maximum of 60 days from the initial receipt of application, excluding the time taken by you to respond fully to the above points.

The committee expects to receive a response from you by no later than 01/12/2010 otherwise we shall consider the application to have been withdrawn.

If you would like further information on any other points covered by this letter please do not hesitate to contact me.

Yours sincerely

Dr Rossela Roberts  
Clinical Governance Officer (R&D/Ethics)



**RHAGLEN SEICOLEG CLINIGOL GOGLEDD CYMRU  
NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME**



Senior Clinical Tutor  
Llyth-el/E-mail: r.rickard@bangor.ac.uk  
Llinell Uniongyrchol/Direct line: (01248) 383778

Our Ref: RR/R&D/Response

Dr Rossela Roberts  
Clinical Governance Officer (R&D/Ethics)  
Betsi Cadwaladr Universtiy Health board  
Ysbyty Gwynedd  
Clinical Academic Office  
Bangor  
Gwynedd  
LL57 2PW

Dear Dr Roberts

Re: **Rickard 10/WNo01/54** Dialectical behaviour therapist's experience of working with people who deliberately self-harm, exhibiting borderline personality symptoms

Further to your letter of 26<sup>th</sup> October 2010 regarding the R&D Committee's response to my application for approval of the above project, I am writing to address the data protection concern raised.

I can confirm that on the advice of the committee, personal details of the study participants will not be stored electronically. A hard copy of the personal details of participants will be kept securely at the North Wales Clinical Psychology Programme for a period of up to 12 months following completion of the study. The patient information sheet will be amended to take out the information regarding the electronic storage of personal information on a password protected pen drive.

I look forward to the Chairman's response to the proposed amendment.

Yours sincerely

Renee E Rickard  
Senior Clinical Tutor/Principal Clinical Psychologist



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

**Panel Arolygu Mewnol Y&D – Y Gorllewin  
R&D Internal Review Panel – West Division**

Ysbyty Gwynedd  
Clinical Academic Office  
North Wales Clinical School  
Bangor, Gwynedd  
LL57 2PW

Telephone/Facsimile: 01248 - 384.877  
Email: Rossela.Roberts@nww-tr.wales.nhs.uk

**PRIVATE & CONFIDENTIAL**

Mrs Renee Rickard  
c/o Dr Michaela Swales  
NWCPP  
School of Psychology  
Bangor University, Bangor  
LL57 2DG

05 November 2010

Dear Mrs Rickard,

**Re: Project Review:**

**Rickard 10/WNo01/54**

Dialectical behaviour therapist's experience of working with people who deliberately self-harm, exhibiting borderline personality symptoms

The above research project was reviewed at the meeting of the Internal Review Panel held on 4 November 2010. Thank you for responding to the Committee's request for further information.

The Chairman considered the response on behalf of the Committee and is satisfied with the scientific validity of the project, the risk assessment, the review of the NHS cost and resource implications and all other research management issues pertaining to the revised application.

**I have pleasure in confirming that the Internal Review Panel is pleased to grant approval to proceed at Betsi Cadwaladr University Health Board (West sites).**

The study should not commence until the Ethics Committee reviewing the research has confirmed final ethical approval - favourable opinion.

All research conducted at the Betsi Cadwaladr University Health Board sites must comply with the Research Governance Framework for Health and Social Care in Wales (August 2009).

An electronic link to this document is provided on the Trust's R&D WebPages.

Alternatively, you may obtain a paper copy of this document via the R&D Office.

Attached you will find a set of approval conditions outlining your responsibilities during the course of this research. Failure to comply with the approval conditions will result in the withdrawal of the approval to conduct this research in the Betsi Cadwaladr University Health Board.

If you would like further information on any other points covered by this letter please do not hesitate to contact me. On behalf of the Committee, may I take this opportunity to wish you every success with your research.

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Chairman/Cadeirydd – Dr Richard Tranter



GIG  
CYMRU  
NHS  
WALES

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List of documents reviewed and approved:

**Documents reviewed:**

	Version	Date
Protocol	1.0	17/05/2010
NHS R&D Form - 56623/147285/14/690	-	-
Checklist	-	06/09/2010
Patient Information Sheet	1.0	17/05/2010
Consent Form	1.0	17/05/2010
CV of CI (Renee Rickard)	-	-
CV (Michaela Swales)	1.0	02/07/2010
CV (Jaci Huws)	1.0	02/07/2010

Yours sincerely



Dr Richard Tranter  
Consultant Psychiatrist, Associate Director of R&D  
Chairman R&D Internal Review Panel

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Chairman/Cadeirydd – Dr Richard Tranter

# **Appendix I**

## **Participant Information Sheets**

English & Welsh Versions

**RHAGLEN SEICOLEG CLINIGOL GOGLEDD CYMRU  
NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME**

Senior Clinical Tutor  
Llyth-el/E-mail: r.rickard@bangor.ac.uk  
Llinell Uniongyrchol/Direct line: (01248) 383778



Our Ref: RR/InfoSheet/Version1/17/05/2010

**INFORMATION SHEET**

**Title of project:** Dialectical behaviour therapists' experience of working with people who deliberately self-harm, exhibiting borderline personality symptoms.

**Name of researcher:** Renee E Rickard

**Invitation**

You are invited to take part in a research study examining the experiences of Dialectical Behaviour Therapists in their work with people who deliberately self-harm exhibiting borderline personality symptoms. If you are a Dialectical Behaviour Therapist with two or more year's experience post-DBT training who is currently practising DBT as part of a DBT team, you are eligible to participate in this study.

**Who is conducting this research?**

This research is being conducted by Renee Rickard, Clinical Psychologist, Betsi Cadwaladr University Health Board and Senior Clinical Tutor, North Wales Clinical Psychology Programme. The study is Renee's large-scale research project, which will be submitted in part-fulfilment of the final award of doctorate in clinical psychology. The investigation is being supervised by Dr Michaela Swales (Consultant Clinical Psychologist; Betsi Cadwaladr University Health Board & Lecturer/Practitioner; Bangor University) & Dr Jaci Huws (Lecturer and Research Fellow; Bangor University)

**Why is this research being done?**

The difficulties experienced by mental health professionals in working with people who self-harm and those with symptoms of borderline personality disorder (BPD) is widely recognised. Attitudes toward these clients have been found to be overwhelmingly negative and staff are reported to experience stress and a range of difficult feelings and emotions in their work with these clients. There is some evidence emerging from studies of professionals undertaking training in DBT that the training has a positive effect on the attitudes and perceptions of professionals to clients diagnosed with BPD. It is hoped that this study will provide more detailed information regarding the potential for DBT to support therapists in their work with this group of clients, and the mechanisms by which this may take place.

**What does participation involve?**

Participants will be asked to complete a consent form and return it free of charge to Renee. Once consent has been received, Renee will contact participants and answer any questions or queries they may have. She will arrange an interview at a time and location most convenient for participants. Participants will be required to engage in a

single interview, lasting approximately sixty to ninety minutes. Each interview will be audio-recorded for the purposes of transcription and analysis. At the beginning of the interview, a small number of demographic questions will be asked. The interview will focus on participants' thoughts, feelings and experiences of their work with this group of clients as well as the sense they make of their clients' problems and behaviour. Some excerpts from the interviews will be contained in the final write-up of the study. Following the interview, participants will have time to ask any questions that may have arisen during the interview. A small number of consenting participants will be contacted once their interview transcript has been analysed and asked to comment on the analysis.

**Are personal details and interview recordings confidential?**

All personal details and interview recordings will be confidential and will be kept securely. Only Renee Rickard, Dr Michaela Swales and Dr Jacqueline Huws will have access to this information. Each participant will be assigned a pseudonym, which will be used on all documentation and transcripts throughout the study in order to maintain anonymity. Information linking participants to their pseudonyms will be kept separately and securely and only Renee Rickard will have access to this information. It is intended to include some direct quotes from the interviews in the final write-up of the study however the quotes will be anonymous and won't identify participants. Upon completion of the study, personal details will be stored for up to 12 months and all research data will be stored for a maximum of ten years before being destroyed.

If information is shared during interview, which indicates that the participant or another person has been harmed or may be at risk of harm, this information cannot remain confidential and the study supervisor and necessary members of the NHS Health Board will be informed.

**Are there any risks involved in taking part?**

It is unlikely that participants will suffer any negative effects as a result of their involvement in this study. Nonetheless, participants will be free to withdraw from the study at any time. In addition, all participants will have the chance to discuss any issues that may have arisen during the interview process once the interview has been completed.

**Are there any benefits to participants/others as a result of taking part?**

There are no material benefits to participants involved in this research. In terms of future gain, it is hoped that this study will lead to a greater understanding of the ways in which professionals can best be supported to work with clients who self-harm with symptoms of borderline personality disorder and that this understanding in turn will contribute to improved mental health care for these clients. Upon completion of the investigation, all participants will receive a summary of the research findings.

**Has this study been ethically approved?**

This study has been approved by the School of Psychology Ethics Committee, Bangor University and has gained ethical approval from the North West Wales Research Ethics Committee.

**How can I get more information about the study?**

If you would like to hear more about this study, please contact:

Mrs Renee Rickard, Clinical Psychologist, NWCPP, Bangor University,

Tel: 01248-383778 Email: r.rickard@bangor.ac.uk

If you would like to take part in the study, please complete the attached consent form and return it in the pre-paid envelope. Please keep this information sheet so that you can refer to it in the future. You will also be given a signed copy of the consent form for you to keep for your information. Should you have any complaints about the conduct of this study, these should be addressed to :

1. Mary Burrows, Chief Executive, Betsi Cadwaladr University Local Health Board, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW, UK
2. Professor O. Turnbull, Head of School of Psychology, Bangor University, Bangor, Gwynedd, LL57 2DG.

**Thank you for taking the time to read this information sheet.**

**RHAGLEN SEICOLEG GLINIGOL GOGLEDD CYMRU  
NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME**

Uwch Diwtor Clinigol/Senior Clinical Tutor  
Ebost/E-mail: r.rickard@bangor.ac.uk  
Llinell Uniongyrchol/Direct line: (01248) 383778



Ein Cyf/ Our Ref: RR/InfoSheet/Version1/17/05/2010

**TAFLEN WYBODAETH**

**Teitl y Project:** Profiad therapyddion ymddygiad dilechdidol o weithio gyda phobl sy'n eu hanafu eu hunain yn fwriadol, ac yn arddangos symptomau personoliaeth ffiniol.

**Enw'r Ymchwilydd:** Renee E Rickard

**Gwahoddiad**

Fe'ch gwahoddir i gymryd rhan mewn astudiaeth ymchwil fydd yn craffu ar brofiadau therapyddion ymddygiad dilechdidol o weithio gyda phobl sy'n eu hanafu eu hunain yn fwriadol, ac yn arddangos symptomau personoliaeth ffiniol. Os ydych yn Therapydd Ymddygiad Dilechdidol gyda dwy flynedd neu fwy o brofiad ar ôl hyfforddiant DBT sydd ar hyn o bryd yn ymarfer DBT fel rhan o dîm DBT, rydych yn gymwys i gymryd rhan yn yr astudiaeth hon.

