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## **DOCTOR OF PHILOSOPHY**

### **Dialectical behaviour therapy for adolescents who repeatedly self-harm : a qualitative study**

Ross, Helen

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**DIALECTICAL BEHAVIOUR THERAPY FOR  
ADOLESCENTS WHO REPEATEDLY SELF-HARM:  
A QUALITATIVE STUDY**

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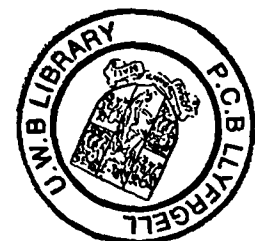
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**HELEN ROSS, BSc, PhD**

**UNIVERSITY OF WALES, BANGOR**

**JULY 2002**



# **Dialectical Behaviour Therapy for Adolescents who Repeatedly Self-Harm: A Qualitative Study**

## **Abstract**

Despite the level of concern generated by adolescents who repeatedly self-harm, there is a dearth of empirically validated interventions for this client group. In the adult domain, dialectical behaviour therapy (DBT; Linehan, 1993) is the only evidence-based intervention for individuals at high risk of repetition, and preliminary research has suggested its utility with adolescents. This study employed a qualitative methodology to evaluate an existing inpatient DBT programme for adolescents with multiple presenting problems including deliberate self-harm. Four female adolescents were interviewed in depth about their experiences and the perceived impact of receiving DBT. Transcripts were analysed for significant and recurrent themes using interpretative phenomenological analysis. Overall, the results supported existing quantitative data indicating that this client group can benefit from DBT. Participants emphasised the role of applying DBT skills in gaining a sense of control over internal experiences and overt behaviours (including self-harm). However, there were marked individual differences in the degree to which such control was attained. Furthermore, for most participants, the effective use of DBT skills was at least partially dependent upon the continued receipt of therapy. Motivation to engage in and comply with therapy appeared to be significantly influenced by participants' perceptions of staff and peers within the inpatient unit. A sense of connection or identification with others emerged as an important source of learning and inspiration, as well as serving to normalise participants' difficulties. The role of social comparison was particularly salient in participants' attempts to

make sense of the changes in self since entering DBT. The findings are discussed in relation to the existing literature, with particular emphasis on the extent to which therapeutic processes deemed important by DBT theory were concordant with participants' experiences. Implications for clinical practice are highlighted and directions for future research suggested.

## TABLE OF CONTENTS

Thesis Abstract .....	i
Acknowledgements .....	v

### SECTION ONE - ETHICS PROPOSAL

Ethics Proposal .....	1
Appendix 1 Research Protocol .....	12
Appendix 2 Interview Schedule .....	22
Appendix 3 Participant Information and Consent Forms .....	24
Appendix 4 GP Letter .....	30
Appendix 5 Ethical Approval Letters .....	31
Appendix 6 Amendments to Research Protocol and Ethical Approval for Amendments .....	35

### SECTION TWO - LITERATURE REVIEW

Title Page .....	1
Abstract .....	2
Literature Review .....	3
References .....	22
Appendix 1. British Journal of Clinical Psychology - Notes for contributors .....	30

### SECTION THREE - RESEARCH PAPER

Title page .....	1
Abstract .....	2
Introduction .....	3
Method .....	5
Results .....	8
Discussion .....	16
References .....	20
Table 1. ....	24
Appendix 1. Extracts from Participants' Interviews Illustrating Themes.....	25
Appendix 2. Psychology and Psychotherapy: Theory, Research and Practice	
- Notes for contributors .....	39

### SECTION FOUR - CRITICAL REVIEW

Critical Review .....	1
References .....	12

### SECTION FIVE - WORD COUNT

## **Acknowledgements**

I would like to thank the young people who participated in this study, and my supervisor, Dr. Michaela Swales, for her support and unwavering faith in my ability to complete this thesis. Most of all, I would like to thank Stuart for being so patient and for looking after me so well over the last few months.