**Pwy sy'n cynnal yr ymchwil?**

Mae'r ymchwil hon yn cael ei chynnal gan Renee Rickard, Seicolegydd Clinigol, Bwrdd Iechyd Prifysgol Betsi Cadwaladr ac Uwch Diwtor Clinigol, Rhaglen Seicoleg Glinigol Gogledd Cymru. Project ymchwil mawr Renee yw'r astudiaeth a gyflwynir i gyflawni'n rhannol ofynion cymhwyster doethuriaeth mewn seicoleg glinigol. Mae'r ymchwiliad o dan oruchwyliaeth Dr Michaela Swales (Seicolegydd Clinigol Ymgynghorol; Bwrdd Iechyd Prifysgol Betsi Cadwaladr a Darlithydd/Ymarferydd; Prifysgol Bangor) a Dr Jaci Huws (Darlithydd a Chymrawd Ymchwil; Prifysgol Bangor)

**Pam mae'r ymchwil hon yn cael ei gwneud?**

Cydnabyddir yn eang yr anawsterau a wynebir gan weithwyr proffesiynol ym maes iechyd meddwl wrth weithio gyda phobl sy'n eu hanafu eu hunain a rhai â symptomau anhwylder personoliaeth ffiniol. Cafwyd bod agweddau tuag at y cleientiaid hyn yn negyddol i raddau helaeth iawn ac adroddir bod staff yn profi straen ac amrywiaeth o deimladau ac emosiynau anodd yn eu gwaith gyda'r cleientiaid hyn. Mae peth tystiolaeth yn dod i'r amlwg o astudiaeth o weithwyr proffesiynol sy'n dilyn hyfforddiant DBT bod yr hyfforddiant hwnnw'n cael effaith gadarnhaol ar agweddau a chanfyddiadau gweithwyr proffesiynol at gleientiaid sydd wedi cael diagnosis o anhwylder personoliaeth ffiniol. Y gobaith yw y bydd yr astudiaeth hon yn rhoi gwybodaeth fanylach ynghylch sut y gallai Hyfforddiant Ymddygiad Dilechdidol gefnogi therapyddion yn eu gwaith gyda'r grŵp hwn o gleientiaid, a'r mecanweithiau allai ganiatáu i hyn ddigwydd.

**Beth fydd yn digwydd os byddaf yn cymryd rhan?**

Gofynnir i gyfranwyr lenwi ffurflen gydsynio a'i hanfon yn ôl trwy radbost at Renee. Unwaith y bydd Renee wedi derbyn y ffurflen gydsynio, bydd yn cysylltu â'r cyfranwyr



ac yn ateb unrhyw gwestiynau neu ymholiadau a all fod ganddynt. Bydd yn trefnu cyfweiliad ar adeg ac mewn lleoliad sydd yn fwyaf cyfleus i'r sawl sy'n cymryd rhan. Bydd gofyn i gyfranwyr roi un cyfweiliad, fydd yn para tua awr i awr a hanner. Caiff pob cyfweiliad ei sain-recordio at ddibenion trawsgrifio a dadansoddi. Ar ddechrau'r cyfweiliad, gofynnir nifer fach o gwestiynau demograffig. Bydd y cyfweiliad yn canolbwyntio ar feddyliau, teimladau a phrofiadau cyfranwyr o'u gwaith gyda'r grŵp hwn o gleientiaid yn ogystal â sut maen nhw'n gwneud synnwyr o broblemau ac ymddygiad eu cleientiaid. Caiff rhai dyfyniadau o'r cyfweiliadau eu cynnwys yn yr adroddiad terfynol ar yr astudiaeth. Ar ôl y cyfweiliad, caiff cyfranwyr amser i ofyn unrhyw gwestiynau a all fod wedi codi yn ystod y cyfweiliad. Cysylltir â nifer fach o gyfranwyr sydd wedi rhoi cydsyniad unwaith y bydd y trawsgrifiad o'u cyfweiliad wedi cael ei ddadansoddi a gofynnir iddynt roi eu sylwadau ar y dadansoddiad.

### **Ydy manylion personol a recordiadau o gyfweiliadau'n gyfrinachol?**

Bydd yr holl fanylion personol a recordiadau o'r cyfweiliad yn gyfrinachol a chânt eu cadw'n ddiogel. Dim ond Renee Rickard, Dr Michaela Swales a Dr Jacqueline Huws fydd yn cael mynd at y wybodaeth hon. Caiff pob cyfranwr ffugenw, a ddefnyddir ar yr holl ddogfennau a thrawsgrifiadau trwy gydol yr astudiaeth i ddiogelu preifatrwydd. Caiff gwybodaeth sy'n cysylltu'r cyfranwyr â'u ffugenw ei chadw'n ddiogel ar wahân a dim ond Renee Rickard fydd yn cael mynd at y wybodaeth hon.

Y bwriad yw cynnwys rhai dyfyniadau uniongyrchol o'r cyfweiliadau yn yr adroddiad terfynol ar yr astudiaeth ond bydd y dyfyniadau'n cynnwys manylion personol ac ni fyddant yn enwi cyfranwyr. Ar ôl cwblhau'r astudiaeth caiff y manylion personol eu cadw am hyd at flwyddyn a chaiff holl ddata'r ymchwil ei gadw am ddeng mlynedd ar y mwyaf cyn ei ddiarffio.

Os caiff gwybodaeth ei rhannu yn ystod y cyfweiliad, sy'n awgrymu bod y cyfranwr neu unigolyn arall wedi cael niwed neu mewn perygl o gael niwed, ni all y wybodaeth hon aros yn gyfrinachol a rhoddir gwybod i oruchwyliwr yr astudiaeth ac aelodau angenrheidiol o Fwrdd Iechyd y GIG.

### **Oes yna unrhyw beryglon ynghlwm wrth gymryd rhan?**

Mae'n annhebygol y bydd y cyfranwyr yn dioddef unrhyw effeithiau negyddol o ganlyniad i'w cyfraniad i'r astudiaeth hon. Serch hynny, bydd cyfranwyr yn rhydd i dynnu'n ôl o'r astudiaeth ar unrhyw adeg. Hefyd caiff yr holl gyfranwyr y cyfle i drafod unrhyw faterion a all fod wedi codi yn ystod y broses gyfweiliad unwaith y bydd y cyfweiliadau wedi eu cwblhau.

### **A fydd cyfranwyr/eraill ar eu hennill o gwbl o gymryd rhan?**

Ni fydd cyfranwyr i'r ymchwil hon yn elwa'n faterol o gwbl. O ran ennillion yn y dyfodol, y gobaith yw y bydd yr astudiaeth hon yn arwain at ddealltwriaeth well o'r ffordd orau o gefnogi gweithwyr proffesiynol orau i weithio gyda chleientiaid sy'n eu hanafu eu hunain ac sydd â symptomau anhwylder personoliaeth ffiniol ac y bydd y ddealltwriaeth hon yn ei thro yn cyfrannu at ofal iechyd meddwl gwell i'r cleientiaid hynny. Ar ôl gorffen yr ymchwiliad, bydd yr holl gyfranwyr yn cael crynodeb o ganfyddiadau'r ymchwil.

### **Ydy'r astudiaeth hon wedi derbyn cymeradwyaeth foesegol?**

Mae'r astudiaeth hon wedi'i chymeradwyo gan Bwyllgor Moeseg yr Ysgol Seicoleg, Prifysgol Bangor a chan Bwyllgor Moeseg Ymchwil Gogledd Orllewin Cymru.

### **Sut caf i fwy o wybodaeth am yr astudiaeth?**

Os hoffech glywed mwy am yr astudiaeth hon, cysylltwch â:

Mrs Renee Rickard, Seicolegydd Clinigol, NWCPP, Prifysgol Bangor,  
Ffôn: 01248-383778 E-bost: r.rickard@bangor.ac.uk

Os hoffech gymryd rhan yn yr astudiaeth, a fydddech cystal â llenwi'r ffurflen gydsynio gysylltiedig a'i dychwelyd gan ddefnyddio'r amlen radbost. Cadwch y daflen wybodaeth hon fel y gellwch gyfeirio ati yn y dyfodol. Byddwch hefyd yn derbyn copi wedi'i lofnodi o'r ffurflen gydsynio hefyd, er gwybodaeth i chi. Os ydych yn dymuno cwyno am y modd y cynhelir yr astudiaeth hon, dylech gysylltu â:

3. Mary Burrows, Prif Weithredwr, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW, DU
4. Yr Athro O. Turnbull, Pennaeth yr Ysgol Seicoleg, Prifysgol Bangor, Bangor, Gwynedd, LL57 2DG.

**Diolch i chi am roi o'ch amser i ddarllen y daflen wybodaeth hon.**

## **Appendix II**

### **Participant Consent Forms**

English and Welsh Versions

**RHAGLEN SEICOLEG CLINIGOL GOGLEDD CYMRU  
NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME**

Senior Clinical Tutor  
Llyth-el/E-mail: r.rickard@bangor.ac.uk  
Llinell Uniongyrchol/Direct line: (01248) 383778



Our Ref: RR/Consent/Version1/17/05/2010

**Dialectical behaviour therapists' experience of working with people who deliberately self-harm, exhibiting borderline personality symptoms.**  
**Researchers: Renee E Rickard, Dr Michaela A Swales & Dr Jacqueline C Huws**

**Consent Form**

*Please initial below*

1.	I confirm that I have read and understood the participant information sheet (17/05/10: Version 1). I have had the opportunity to ask questions and have received satisfactory answers.	
2.	I understand that participation is voluntary and that I am free to withdraw at any time without consequence.	
3.	I agree to a single interview lasting 60 to 90 minutes and consent for this to be audio-taped and later transcribed.	
4.	I agree that quotations from the interview can be reported and understand that nothing which identifies me personally will be included in the reporting of the study.	
5.	If selected, I agree to read the analysis of my interview transcript and to speak to the researcher by telephone to discuss my views on the analysis.	
6.	When the study has been completed, I would like to receive a summary of the results.	

**Print Name**.....**Date**.....

**Signed**.....

**RHAGLEN SEICOLEG GLINIGOL GOGLEDD CYMRU  
NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME**

Uwch Diwtor Clinigol/Senior Clinical Tutor  
Ebost/E-mail: r.rickard@bangor.ac.uk  
Llinell Uniongyrchol/Direct line: (01248) 383778



Our Ref: RR/Consent/Version1/17/05/2010

**Profiad therapyddion ymddygiad dilechdidol o weithio gyda phobl sy'n eu hanafu eu hunain yn fwriadol, ac yn arddangos symptomau personoliaeth ffiniol.  
Ymchwilydd: Renee E Rickard, Dr Michaela A Swales a Dr Jacqueline C Huws**

**Ffurflen Gydsynio**

*Rhowch eich  
blaenlythrennau isod*

1.	Cadarnhaf fy mod i wedi darllen a deall y daflen wybodaeth i gyfranwyr (17/05/10: Fersiwn 1). Rydw i wedi cael y cyfle i ofyn cwestiynau ac wedi derbyn atebion boddhaol.	
2.	Deallaf fy mod i'n cymryd rhan o'm gwirfodd a'm bod yn rhydd i dynnu'n ôl ar unrhyw adeg, heb unrhyw ganlyniadau.	
3.	Cytunaf i un cyfweiliad fydd yn para rhwng awr ac awr a hanner a chytunaf i'r cyfweiliad gael ei recordio ar dâp sain a'i drawsgrifio wedyn.	
4.	Cytunaf y gellir defnyddio dyfyniadau o'r cyfweiliad yn yr adroddiad a deall na fydd manylion personol fydd yn dangos pwy ydw i'n cael eu cynnwys wrth adrodd am yr astudiaeth.	
5.	Os caf fy newid, cytunaf i ddarllen y dadansoddiad o'r trawsgrifiad o'r cyfweiliad ac i siarad gyda'r ymchwilydd dros y ffôn i drafod fy marn ar y dadansoddiad.	
6.	Pan fydd yr astudiaeth wedi ei chwblhau, hoffwn dderbyn crynodeb o'r canlyniadau.	

**Printiwch eich Enw:.....Dyddiad:.....**

**Llofnod: .....**

## **Appendix III**

### **Interview Schedule**

## Participant Interview Schedule

### **Experiences of working with DSH/BPD clients**

To begin with, please describe a positive or rewarding experience in your work with one of these clients.

*[Prompts: Tell me a little about the client. Tell me about your work with this client. What was it about the experience that you found to be rewarding or positive?]*

Follow-up Questions:           How did you make sense of this experience?  
  How did the experience make you feel?  
  Was DBT helpful to you in this situation?  
  Were there any ways in which it wasn't helpful?

Please describe a challenging or difficult experience in your work with one of these clients.

*[Prompts: Tell me something about the client. Tell me about your work with this client. Describe the lead up to the experience. What was it that you found to be challenging or difficult in this situation?]*

Follow-up Questions:           How did you make sense of this experience?  
  How did this experience make you feel?  
  Was DBT helpful to you in this situation?  
  Were there any ways in which it wasn't helpful?

### **Sense Making re: DSH/BPD**

How do you make sense of the behaviour of these clients?

*[Prompts: Why do you think these clients behave in the way they do? How do you understand the problems of these clients?]*

### **DBT as a therapy**

What is it like practising DBT?

*[Prompts: How do you feel as a DBT therapist? Are there any aspects of the therapy you find to be particularly helpful? Are there any aspects of the therapy you find to be unhelpful?]*

Before you trained in DBT, how did it feel to work with these clients?

How does it feel to work with these clients now, as a DBT therapist?

## **Appendix IV**

### **Excerpt from sample transcript analysis**

Participant – 'Nick'



## Appendix IV

### Excerpt transcript analysis (p. 1-3) – Rewarding experience

Emerging Themes	Interview 8 'Nick' – 17/03/11	Exploratory Comments
	<p>RR – Okay so I'm interested in DBT therapists' experiences of their work with clients who deliberately self-harm and who may be presenting with some symptoms of Borderline Personality Disorder. So to begin with I wonder if you could describe for me a positive or a rewarding experience in your work with one of these clients.</p>	
<p>Unpredictability - Ups and downs of the work – roller coaster ride.</p> <p>Emotional demands of the therapy for the therapist</p> <p>Unpredictability – good times Vs bad times</p>	<p>P8 – Okay. Ahmm, well for instance I mean, I, I remember working quite intensively with ahmm a young lady who had spent time at the inpatient, ah tier 4 inpatient, quite a long time actually and then I, and then she, then I worked with her in the community intensively over quite a long period of time. Ahmm and it was a real roller coaster ride, but she, she was ahhh, it was a very rewarding experience to work with her and she had a lot of potential an[d], and although there were significant difficulties along the way and there were occasions when, when it was difficult to see how and whether we were going to make meaningful progress, I think at the time she actually did pretty well. And by the time you know, we reached, came towards the end of the work I was, I was very, I was really pleased, I was heartened that she'd come from such a difficult ahmm, period in her life</p>	<p>Brief intro to his work with her.</p> <p>Image of roller coaster ride illustrating the intensity of the experience perhaps – the up and downs of the experience?</p> <p>Something of the extremity of the difficult times – therapist having to sit with feelings that no progress will happen.</p> <p>Ups and down of the work again evident – contrast of the times where can't see possibility of any progress and the pleasure at the end emphasised by 'really' pleased and use of the word heartened.</p>

## Appendix IV

<p>Enormity of the challenges</p> <p>Wider systems and the pressures resulting from outside the therapy.</p> <p>Emotional intensity of the work.</p>	<p>and also extraordinarily complicated and ah difficult, invalidating home environment as well. Ahmm, you know the, the self-harming decreased in severity and frequency at the time and that was maintained. Ahmm I guess at the time as well it was possible because it was a few years ago, it was possible to, there were less pressures to work swiftly and bring cases to closure, so I had the opportunity to see her consolidate her, her achievements you know, which was wonderful really. So...</p>	<p>Challenges and difficulties facing the client evident in the use of language extraordinarily complicated, difficult, invalidating. Does this illustrate something of the challenges of the work but also the potential rewards when it goes well?</p> <p>Reference here to the systemic influences that can create additional pressure.</p> <p>Again the intensity of the rewards, the experience of seeing her move forward – use of the word wonderful.</p>
	<p>RR – Yeh, so it was rewarding to you in terms of seeing the change?</p>	
	<p>P8 – Yes</p>	
	<p>RR – Were there any other things about that work with this young woman that you found to be rewarding?</p>	
<p>Working at the extreme – rewards and pleasure gained</p> <p>More extreme the problems the more intense the rewards</p>	<p>P8 – Ahmm I know I, well, yeh. I mean I, you see I, I get a great deal of pleasure from ahmm vicariously experiencing another person's way of being in the world really, you know. An[d], and if it's, if it's at the more extreme end then somehow for me that's, I mean it's challenging but it's also edifying in a way, d'you know? An[d], an[d], and fascinating if it's something that, that's, if someone is, someone's way of being is so different, d'you know? So I guess that was part of it. Ahmm (pause) there was something about her ability, I</p>	<p>Sense of how difficult it is to put things into words, as though thinking about it and processing it as he speaks – halting speech, repetition of 'I'. Giving us a window into his personal experience of his work – pleasure gained by vicarious experience of another person's way of being.</p> <p>Illustration again of how the more extreme the client's problems/difficulties, the more at the edge, farther removed from the lived experience of the therapist, the more intense the potential rewards – 'edifying', 'fascinating'.</p>

## Appendix IV

<p>Difficulty in sensing/connecting with a real person</p> <p>Emerging sense of client as a person.</p>	<p>don't know how you put this really. There are occasions when I'm working with young people at the extreme end with emerging borderline presentation where it's difficult to get a sense of the person you're working with. Ahmm and I did feel with, with this young lady that as time went by there was a real sense of, of a personality working, d'you know? That maybe wasn't so present earlier on in our work. So I again, I, I don't know, how, how to describe that really but somehow...</p>	<p>A connection between the extreme nature of the behaviour/problems making it difficult to sense the actual person. Is this because of the instability of the client, moods, emotions, behaviours constantly changing perhaps? NB: this idea in relation to the concept of a disorder of 'person'-ality and as progress was made his increasing sense of the client as a person with a personality.</p>
	<p>RR – You mean really getting to know her?</p>	
<p>Having confidence – faith – trust in experience of client as a person</p> <p>Experience of being lost.</p> <p>Personhood of the client changing from time to time</p> <p>Client becoming more real as progress is made</p>	<p>P8 – Yeh, yeh and also ha[ving], having confidence in, in my experience of, of another person. You know there are times when you, you, or in my experience anyway where you often just don't know where you are. You have a sense of a person at one point and then a week or so later you have a, an entirely different experience of, of spending time with, in the company of that person. Whereas this girl over time, it became a more constant...does that make sense?</p>	<p>Interesting choice of term – confidence – 'with faith' – (etymological root of word confidence) in his experience of her. Times of feeling lost, illustration of the intensity and extremity of the client's being affecting him as a therapist – lost, doesn't know where he is – NB idea of trust in relation to this. Unable to trust his experience – he now explicitly links this to the instability of the client – his experience of her can be like being with a totally different person. Toward end of therapy she is more real to him, more present as a person and this linked somehow to stability.</p>
	<p>RR – Ah, yeh it does.</p>	<p>NB: <i>on personal note, the fact that I'm fascinated in what he's telling me almost as though I'm gaining pleasure by vicariously experiencing his experience of being as a therapist and with this client.</i></p>
<p>The highs of the work</p>	<p>P8 – Right, right and that was a joy. And I, I, I think you know I think part of that was about her making meaningful progress in therapy really.</p>	<p>Again the impact of the word – joy- despite the challenges of the work or maybe because of the challenges! He ties the emerging sense of her as a real person to her progress in therapy.</p>
	<p>RR – Yeh, so how did that experience</p>	

## Appendix IV

	make <i>you</i> feel?	
Highs and the lows – the contrast, the extremes	P8 – Ahmm, overall? Exhausted and ahhh with a real sense of ahmm achievement and satisfaction in my work. Yeh, yeh absolutely.	Power of the contrasting language – exhausted Vs achievement & satisfaction, emphasised by use of word absolutely – back to the idea of the roller coaster. No hesitancy in his description this time, in contrast to previous speech when attempting to put his experience into words.

### Excerpt transcript analysis (p. 6-15) – Challenging Experience

Emerging Themes	Interview 8 ‘Nick’ – 17/03/11	Exploratory Comments
	RR – Mmm, okay, lovely. So I want to take you now to the opposite end of the spectrum really and to ask you to tell me or to describe a challenging or difficult experience in your work with one of these clients?	
	P8 – Okay. A particular experience?	
	RR – Yeh. Maybe thinking of a particular client in your mind.	
At the edge – severe end  Chaos and crisis leading to disruption	P8 – Okay, yeh, yeh I’ve got it. Okay so, young lady again at the severe end, has had a number of ahmm, ah, admissions to the tier 4 facility. Ahmm I’ve been working, I’m currently with her and have been working with her for ahmm, oh I don’t know, probably about six months or something now, with, with the admissions amongst the work which have kind of disrupted to some extent. Ahmm there was an occasion oh, maybe a couple of months ago when, I see her at a GP surgery (names local town) in the afternoon on a Thursday generally. Ahmm, I’d gone along ah, to meet with her	Again use of the term severe, another client at the extreme – at the edge?  Severity of the client’s problems illustrated by the need for a ‘number of admissions’ to inpatient facility. Disruption of the work as a result illustrating another challenge to him as therapist.

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<p>Emotional intensity of the work</p>	<p>for the session. She arrived with her boyfriend. She was clearly ahmm in quite a state. Ahmm she was distressed, her boyfriend was anxious an[d], and saying that he was fearful that he wasn't able to keep her safe. She was talking ac...you know she was actively suicidal. She was certainly talking of suicide. She was hopeless. She was ahmm emotional, tearful, <i>very</i>, very difficult to engage. You know and really closing in on herself and very limited eye contact. It was late in the day. Ahmm and I worked <i>very</i>, very hard <i>indeed</i> for about three quarters of an hour to try and engage this girl and, and also with this sinking feeling because my, the,</p>	<p>This section describes the emotional intensity of the situation – P8 dealing with the emotion, distress, active suicidal thinking, hopelessness of the client as well as the boyfriend's fear of not being able to keep her safe.</p>
<p>The struggle to engage, just to connect</p>	<p>the emphasis of the work with her has been, cos she's an older adolescent, she's not far off eighteen now and very much wanting her, I guess feeling pressure in a way and wanting her to get the optimum from the remaining time that she has within the DBT programme. Also bearing in mind that once she transitions to adult services she won't be able to access, so, so there were a number of pressures really. Ahmm so the session moves along and then I reach, it's getting on, it's a quarter to five or something like that and I'm thinking, I, I'm really not getting anywhere here, you know. She, she's not engaging and I'm not able to get her to think in terms of ahmm, ah, strategies for getting through this crisis,</p>	<p>Challenges of the work emphasised by repetition of 'very' - P8 struggling to engage her – not struggling with a task in particular but just the ability to connect with her – limited eye contact, closing in – i.e. closing him and possibly others/the world out.</p>
<p>Impact on the therapist – managing own emotion</p>	<p>Not only sense of it being hard to engage her but now demanding in terms of what is arising in him – a sinking feeling, pressure due to her age and time left in the programme.</p>	<p>NB: how difficult the work is emphasised again by repetition of very and spoke emphasis on 'indeed' – as though it's difficult for him to get across just how hard it was for him.</p>
<p>Systemic pressures – lack of resources in adult services – added pressure on therapist</p>	<p>Systemic pressures also due to lack of continuity of the work into adult services – all of the above being experienced in him as she continues to try to engage her.</p>	<p>Systemic pressures also due to lack of continuity of the work into adult services – all of the above being experienced in him as she continues to try to engage her.</p>
<p>Not being able to connect despite trying really hard, using all of his resources</p>	<p>Sense of how difficult it must be having to accept that 'I'm not able to get to her' – despite his trying really hard, he can't reach her – how does this impact on his sense of his own efficacy?</p>	<p>Sense of how difficult it must be having to accept that 'I'm not able to get to her' – despite his trying really hard, he can't reach her – how does this impact on his sense of his own efficacy?</p>

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<p>Hopes being dashed.</p> <p>Having to accept defeat at least momentarily</p> <p>Benefit of validation to the therapist</p>	<p>even the most rudimentary basic things. We're just not getting there at all. Ahmm (pause) so, I, I'm well that was a particularly difficult experience and I had a sinking feeling and anyway I ended up having a conversation with ahmm the Consultant Psychiatrist and ah, gave him a brief summary of, of what happened. And that was actually a very useful conversation and ah, she was requesting admission, ahmm, which I felt was just not the way to go for her. It would be so much more, it would be so much more useful for her if she were to find a way, with support, to come through this crisis without it necessitating a, an admission or without it ahmm precipitating some extreme high risk behaviour. So she would have taken a significant overdose or she would have self-harmed in a fairly significant way. Ahmm, anyway so I speak to the Consultant Psychiatrist and ah, we decide that in the circumstances that if possible, if we can arrange a short admission without it, without the young lady engaging in whatever the behaviours, then that would be a reasonable outcome in the circumstances. Ahmm, the Consultant was very validating of me, you know (names himself) if you've not been able to access then it's very unlikely that you know, it's possible at the moment. Ahmm, and it panned out very well in the end because I mean he had a conversation with a, with</p>	<p>Difficulty of the experience made clear and the sinking feeling again referred to.</p> <p>Some support from his colleague although leading on to his sense of conflict about the outcome – discussion re: admission and his feelings that this is not the way to go.</p> <p>Sense of his hopes having been dashed, wanting her to come through this crisis in a different way but having to accept that this isn't going to happen. Again the emotional impact of the work for P8 evident throughout this section.</p> <p>Having to accept the admission as the next step.</p> <p>Indication that he has accepted it in that it is now described as a reasonable outcome in the circumstances if it prevents significant self-harm.</p> <p>Importance of the Consultant's validation in the situation given his own process, having to accept that he can't engage her, can't encourage her to find a different way through.</p>
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## Appendix IV

<p>Rapidity of change in clients emotional state – unpredictability, nothing solid to hold on to.</p> <p>Impact on therapist’s sense of self-efficacy – sense of having failed</p> <p>Re-processing of experiences</p> <p>Being hopeful Vs being realistic</p> <p>Limitations of the work – acceptance Vs hope for change</p>	<p>one of the paediatricians in the hospital who was happy for this young lady to have a short admission. So I transported her along and spent the one night on the paediatric ward and the following morning was in a very different state of mind and ahmm and was happy to be discharged and ahmm engage once again. So in some ways, it’s funny, you see a, at the time it, in some ways I felt that that was a fail[ure], a failure you know or, or it just hadn’t worked out in as positive a way as I would’ve liked. But with hindsight now, there are many, many positives from that experience really. You know I thought it was, it was well managed. You know it wasn’t necessary for her to escalate in the way she often does. It was a short admission. Ahmm you know, the suicidal crisis passed. Ahmm so all in all looking back, and also I think I came to realise with this girl that realistically although she’s a very, in some regards a very able girl, she’s a bright girl, she’s been involved with DBT for a <i>considerable</i> amount of time. She has a very good grasp of the skills but she has huge difficulty in using skills when she’s in a crisis of that description. And that, and that’s, you know, that’s being pretty ahmm consistent through time and I think that is the way it is with this girl. You know in some ways I think that, that part of what the system needs to do is support her in, in a helpful way is to accept</p>	<p>Ups and downs of the client apparent in the fact that only the following morning she is in a different emotional state. Backing up his observations toward beginning of interview of the shifting and changing nature of the client from one extreme to another in a short time.</p> <p>Giving further insight into his emotional state at the time, feeling it had been a failure – awareness of how difficult this can be for anyone to process.</p> <p>Benefit of hindsight and evidence of his ability to process the event.</p> <p>It has prevented an escalation of her behaviour, the crisis has passed.</p> <p>Use of the word realistically, implies that he might have been driven by a more idealistic view of what was possible. Despite her familiarity with DBT and the skills, the problems she has in using them in crisis.</p> <p>Having to accept that it ‘is the way it is’. How does this impact on his sense of the efficacy of DBT as a therapy?</p>
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## Appendix IV

<p>Need for balance, knowing when to push and when to accept the client can't manage the emotion.</p> <p>Maintaining hope and balance.</p>	<p>that there will be occasions when for <i>her</i>, the sensible route would be to arrange short periods of admission in a place that she experiences as safe. And maybe it's not realistic at the moment for us to expect her to employ the skills in a meaningful way when she, when she's as dysregulated to the, to the extent that she is on occasion. You know? Which, which enables me to feel a bit more positive ah, ah, and maybe it's a more realistic goal you know, than, than, than kind of pushing, pushing, pushing and somehow expecting this young lady in, in the amount of time we have left to really put into practice these DBT skills when she does experience crises in the community. That's, I don't think that's a very realistic goal from, from where I am now. You know, which is better for, for me. It allows me to feel more hopeful ah, a little bit more relaxed ahmm and I think more balanced in a way. You know, so does that? Yeh?</p>	<p>Word 'realistic' used again and below 'realistic goal'. Recognising the limits of DBT as a therapy maybe. Is this difficult for him, is there a sense of resignation here or more a sense of true acceptance?  <i>NB: Thinking about this in relation to the dialectic in DBT between acceptance and change and how important this seems to be for the therapist as well as for the client, but also that this is a fluid, moving, real process, not a hard and fast thing that can be assessed or measured at one point in time and seen as 'true' subsequently.</i></p> <p>Recognition of how if there is a mismatch between client and therapist in this way then the experience for the client could be of being pushed and for the therapist of pushing.</p> <p>Perhaps an indicator here that this is more about acceptance than resignation in his resulting experience of it being 'better', more hopeful, more relaxed and balanced. <i>Again the ideas of balance and of something shifting and moving, the opposing forces – acceptance Vs change – that it is always moving and shifting – challenges in being able to find the balance point? The art to this work – no one 'truth' in a situation, but having to enter into the emotional waters, to sense when to push and when to draw back.</i></p>
	<p>RR – Yeh, yeh lovely, Yes absolutely, that answers the question. And obviously my interest here is in your <i>experience</i>, the lived experience in that particular situation. So going back to the challenging situation</p>	



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	itself...	
	P8 – Yes.	
	RR - ...sitting with her in the GP surgery...	
	P8 – Yeh.	
	RR – How did the experience make you feel?	
<p>Unpredictability/instability – vast range of emotions/feelings</p> <p>Roller coaster ride – being willing to go along with whatever arises, positive or negative</p> <p>Highs of the work – unexpected challenge, satisfaction</p> <p>Intensity of the work for the therapist</p> <p>Willingness to enter the emotional waters</p> <p>Commitment to use all resources – demands of the work for the therapist</p> <p>The lows – despair – hopelessness</p>	<p>P8 – At the time? Well I, you know, the, there will have been a <i>gamut</i>, you know? I mean, I, I, I would have kind of a, a response when I first met (names client) and saw her as she was. And know, knowing her well enough to know, okay, here we go, this is gonna be, you know, this is gonna be ah, a particularly demanding piece of work. You know so that, I'm going to that and you know, with a mixture of feelings. I mean ahmm you know there's some pleasure to be had in, in a, well in an unexpected challenge. I mean it is the work that I do, the work that I've chosen to do. My, my preference <i>is</i> to work with the more challenging end, older teenagers. That's where I get most of my satisfaction I <i>think</i>, probably. So you know there is an element of ahmm, okay, here we go. You know ahmm, you know, I, I will do everything I can. You know, I'll, I'll dig deep into my repertoire of skills and experience and I'll really work hard to engage and all that. Ahmm, mixed in with that maybe a little bit of ahmm despair and hopelessness possibly d'you know? Oh no, we're not here, you know an[d], and I've</p>	<p>Again the intensity of his emotional experience illustrated by the word 'gamut'</p> <p>Emotional experience beginning right from seeing her – immediate arising of emotion for him. Phrase 'here we go' reminiscent of his earlier metaphor of the roller coaster ride. Sense of having to brace himself for the demands of the work.</p> <p>Polar opposites in terms of experience, pleasure in the challenge and below contrasted with despair and hopelessness. Use of unexpected – sense of how nothing is certain in working with these clients, nothing predictable.</p> <p>Use of satisfaction to describe his being drawn to this kind of work. Again 'here we go' – bracing himself for the ride, no means of predicting what will follow, whether it will be thrilling or scary perhaps – degree of uncertainty.</p> <p>Degree of commitment shown, willingness to go on the ride with the client – he'll do all he can, dig deep – again illustrative of the intensity and demands of the work.</p> <p>Pleasure, satisfaction of the challenge mixed in with, almost dread, 'oh no', having to accept what he's</p>

## Appendix IV

<p>Hope Vs experience</p> <p>Maintaining hope</p> <p>Lows – disheartening</p> <p>Life at the edge – clinging on by fingertips – the power of the emotion</p> <p>Lows – disappointed, disheartened</p> <p>Questioning therapist’s self-efficacy</p> <p>Hopes being dashed</p> <p>Therapist’s need to reprocess events</p>	<p>gotta you know, I’ve gotta accept that’s what I’m hearing from boyfriend for instance who’s telling me very clearly that (names himself) you know I don’t think I can keep her safe. And it’s like, an[d], and I’m sure that what you’re saying is true an[d], and, and it’s not a great place for you to be. And it’s I guess a little bit disheartening, this girl that is so familiar with the skills isn’t able in the moment, in that moment because that would be such a wonderful opportunity to validate and reinforce massively if she were just able, just you know, just to cling on by her fingertips and just come up with just one or two basic ahmm, ah, skills just to get her through. You know, that would’ve been, you know, that would’ve been lovely an[d], and you know? But that isn’t the way it panned out. And at the time you know at the time like I said before I, I probably did feel a little bit ahmm disappointed, disheartened and ahmm maybe questioning whether I could’ve been more effective. Ahmm and then also maybe that having a bit of a knock on in terms of ah, hope for the future or a little bit less hope for the future, you know, at, at that time. Like I say, I feel I have a more balanced, realistic take on this now but at the time. So, so what are we saying? So we’re saying a whole mixture from, from excitement and ah, looking forward to the</p>	<p>hearing but a sense that this is difficult for him.</p> <p>He has to retain some hope despite having to take on board what boyfriend is saying?</p> <p>Poweful descriptor – disheartening – again illustrating just how emotional the work is for him as therapist. Something here about the fact that although DBT is teaching skills and this girl is so familiar with them, it isn’t as simple as teaching them leading to use of them when needed.</p> <p>Another powerful metaphor, cling on by her finger tips – illustrating the power of the emotion – as though being swept along in the wave of emotion. His hopes that she can cling on, seeing this as an opportunity for learning and validation, how lovely that would be for him.</p> <p>Disappointed, disheartened – questioning of himself and his efficacy as a therapist.</p> <p>Leading to less hope on his part.</p> <p>Reiterating, summarising what he’s said. Even the need to do this suggesting something of the extent of the experience.</p>
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## Appendix IV

<p>Huge emotional investment of the therapist – the use of the therapist's self – a real encounter</p> <p>Systemic influences and the importance of them on the emotional experience of the therapist – helping or hindering</p> <p>A real encounter – investment by the therapist.</p> <p>Emotional intensity of the work – frustration, working so hard to connect</p>	<p>challenge and knowing that I'm gonna have to you know, use a great deal of myself in that session, perhaps more than I would ordinarily because, because of the, the challenges I'm being presented with. I also quite enjoyed ahmm you know, managing the systems as well. You know it was a wonderful thing that it was possible to organise that, that admission so simply and in such an unfussy kind of way, you know? It's oftentimes not that way is it? You know when you're thinking about admissions and everything it's really complicated and difficult and there are, you know there are no places and then suddenly you've got another raft of problems on top of what you're being presented with in session and, and you know it's like, my God, please God, this is inhumane almost, you know. Ahmm so yeh, really, a whole mixture. Frustration with (names client). Come on girl, you can do it, I <i>know</i> that you can do better than this, you know? We've been in similar situations perhaps not quite to the extent of where you are at the moment but come on now, a bit of eye contact, you know? This is the real world. This is what all this is about. All this, all the stuff that we do week in week out is about helping you through these experiences in your life when they come along. This is an opportunity for you now. Come on (names client) but not in that moment, no, no, no. So, yeh, yeh.</p>	<p>Idea of how much of himself needs to be invested in the work. More of himself required the more challenging the situation – again illustrative of the demands of the work for the therapist personally and emotionally.</p> <p>Awareness again of the impact of the system surrounding the client and therapist that on this occasions worked out to be supportive and enabled the situation to be dealt with easily and without fuss.</p> <p>Acknowledgement that this is not always the case and so pressure is also exerted on the therapist as a result of the system and it's lack of resources e.g. inpatient place availability.</p> <p>Again powerful language used to describe his experience of how it feels when the system is problematic – use of the word God, appealing to a higher authority, as though at the end of his tether and then use of 'inhumane'.</p> <p>Something here of the dynamic between him and the client, feelings of frustration, her inability to draw on what he has been working with her to cultivate, when the going gets tough. In this section he sounds as though he is taking a tougher stance – 'I know you can do better' with spoken emphasis on 'know' – This is the real world – again as though his stance is tough, wanting her to take responsibility for herself? – real world, does this imply he thinks she's living in a fantasy or unreal world? Again something here about the intensity of the contact with the client and his degree of emotional involvement in the process.</p>
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## Appendix IV

	<p>RR – But it sounds like you really thought it through subsequently so your views of it actually changed quite a bit after the event.</p>	
<p>Re-processing after the event – support from colleagues</p> <p>Support of the consult group</p> <p>Being open to self-examination and questioning own efficacy – being willing</p>	<p>P8 – Undoubtedly, yeh, yeh. Yeh, yeh, absolutely right. Yeh and I guess you know, a part of that is about me being, just reflecting on that experience. Ahmm part of it's been talking to some of the people that were involved. Part of it's been I guess talking in the, in the consult group, you know, people who are familiar with the, this young lady. Ahmm and also yeh, partly it's also about you know, if I'm noticing in myself responses that are ultimately not particularly helpful in terms of my being effective therapeutically then, then I need to do, I need to re-orientate myself a little bit don't I so that I, I'm, I remain ah, reasonably effective, you know? So, yeh.</p>	<p>Importance of his being able to reflect on the experience – so the experience doesn't end when the immediate situation ends with her admission but rather the extent of processing required afterward.</p> <p>Support required from others in order to help him process the experience, speaking to others directly involved and indirectly involved via the consult group.</p> <p>His willingness to be open to the possibility of self-examination, identifying potentially unhelpful responses. Not seeing it all as being to do with the client. Another potentially demanding part of the work, being able to look honestly at his own potential inadequacies and not being too defended to look?</p>

## **Appendix V**

### **Covering Letter & Summary Findings**

**RHAGLEN SEICOLEG CLINIGOL GOGLEDD CYMRU  
NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME**

Senior Clinical Tutor  
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Our Ref: RR/PS/

18<sup>th</sup> August 2011

Dear

**Re: A qualitative analysis of DBT therapists' experiences of their work with young people exhibiting features of borderline personality disorder.**

Many thanks for having participated in the above study examining the experiences of DBT therapists working with young people with BPD features. 8 DBT therapists consented to take part in the study and interviews with each participant were transcribed and analysed using Interpretative Phenomenological Analysis (IPA). When you consented to participate in the study you indicated that you were agreeable to being contacted after the data had been analysed to give your feedback on the credibility of the analysis.

In consultation with Dr Jaci Huws who has particular expertise in qualitative analysis it has been suggested that the most useful way to gain feedback from participants is for you to be provided with a summary of the overall analysis. I would be most grateful if you could read through the attached summary and consider it in relation to your recollections of your interview for this study as well as your experience of working with these young people more generally. Your thoughts on the analysis and its applicability to your particular experience would be much appreciated.

You can reply with any comments you would like to make to [r.rickard@bangor.ac.uk](mailto:r.rickard@bangor.ac.uk) or alternatively I can arrange a telephone call at your convenience. If you would like me to arrange a telephone call, please contact me via e-mail or on 01248-383778/383883 to let me know.

Many thanks,

Renee E Rickard  
Senior Clinical Tutor/Clinical Psychologist

## **A qualitative analysis of DBT therapists' experiences of their work with young people exhibiting features of borderline personality disorder.**

### **Summary of findings**

The interviews generated a wealth of interesting and valuable information in helping us to gain an 'insider' perspective into the experience of DBT therapists in their work with these young people. The amount of information generated means that there are 2 and perhaps even 3 research papers emerging from the study.

1. Paper 1 will concentrate specifically on the therapists' 'lived' experience within the therapeutic relationship with their clients.
2. Paper 2 will concentrate on the therapists' experiences of DBT and of practicing DBT with these young people.
3. Paper 3, is the least developed at present and if there is sufficient data for a complete paper, will focus on DBT therapists' understanding and perceptions of their clients' problems.

### ***Therapists' experiences within the therapeutic relationship.***

The analysis resulted in a super-ordinate theme of '*the impact of the therapy on the therapist*'. This super-ordinate theme was illustrated vividly by metaphors of a whirlpool and 'setting up a tent in a hurricane' which were seen as providing a unique insight into the powerful way that the therapy impacted upon the therapist. Additionally, one participant described working with this client group as qualitatively different to working with young people with other mental health problems and illustrated the depth to which these clients entered his/her internal world by describing the experience at a visceral level.

The super-ordinate theme '*the impact of the therapy on the therapist*' contained five themes as follows:

(i) *working at the extremes - the highs and the lows*

One participant's metaphor of a roller coaster ride illustrated the rapid swings of emotion that the therapists experienced in their work with these young people. Positive feelings and emotions including joy, a sense of achievement, fascination and pride were experienced alongside more difficult emotions including anger, irritation, frustration, pessimism, powerlessness and hopelessness.

(ii) *instability, unpredictability and rapidity of change*

Participants spoke of the transient or momentary nature of their experience suggesting that therapists had nothing solid or stable to hold onto in the midst of the highs and lows of the work. Several participants illustrated how rapidly and completely things would change within the therapeutic relationship. Their clients' views of the therapy and the participants, as therapists, changed frequently. For one participant this instability and rapidity of change led to a lack of trust in his/her experience.

(iii) *challenges to the therapist's self-efficacy*

Faced with the on-going highs and lows and the instability and uncertainty inherent in their work with these clients, a theme across participants was the questioning of themselves and their efficacy as DBT therapists. The consistency of this theme across participants was particularly interesting given the range of experience practising DBT (range 2-13 years). Therapists described self-doubt, and experiences including worry, feelings of failure, inadequacy, incompetency and uselessness.

(iv) *the emotional demands of the work*

This theme was closely related to the low points of the work however, in addition to the range of difficult emotions experienced, this theme illustrated the significant demands placed upon the therapists in their work with these clients. Participants stressed that the work was 'taxing', 'emotionally challenging', 'really hard work' and that these clients 'are probably one of the most difficult client groups to work with.' Participants spoke of experiences including, 'anxiety', 'worry', 'pressure', 'feeling conflicted' and 'inclined toward hopelessness' and two participants gave insight into their own struggles to regulate their emotion.

(v) *dealing with the turbulence.*

In the context of the extremes of emotion experienced, the uncertainty and rapid shifts in the therapy and the significant emotional demands of the work, this theme centred on the different ways in which participants responded to the challenges of their work. Therapists reacted in different ways to these demands for example by trying to become stronger internally, trying harder and using more of their own resources, trying harder to make sense of their clients, looking forward to the ending of therapy, and ultimately for one therapist, a focus on self-preservation.

***Therapists' experiences of practising DBT***

Although the write-up of this section hasn't begun as yet, the analysis indicates several core themes as follows:

(i) *The Dialectic of DBT*

- *The Thesis – DBT as Containing*

Across participants there was a consistent experience of DBT as 'containing' for the therapist in the midst of the highs and lows and the unpredictability inherent in working with these young people. In particular the structure and framework inherent in the model and the support of colleagues via the DBT consultation group were experienced as helpful and supportive. These aspects of the therapy were experienced as helping therapists to manage risk in their clients and to manage their own emotions e.g. anxiety in this process. Language such as 'secure', 'safe', 'solid', 'supported', 'having a foundation', 'steady' illustrated the sense of containment provided by DBT.

- *The Antithesis – DBT as Constraining*

Conversely some participants also experienced DBT as constraining. The clear structure and framework were at times experienced as too prescriptive with



some participants speaking of a desire for it to be 'looser' to be able to 'break out of the rules a little bit'. Two participants spoke of finding it hard to prioritise issues that the model would indicate are most important when so many other, potentially more distressing events may have taken place in the client's life. For another participant, the focus on the behaviour of the client led to the concern that the personhood of the client could somehow be overlooked.

- *Finding the Synthesis*

There was a sense from some participants that over time they had begun to feel less constrained or less worried about getting things right in terms of the model and the strategies that DBT incorporates. Some participants felt more able to be creative within their practice of DBT. One participant found strategies that fitted well with his/her 'natural inclinations', another spoke of 'letting myself loose a little bit' and feeling more comfortable with strategies that 'sit well with me'. Another participant talked about 'freedom' within the model to 'do it in your own way' and indicated that this was a process that 'develops over time'.

(ii) Complexity of DBT

Another theme across a number of participants related to finding DBT to be a complex therapy to learn, to understand and to remember. The main textbook was referred to as complicated, another therapist referred to the therapy itself as a 'complicated therapeutic modality' and for another the strategies were regarded as 'complicated'. There was a sense of therapists finding it difficult 'to hold onto everything' of 'such a lot to hold in your head' when trying to work out what to do at any one time. This seemed to be related to the feeling that some therapists had of not following what his/her intuitive or 'gut instinct' would suggest.

(iii) The fit of the therapist to DBT

This theme illustrated the importance of the fit between therapist and model or between therapist and client group. Although some participants found strategies that fitted them well and with which they felt at ease, there were other accounts of a tension between the response that DBT would indicate and the 'natural style' of the therapist. Two participants specifically referred to feeling 'clumsy' when responding according to the model but in a way that didn't fit with their 'instinctive gut response'. Another participant reflected that the client group were probably not one that he/she was drawn to and hence feeling that 'it wasn't such a good fit with me'. At the opposite end of the spectrum another participant reflected that he/she had always been 'attracted' to working with these young people and was keen to 'soak up the learning' regarding DBT.

(iv) Work with BPD clients before DBT

A common theme was the difficult experiences therapists had with BPD clients before training in DBT. The descriptors used by participants were powerful in illustrating the challenges they faced. Participants described feeling 'completely lost', 'confused', 'ineffectual', experiencing the work as 'chaotic', as 'hard work',

having high levels of anxiety and feeling as though 'burning out...just wanting to close the case and run away from the therapeutic work'. These reflections were particularly interesting when considered alongside the experience of DBT as containing.

***How DBT therapists' make sense of their clients' problems***

Preliminary analysis of this section of the study indicates the following themes:

(i) Neglect, trauma and invalidation

The problems of young people with BPD features were consistently understood by therapists as occurring in the context of difficult early experiences including neglect, trauma and invalidation.

(ii) Problems related to attachment

A consistent theme across many therapists was an understanding of their clients' problems in relation to disrupted/inconsistent attachment in early childhood.

(iii) Fears of rejection and abandonment

This theme is connected to the view that the problems of these young people are related to insecure attachment. They were seen as having an 'extreme sensitivity to rejection', to be 'vigilant' to changes in the therapeutic relationship as though on the look out for signs of rejection. Their behaviour was also conceptualised as attempting to prevent abandonment by key figures in the young person's life.

(iv) Regulation of emotion

In keeping with the DBT model of BPD, therapists viewed their clients' behaviour as a means of regulating emotion and as a way of trying to cope.

(v) Normality Vs Pathology

Across participant accounts there was a sense of these young people being understood and in that understanding, being normalised rather than pathologised. Therapists viewed their client's behaviour as an understandable reaction to difficult early experiences and as having been conditioned by the environment. These clients were described as 'desperate young people', 'ordinary kids dealt a bad hand', as simply 'people trying to get through' and as 'wanting things we all want'. These views of the client seemed to result in a sense of connection with the client, of the shared humanity between client and therapist. This was illustrated particularly strongly by the comments of two participants that the diagnostic criteria for BPD 'could describe everyone at some point' in their lives and that we're 'all a bit borderline here and there aren't we?'.

## **Appendix VI**

### **Participant Feedback - 'Tom' and 'Beth'**

**E-mail feedback from 'Tom' received 24/08/11**

*"Wow! I have just read through your themes and definitely feel they touched me in a meaningful way, and reflect my ideas when we spoke<sup>4</sup>. Well done!*

*No further comments - I hope you see that as a good thing."*

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<sup>4</sup> NB: one sentence was deleted to maintain the participant's anonymity

**Notes from Phone Call with 'Beth' – 03/10/11**

Great metaphor – putting up tent in hurricane – reminded her of a film she'd seen, someone trying to seek shelter under a sarong in a desert. Liked the metaphor visually. Reflected that 'you're not going to get rid of the desert but to help people get by, in chaotic complex situations'.

When she read the summary she thought it made the job seem impossible – 'seems like an overwhelming task at the start'. However, this feeling reminds her to break it down, to do small things, small skills.

Highs and lows / instability / unpredictability – she related to this 'absolutely'. She then commented that it led to radical acceptance and having to let go of her attachment to the outcome.

Talking of the challenges to self-efficacy and the emotional demands she spoke of the importance of the consultation group – commenting that at times 'you can spin off on it all'.

The dialectic of DBT as containing and constraining 'spoke' to her greatly although for her personally the structure fits well.

She then went on to talk about the challenges of the organisations and structures around the young person and that the agencies and associated staff often don't know how to deal with the young person or can expect a 'fix' from CAMHS.

Asked to reflect on the summary findings generally, she explained that the 'themes really did resonate'. She then pondered that perhaps she didn't 'worry enough about people', realising that she often takes what she does for granted including managing risk – now she realises 'how challenging the work is when it is seen written down in this way in black and white'.

## **Appendix VII**

Superordinate Theme: The Impact of the Therapy on the Therapist

### **Theme Quotes – All participants**

## Super-Ordinate Theme: The Impact of the Therapy on the Therapist

### Quotes – All Participants

#### ***Overarching metaphors/quotes***

Ahmm you know that, that, yeh, you know this thing about setting a tent up in a hurricane or you know those kinds of ways of describ[ing] and it, and it's very much that way.... (Nick)

So yeh, I could have some sort of feelings of bafflement and just contained in the sense that it's okay to have those, phenomenologically they went with the territory. Actually it would, it would be a bit bizarre if I didn't because it was chaotic and whirlpooly and messy. (Beth)

but *all* of that still doesn't take away from the fact that to sit in a room with some of these clients sometimes *is* really, really difficult and it's difficult in a *different* way to how it is to sit in a room with someone that's quite low. Very often, *even now* I will leave a session with a DBT client *feeling* like a bit jiggled up inside, feeling a little bit like someone's just got inside me and kind a like, I don't know, messed it up a bit and then it'll take me a little bit of time to just kind a come back down an[d], and obviously you know that, that's an example of their experience, it's just, it's just a, a transference thing but, I don't think that'll *ever* stop because they bring up something quite *specific* and sometimes I wonder like who's the most scared, me or them, of that. I sometimes wonder are they scared of becoming regulated and I'm scared of becoming dysregul[ated], I don't know, people that you know, benefit from DBT *are* like, are really, really difficult to work with, I think that they present, they are very *taxing* to work with the most...(Tom)

#### **(i) Working at the extremes - the highs and the lows**

##### *Therapy as a Roller Coaster Ride*

it was a real roller coaster ride, but she, she was ahhh, it was a very rewarding experience to work with her... there were significant difficulties along the way and there were occasions when, when it was difficult to see how and whether we were going to make meaningful progress (Nick)

##### *Working at the extremes - the highs:*

It felt like an achievement...I think that once I felt that I, I *had* her in some way, kind of I had *hold* of her, not in a squashing kind a way, like a just holding her (moves his hand to demonstrate from a tight fist to an open palm) I felt...I did feel a sense of achievement. I felt, happy isn't the right word. It was (pause) yeh...it was a relief and it was an achievement I suppose. (Tom)

Ahmm so, yeh we've got one girl who kind of it's quite nice seeing her come in with her *folder* and clearly refers to *skills* and who is, says would it be alright if

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she discussed the skills with her *sister*. So you know, things like that's quite nice. (Kate)

I suppose just really kind of proud, kind of proud of her, proud of some of the work we've done. (Kate)

ah touched I suppose an[d], and I don't know, *in* touch a bit with *their* feelings I think (Roz)

And ahmm kind of the profound effect of having, having some language to go along with some of the descriptions of his experiences, how that's what it, it was like a light went on really I can only describe it like that. I, I think that was really, really, that was really lovely to see and ah so[rt], ju[st], ju[st] you know, kind of confirmed that it was the right, the right way to be working with this young person. (Beth)

I think that what was particularly rewarding was that she was ahmm, quite difficult to ahmm engage in therapeutic work. Ahmm and I think that we managed to find ahmm a really good working relationship quite quickly ahmm and so we were running in the therapeutic sessions together to help manage difficult feelings. Ahmm and ahmm and, and, and she was not on[ly] she was wanting to, to self-harm because that was her goal but also it was, she had a lot of pride in terms of telling me how she had managed not to, to carry out a sort of a highly suicidal thought or urge that she had and how she'd managed to sort of use the skills to, to bring it back. Ahmm and so ahmm so we would both celebrate the fact the she'd used the skills in, in session sort of positive experience for her and for me. (Megan)

it's ahmm it's quite a challenge and, and quite a sort of I really enjoy working with them ahmm and ah cos ahmm if, if you can engage them in the therapeutic work then ahmm then you can have sort of like ah positive outcomes and you know, ahmm potentially. And I think the key bit is, is if you can engage with them cos sometimes they're a, they're a fickle group of people that have ahmm relationship issues as a you now as part of their formulation and so if you can ahmm engage them and work with them then they're very rewarding and ahmm ah and I enjoy the challenge that, that working with them brings. (Megan)

it meant we were able to kind of get a focus to the session... and it felt like you know, she, she really wanted to have some help with it and had a plan about you know, how you go about that. Ahmm it felt really collaborative... and then she had a plan to kind of, go away with... leaving the session thinking oh that hu[ng], you know hung together really well, felt it was a success. (Emma)

it was really rewarding because we'd got to the point where she was very, not just, ahmm open to the idea of doing the chain analysis, she actually really wanted to, to do it I think. She ahmm ah, I could see she found it valuable and she did it really thoroughly and she'd sort of said, I've been thinking about this beforehand and she could do it very quickly. You know it was just rewarding in



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that I could see it being valuable to her and that it generated sol[ution], the solutions to, you know she could identify the bits that were changeable that she would want to do differently and ahmm she went through it without a lot of intervention from me. I think what, yeh, so just staying positive it as ahmm that she was using the model and using ahmm the skills and you could see that they were helpful for her. (Becky)

I suppose, it, it's, it makes you feel ahmm quite effective really cos it, cos the DBT skills aren't, aren't easy to ahmm to, to use in a crisis situation for young people. (Megan)

Yes, when you get those kind of experiences you think, I do know what I'm doing (laughs). I think that's the, that's the kind of cycle that you go round and round in, well in other models as well, but particularly with DBT, kind of think, I don't know, I don't know it all, I can't remember this strategy or this bit or that bit and so it's when you get those, you know those experiences where it all seems to come together you think, yes I *do* know what to do and I *am* referring to the principles and I know why I'm guided, where I'm going. So yes, it's, it's validating in that way I suppose (Emma)

I was, I was very, I was really pleased, I was heartened that she'd come from such a difficult ahmm, period in her life and also extraordinarily complicated and ah difficult, invalidating home environment as well. Ahmm, you know the, the self-harming decreased in severity and frequency at the time and that was maintained. (Nick)

I had the opportunity to see her consolidate her, her achievements you know, which was wonderful really. (Nick)

I mean I, you see I, I get a great deal of pleasure from ahmm vicariously experiencing another person's way of being in the world really, you know. An[d], and if it's, if it's at the more extreme end then somehow for me that's, I mean it's challenging but it's also edifying in a way, d'you know? An[d], an[d], and fascinating if it's something that, that's, if someone is, someone's way of being is so different, (Nick)

Right, right and that was a joy. (Nick)

I also quite enjoyed ahmm you know, managing the systems as well. You know it was a wonderful thing that it was possible to organise that, that admission so simply and in such an unfussy kind of way, you know?... (Nick)

*Working at the extremes - the lows:*

it's I guess a little bit disheartening, this girl that is so familiar with the skills isn't able in the moment, in that moment because that would be such a wonderful opportunity to validate and reinforce massively if she were just able, just you know, just to cling on by her fingertips and just come up with just one or two

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basic ahmm, ah, skills just to get her through. You know, that would've been, you know, that would've been lovely an[d], and you know? But that isn't the way it panned out. And at the time you know at the time like I said before I, I probably did feel a little bit ahmm disappointed, disheartened (Nick)

Frustration with [Jess]. Come on girl, you can do it, I *know* that you can do better than this, you know? We've been in similar situations perhaps not quite to the extent of where you are at the moment but come on now, a bit of eye contact, you know? This is the real world. This is what all this is about. All this, all the stuff that we do week in week out is about helping you through these experiences in your life when they come along. This is an opportunity for you now. Come on [Jess] but not in that moment, no, no, no (Nick)

Anger, irritation, kind of feeling a little bit like, what's the point? (Tom)

I think to begin with was quite pessimistic about what we would be able to give this young person ahmm, in terms of kind of, she was presenting in a worse position than when she had first come (Kate)

some of the crises that they get into i[t], they find it really hard to see their part in it. And while sometimes my heart goes out to them, there's other times like, last week I had a DBT client cancel her appointment to phone with a crisis the following day (soft laugh). And I find that really frustrating. (Kate)

Annoyed. Yeh, ah, we[ll] I *was* annoyed with this client because you know, I think it does them no favours to then say well you know don't worry about forgetting yesterday, we'll do it today because actually that's not how life works. But I think we could have perhaps avoided the crisis had she attended and it's *really* hard for her to see some of those links. (Kate)

So I feel a little bit sort of ahmm powerless to, to repair or to work out with her what, what's gone wrong really which feels a bit uncomfortable. (Megan)

Well I guess there's still temptation to slip into that sometimes. You can kind of like well we're not getting anywhere (Emma)

well it was yes, difficult at lots of levels. She was still so distressed it was very hard for her to engage in the process ahmm and she was so overwhelmed, so kind of ahmm, it was so prominent in her thinking, the, the suicidal thoughts that she couldn't really, she couldn't use any of the skills for example but also I suppose partly what you're asking someone to do in this session is to take that step back, so be slightly mindful, to observe what it is we're talking about rather than just experience it and that was so difficult. (Becky)

to some, some extent also, yeh, how do we *expect* these young people to *do* this (sounds incredulous). You know this is really a big ask, you know to do this and yeh we would want to die and kind of finding, not that I wouldn't, I've lost

faith in the model but ahmm yeh, this is, this is [an] incredibly hard thing to ask you to do. (Becky)

You know there are times when you, you, or in my experience anyway, where you often just don't know where you are. (Nick)

but I think with that client there was just a general feeling of i[t], there was a lot being played out in the relationship and it was difficult to manage. (Roz)

but it's not a pleasant experience when you have such hostility really, yeh. (Megan)

*The highs juxtaposed with the lows:*

Ahmm, overall? Exhausted...with a real sense of ahmm achievement and satisfaction (Nick)

I mean ahmm you know there's some pleasure to be had in, in a, well in an unexpected challenge. I mean it is the work that I do, the work that I've chosen to do... Ahmm, mixed in with that maybe a little bit of ahmm despair and hopelessness possibly d'you know? Oh no, we're not here... (Nick)

I mean i[t], it just evokes a whole range of, of, of feelings and, both negative and positive I think, you know? (Nick)

So you can go from you know, [a] sense of exhilaration and, and great satisfaction in the work that you're doing and feeling positive and, and ahmm you know, at the one end and then at the other end, it, it can be ahmm overwhelming and confusing and ah profoundly disheartening (Nick)

**(ii) *Instability, unpredictability and rapidity of change***

So I transported her along and [she] spent the one night on the paediatric ward and the following morning was in a very different state of mind and ahmm and was happy to be discharged and ahmm engage once again. (Nick)

and within you know a relatively short space of time and I think that that, that in a way replicates the experience of the emerging borderline individual of their own lives. It's almost that, a kind of ahmm pattern, so... I mean that is how it is for me. I mean even in the course of a day. (Nick)

and ahmm I saw her on a Thursday and she was, she was on very good form indeed, she was at her best. You know, she was engaging, she was lively she was alert, she was ahmm, ah, happy with, with some of the things she's been able to achieve, she was ahmm, good humoured. You know, it was, it was a really enjoyable session and I, it was a really, it was a pleasure to be able to be so positive and validating of her. You know, I've really enjoyed the session today, you know, da, da, da, da, da.... Ahmm but then that *evening* she was admitted in crisis. D'you know? How does that work? (Nick)

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the, the only sort of whisper that I had that, that there was something that was kind of beginning to niggle her was the fact that her mother had ahmm promised that she would visit on a number of occasions over, over the few days coming up to that Thursday and hadn't, had repeatedly let, let her down. And that was the only kind of little indication of something that could potentially develop into a bit of a crisis for her. But ah, you know, extraordinary really. (Nick)

And I think the trouble I find often is when you have a rewarding experiences with clients and maybe a couple of weeks later they've gone back *down* again and it feels like, well that didn't, you know it wasn't *sustained* so... (Roz)

I remember drawing on the acting opposite skills an[d] and the foster car[er], we, we rehearsed what she might do ahmm which was to give the foster carer a hug and to say I'm still angry but I, you know, I *do* love you. And so she did that and it was so moving, cos they were both sort of, kind of crying and hugging really and I was, you know I was welling up as well, ahhh it was so... And I think, oh, it was yeh cos she was saying she was *definitely* going to kill herself it was one of those moments where, we're on the verge of having to send her, having to say look you better just take her to A&E. Ahmm cos she was refusing to give us any guarantees that she wouldn't ahmm and that dissipated it in that moment. But that, the thing I was saying before about you, you know the ah, transient nature of that is I think we, a week later we were pretty much in exactly the same position and that time we did have to send her to A&E an[d] she wouldn't change her mind and she still struggles now. So along the way you have moments (Roz)

Yeh, well, my experience of it, of working, of that session but generally with that client was that sometimes she would be very compliant and keen and eager and then other times she'd really switch to, 'well it's not working this, it's useless, there's no point' and you could see that she was angry when she'd arrive. She was obviously in a state of anger... but couldn't really acknowledge it and would say 'I'm fine, no' you kind've got the sense that she was angry at me. I suppose that's what's difficult that sometimes the anger would be directed at myself or other professionals or and yeh, she'd say 'well I didn't wanna come anyway' and then a couple of weeks later she'd say 'no, it's been really helpful and, and I have been using the skills'. (Roz)

Yeh because of the, the shifting nature of it and like I said the fact that sometimes it sounds like it's going well, it's *so hard* to know anyth[ing], whether you're *doing* anything. (Roz)

Ahmm and I'd a period then of engaging and then sporadically disengaging, things settling down in the, in the system you know, like school, home and then things blowing up again and then so jump, basically jumping kind of from crisis to crisis. (Beth)

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Ahmm but the young person did a lot of ahmm jumping in and out of crisis, wanting to come to sessions, not showing up, walking out of sessions (Beth)

because sometimes they're, they're a client group for reasons in relation to their history that they, they split, they love you one minute, they hate you the next. They're very punishing (Megan)

Yeh, with moments, I mean that's the thing that you know, moments of them saying that's been really helpful you know, you're the only person that's understood me, but then the complete opposite in the next session. (Becky)

### *Unpredictability affecting Trust*

I wonder whether working with these clients sometimes because progress often seems slow or steps are few and far between that it's a bit like you're, I've been making sense of it in a behavioural way i[t], it's a bit like you, you're *starved* of it aren't you, you've got a real hunger for *something* and then you get a peanut thrown and you think Oh thank God something's happened, something's worked (laughs & RR laughs). And you gotta kind of cling on to those moments that you think well maybe. But then again when it goes backwards and you think oh was just a, not a real peanut was it (laughing) just a false peanut, I don't know ahh (Roz)

Yeh, yeh and a lot of contradictions between what she would say, like I said, sometimes she would say, 'yeh I've been trying the skills out and they are helping' and then two weeks later, 'well I, I don't do that stuff anyway I don't wanna go any more it's not helping'. So even, tha[t], that's the thing when I say you get the, the good bits, peanuts and you think, but you don't trust them anymore either. You start to think well what's, what's going on? (Roz)

I know that they cared about me and she like me and she, that particular client would alternate from sending me cards full of gratitude and how much I'd changed her life to telling me to fuck off and slamming a door in my face. And I'd think well which is it? (laughing) And telling me none of it works anyway. (Roz)

this client was doing you know, particularly well and had managed to reduce self-harm to, I was concerned about this, but to almost a non-existent level. You know, her self-harm had somehow magically disappeared and I wasn't convinced about where it had gone because regardless of whether the behaviour had gone, *she* was still not *feeling* that great. (Tom)

There's always been within each person that I've worked with there has always been those moments of 'Oh yeh, yeh I get that and, and seeming, but then that elusive feeling that it hasn't lasted or it hasn't really been taken on board (Roz)

*In the following quotation, this sense of uncertainty and unpredictability experienced as though going on a roller coaster ride is emphasised by the repetition of the phrase 'okay, here we go'.*

At the time? Well I, you know, the, there will have been a *gamut*, you know? I mean, I, I, I would have kind of a, a response when I first met [Jess] and saw her as she was. And know, knowing her well enough to know, okay, here we go, this is gonna be, you know, this is gonna be ah, a particularly demanding piece of work. You know so that, I'm going to that and you know, with a mixture of feelings....So you know there is an element of ahmm, okay, here we go...(Nick)

**(iii) Challenges to the therapist's self-efficacy**

one of the things that, that can be difficult is when a particular client that you're working with maybe isn't doing so great...that if a client *does* self-harm while they're in DBT *that* doesn't feel too great. May be very understandable why they've *done* it but if you know...if a particular client any client that I'm thinking of you know, taking an overdose while I'm working with them that's not, it doesn't particularly make you feel that *good* cos it makes me feel like I'm failing *them* in some way. (Tom)

I worry that I haven't got it right (laughs and this continues in her voice through rest of sentence) all the time, just ahhh, I don't know, I've found the books harder to kind of access an[d] I don't know. I th[ink], I think I'm naturally [the] sort of person that worries that I've got, that I haven't got it right... and I don't know what it is about DBT but DBT seems to raise more of that in me... or perhaps it's something about the clients that, oh, I don't know that kind of, they're up and down and that, but I do feel it more with DBT. (Kate)

Ah, with a little bit of concern and cynicism I suppose, thinking you know you hear the kind of reputation that comes along with borderline patients and ahmm about having to be careful about your boundaries and not get too involved and then. I think I struggle with that a lot actually ahmm over the years I have generally, thinking that I don't want to be *inhuman* and I think it's important to *be* human but then it *can* get too much maybe for yourself or a worry about professional boundaries and worrying about whether I *should* be, you know *should* I be moved... trying to make sense of it was with a bit of concern that oh, am I getting too, is my own self, you know I said before about being competent, so thinking is my, is my self-esteem too dependent on this person's well-being and my self-esteem as a psychologist (Roz)

Useless, Ahmm, sometimes. Sometimes you think, am I you know it's, you know, yeh at times you think am I just rubbish at being a therapist? Am I, should I just do assessments instead? Or do, you know just give up trying to be a therapist because I don't seem to be getting anywhere with people ahmm. Self-doubt, a lot of self-doubt. And frustration... (Roz)

Mmm, it's quite sad to think that I feel like I can't think of any real successes and I'm noticing that kind of, God you must be a crap therapist thought creeping back in (laughs). I'm just trying to be mindful of that (laughs). (Roz)

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At the end of the day, you know, you don't wanna be a defensive practitioner but on the other hand if it came to the position where you know young people do kill themselves and adults kill themselves that if there was an inquest you know, it, that you would be able to think that you had done everything that you reasonably could in that situation you know, regardless of the public nature but in yourself in terms of you as, as a therapist ahmm and, and you've got confidence in that rather than feeling that you wanna just close the case or hand them on to somebody else quick because you just can't manage it cos that doesn't help the young person either. (Megan)

Ahmm and she was very *keen* on DBT and she was almost an ahmm well she was a DBT convert. She knew all the skills but it still didn't seem to be making that much difference to her so then I guess it was easier to feel that maybe I'm doing something wrong or I've missed something or... maybe it's something about me or the way I'm doing it. (Emma)

she couldn't take those steps back at all, even with me. You know, she didn't, she didn't. yeh ahmm, she could[n't], so I suppose she just couldn't see any alternative than just 'I want to die'. And I suppose as I'm saying this I suppose I'm thinking I bet there are DBT things to *do* with this which I probably wasn't doing very well. But that, that was that, faced with that *absolute* determination to die, 'I just want to die', that I find really, really difficult (quiet laugh). Yeh. (Becky)

Yeh, really worried and really ahmm inad, inadequate (laughs) I think... You know, so ahmm, ah, lost touch with what it was that I should be doing, I suppose I wasn't necessarily doubting the model but I was doubting my own ability to do it and I was thinking, 'Oh I should, you know I should, what would be the right thing to say, what would Marsha [Linehan – author of DBT] say right now and I'm not doing it' you know that sort of thing although I didn't actually say that but that's the kind of thing. I'm not sticking to the model, I'm not doing this right ahmm. Ah, but yeh, so yeh, definitely reflecting on myself as in adequate or incompetent (Becky)

and ahmm maybe questioning whether I could've been more effective. (Nick)

partly it's also about you know, if I'm noticing in myself responses that are ultimately not particularly helpful in terms of my being effective therapeutically then, then I need to do, I need to re-orientate myself a little bit don't I so that I, I'm, I remain ah, reasonably effective, you know? (Nick)

and ahmm you know, ah, challenging one's sense of one's own efficacy in the work that we do (Nick)

it's funny, you see a, at the time it, in some ways I felt that that was a fail[ure], a failure you know or, or it just hadn't worked out in as positive a way as I would've liked. (Nick)

**(iv) *The emotional demands of the work***

as I look back on the experience now, I kind of think that was, that was the process that, that she needed to go through and that I needed to go through but actually in it I did *feel* quite anxious and quite worried a lot of the time that...that maybe I was giving her too much freedom (Tom)

So I was kind of feeling conflicted all the time between do / try and be the adult and provide her with a structure and guidance and maybe a little bit of discipline in some way as well *or* which is what I ended up doing which was actually to give her more choice. And luckily that seemed to work but there were certainly times where when she'd left the room I thought well that's it I've lost her, I won't see her again. And it i[t], it was a discomfort all the time trying to work out which...which would be most helpful (Tom)

and / was pissed, I got really dysregulated myself about all this...they weren't kind of giving her a break, they were just seeing her as like this difficult kid that they had and I don't, I, I, *struggled* to not get angry in meetings very often to (Tom)

They're, they are probably one of the most difficult client groups to work with I think. They only, the only one that kind of *equals* them in a slightly different way is the younger children with, what you know, what people would call attachment disorders... (Tom)

I think initially there were frustrations with DBT... I find it a hard model to get my head around and all, all the kind of ahmm strategies ah, and that it's ahmm I found it quite ahmm, almost jargon, so you know the names for strategies so that you know I think ahhh (sharp intake of breath) God I'm not doing that and then perhaps you were doing a bit of it but I wouldn't have called it that. Or you know there are 5 for this and I could only ever think of 3. So I found those, those sort of things and I still don't remember all 5, so I find that stressful but the thing I find more stressful now is the clients. (Kate)

I still, I still find it taxing, yeh, go[d] what am I doing (last part said almost under her breath), an[d] ah but then I thin[k] the, the fitness kind of, there's, there's just sufficient you know, like, like this girl with this she, this, you know, kind of with this *massive* folder. And so there's things like that. (Kate)

Yeh, yeh it's more of a selfish worry that I've, I've done what I should have done, everything I could have done to the best of my ability. (Roz)

But, ah, emotionally it was diffi[cult], it was challenging emotionally. Cos there was at one moment in that session when she, *she knew* that trying to stay on track was one of the things that I was trying to do and then... and she made a comment about that like, she'd also started being assessed at ahmm (names local adolescent unit) for possible admission and I think she said something like, 'don't worry, I won't tell that lady that you didn't stick to the ahmm structure'. (Laughs) Little madam (laughs & RR laughs) so actually I am,



because if we're not willing to work on target one, we're, the next thing we have to do is look at th...therapy interfering behaviours (says this gruffly). I didn't say it like that but I was thinking like, it was quite ah competitive as well, I was feeling this urge to not be outdone, be, not have one put over me (Roz)

I just felt really helpless and it was unfortunate cos it was a Friday afternoon that I see this girl which is like a mega mistake. And so there was nobody here, so it was, I felt really dysregulated myself and really sort of churned up you know, in terms of what went on and you sort of replay the session in terms of okay, in terms of natural therapeutic reflection in terms of what, what, at what point did it go wrong and at what point should I you should I have done something differently, you know. And so ahmm I felt a bit, a bit helpless and a bit powerless and a bit ahmm useless (laughs), the truth be known (laughs & RR laughs). Yeh, yeh in terms of you know total rejection I suppose ahmm (Megan)

long term one who didn't, at least on the surface, seem to make much progress and it was really hard work, to keep going and ahmm felt you know, I'd lost my way often, or well wasn't really sticking to the model and didn't quite know what to do with her so (Emma)

There was a lot of chaos and all kinds of things happening an[d], and occasions when you're feeling quite overwhelmed and, and you know just so much to deal with and frankly, trying to keep pace and also deal with some of the ahmm, you know when she was very low, it was, it was ahmm, ooaahh, it was, it was quite draining. (Nick)

You know I've seen her this morning at a meeting at (names local facility) and I've come away from that and my head's spinning a little bit (Nick)

I mean the face to face we've talked a lot about haven't we? And it, it raises you know, every imaginable feeling and, and, you know all kinds of thinking and stuff. (Nick)

I think you know there are times aren't there, where, where for the, the pressures and, and, and you're feeling worn out and you're inclined towards hopelessness and, and maybe little judgements are creeping in, all kinds of stuff (Nick)

**(v) *Dealing with the turbulence***

It's being able to give them the message that, not necessarily that you're completely unshockable or you know, unmoveable or you know not like trying to make yourself seem like a robot but trying to give them the message that (pause) that you can attempt to try and understand and contain what it is that they're bringing and certainly with this client she was doing some quite extreme forms of, of self-harm. You know and if I'm honest there certainly was kind of anxieties within me at times when she was reporting some of the things that she

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was doing but being able to not kind a transfer that onto her too much and being able to give her the message that actually we can kind of talk about this stuff and it isn't...you're not gonna kind a destroy me in any way or you're not gonna make me you know think oh God, I can't cope with this or I don't know what to do with it, being able to instil a sense of strength in me so that they can kind of lean on you a little bit or not try and protect you I guess, from how destructive they think that they are, if that makes sense. (Tom)

I almost feel quite selfish cos I know, when you tell people the kind of work you do or maybe other people who do this kind of work they talk about caring too much for your clients and ah, being worried about them, but I think for me often it boils down to self-preserv[ation], preservation of self-worth so if I'm worried about them I, I get to the point where I'm worried that I've done everything I should have done and I'm not going to get told off or get found out to have been unprofessional or not, not have done the right job. And, I wouldn't say, it's not that I *don't* care about them but actually maybe you can't care about them all, that much. (Roz)

you've gotta look after yourself and observe your limits because you can't take them all on because they are, they are a high need group defined aren't they. (Beth)

And so, you, it, you really sort of like you're pulling at ahmm at all your therap[eutic], your resources in order to help them you know (Megan)

So it's, it involves, sometimes a lot of creativity in order to help young people remember the skills as well as use them effectively. (Megan)

I think I was torn between wanting to with her, really stick with it and ahmm because she had questions about 'well there's not really much point is there I'm really hopeless and useless, you should give up on me'. So I said 'Well how could you think, I'm *not* going to give up on you. I *will* stick with you.' But also feeling like actually part of you, you know, is looking forward to an ending because it's difficult to carry this all the time *and* that has to happen at some point. (Emma)

But with hindsight now, there are many, many positives from that experience really. You know I thought it was, it was well managed. You know it wasn't necessary for her to escalate in the way she often does. It was a short admission. Ahmm you know, the suicidal crisis passed. (Nick)

it can be quite ahmm you know if you, if you're working in isolation you know, prior to, to the community DBT programme being properly set up, i[t], it does, it can be ahmm it can be, it can be pretty difficult to ah, somehow process it all and you know deal with your own responses an[d], and just you know, all the stuff really. (Nick)

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I don't, I don't know. They *do* make me *puzzled* these kind of clients. An[d], and they *do* take up a lot of mental energy sometimes at the time with thinking. And I notice at the moment for a few months I haven't been involved with a client who's, I'm doing DBT with one client but she's not particularly risky or demanding in that way and it's quite nice to have a little break from it actually cos sometimes it's just, you go into work wondering what's, what messages are you going to have from social workers or hospitals or... (Roz)

I think I spend a lot of time trying to make sense of them (Roz)

So I used to spend a lot of time trying to make sense of it and not necessarily *sticking* to DBT. I sometimes feel guilty about that. Only slightly, but thinking about like I said before, using interpretative comments and not just describing the behaviours and trying to be quite rigid about it (Roz)

and ahmm and she tends to twist what you say and even though you try and rescue, 'okay I didn't mean that' it was just impossible in that interpersonal situation to, to ahmm try and resolve an issue that had risen or had, she'd brought into the room and so she walks out on you and I, and it, sometimes there's issues of very strong issues of transference that these young people bring to the therapeutic experience that leaves you needing ah a team of people around to, to ahmm to think about what you might have brought to the session. (Megan)

So it isn't personal to me but sometimes you have to, you're, you're left with feelings that you think, hang on a minute where's, where's this coming from, yeh. So that was how it, how she left me feeling really and a bit of difficulty in terms of how do I manage this? (Megan)

Like I say, I feel I have a more balanced, realistic take on this now but at the time... (Nick)

Ahmm and I worked *very, very hard indeed* for about three quarters of an hour to try and engage this girl and, and also with this sinking feeling... feeling pressure in a way and wanting her to get the optimum from the remaining time that she has within the DBT programme. (Nick)

so the session moves along and then I reach, it's getting on, it's a quarter to five or something like that and I'm thinking, I, I'm really not getting anywhere here, you know. She, she's not engaging and I'm not able to get her to think in terms of ahmm, ah, strategies for getting through this crisis, even the most rudimentary basic things. We're just not getting there at all. Ahmm (pause) so, I, I'm well that was a particularly difficult experience and I had a sinking feeling (Nick)

I, I will do everything I can. You know, I'll, I'll dig deep into my repertoire of skills and experience and I'll really work hard to engage and all that. (Nick)

## Appendix VII

knowing that I'm gonna have to you know, use a great deal of myself in that session, perhaps more than I would ordinarily because, because of the, the challenges I'm being presented with.(Nick)

**Word Count Statement**

Thesis Abstract		<b>299</b>	<b>299</b>
Section 1: Literature Review			
Abstract	217		
Key Practitioner Message	93		
Main Text	6,668		
<b>Total Excluding References</b>		<b>6,978</b>	
References	1,636		
Tables	1,233		
<b>Total Including References/Tables</b>			<b>9,847</b>
Section 2: Empirical Paper			
Abstract	240		
Key Practitioner Message	88		
Main Text	6,132		
<b>Total Excluding References</b>		<b>6,460</b>	
References	1,052		
<b>Total Including References</b>			<b>7,512</b>
Section 3: Theory and Practice			
Main Text	4,924		
<b>Total Excluding References</b>		<b>4,924</b>	
References	438		
<b>Total Including References</b>			<b>5,362</b>
Appendix I: Information Sheets			
English Version	1,061		
Welsh Version	1,061		
<b>Total</b>			<b>2,122</b>
Appendix II: Consent Forms			
English Version	178		
Welsh Version	197		
<b>Total</b>			<b>375</b>
Appendix III: Interview Schedule			<b>285</b>
Appendix IV: Excerpt Sample Analysis			<b>5,166</b>
Appendix V: Participant Summary			<b>1,949</b>
Appendix VI: Participant Feedback			<b>333</b>
Appendix VII: All Theme Quotes			<b>6,918</b>
<b>Thesis Total Excluding Reference/Appendices</b>	<b>18,661</b>		
<b>Thesis Total Including Abstract/References/Appendices</b>			<b>40,168</b>