## **SECTION ONE - ETHICS PROPOSAL**



*Awdurdod Iechyd Gogledd Cymru  
North Wales Health Authority  
Research Ethics Committee  
(West, Central & East sub-committees)*

**1. Title of project :**

Evaluation of a dialectical behaviour therapy service for adolescents: A qualitative study of clients' experiences

**2. Principal investigator :**

**name :** Dr Helen Ross

**address :**

**job title :** Trainee Clinical Psychologist

**telephone number :**

Please direct all correspondence to Dr Helen Ross at the above address.

**3. Other investigators :**

**name :** Dr Michaela Swales

**address :**

**job title :** Consultant Clinical Psychologist / Director, Centre for the Study of Adolescence & University Lecturer

**telephone number :**

**4. Who is initiating this project?**

This research is being conducted by Dr Helen Ross as part of her academic studies on the North Wales Clinical Psychology Course (D.Clin.Psy.), University of Wales, Bangor. The project is being supervised by Dr Michaela Swales, who will also be Dr Ross's clinical supervisor over the duration of the study.

**5. Where will the research take place?**

The study will involve interviewing former clients of the Adolescent Service, . Participants will be given a choice of venue for the interviews, namely at their home, at , or at any other Health Service premises. Permission to use the latter premises will be sought as and when

necessary. Permission to conduct the research at former patients' records, has been granted by Dr Psychiatrist at .

, and to gain access to , Consultant

## **6. Objectives of the project :**

This project proposes to use a qualitative methodology to evaluate an existing in-patient treatment programme based on dialectical behaviour therapy (DBT) which is designed to treat adolescents with multiple presenting problems, in particular parasuicidal behaviour and / or substance misuse in the context of other mental health problems. It aims to provide preliminary evidence regarding the effectiveness of the treatment programme as it is ordinarily delivered in the clinical setting from the perspectives of former clients. Thus, it will examine how the receipt of DBT affected participants (e.g., cognitively, affectively, behaviourally, socially), both during and after treatment. In addition, the study will explore aspects of treatment programme that participants believed to be helpful or unhelpful, and those that were perceived to be most difficult to comply with.

Being a qualitative study, it will not set out to test specific hypotheses. Rather, the use of this methodology will allow issues deemed as important to participants to emerge from the interviews. However, it is anticipated that the findings of the study will reveal client, therapist and treatment factors that differentially contributed to positive and negative client outcomes. Such information would be invaluable in terms of shaping future service provision. Furthermore, the identification of factors deemed relevant to treatment outcome by former clients will inform the selection of measures to be employed in the future evaluation of the DBT programme.

## **7. Scientific background to the project :**

Parasuicidal behaviour, or deliberate self-harm, is a major health concern in the UK and is particularly common in adolescents. Individuals engaging in such behaviour often have significant mental health problems and are at increased risk of completed suicide. Although considered a high priority group, there are at present no empirically validated treatments for adolescents presenting with these complex difficulties. Of the few controlled treatment studies conducted with this client group, the intervention under investigation - e.g., intensive home-based family problem-solving sessions (Harrington, Kerfoot, Dyer, et al., 1998), or the provision of tokens to parasuicidal adolescents allowing hospital readmission if they felt actively suicidal (Cotgrove, Zirinsky, Black, & Weston, 1995) - in addition to routine care has typically failed to demonstrate a significant reduction in parasuicidal behaviour compared with routine care alone.

The treatment approach that currently holds most promise in reducing parasuicidal behaviours in adolescents is Dialectical Behaviour Therapy (DBT; Linehan, 1993). This psychological intervention was originally designed to reduce the risk of self-harm in parasuicidal adult women meeting criteria for a diagnosis of Borderline Personality Disorder. DBT has been shown to be effective with this group in reducing psychopathology and frequency of parasuicidal behaviour in both out-patient and in-patient settings (e.g., Bohus, Haaf, Stiglmayr, et al., 2000; Linehan, Armstrong, Suarez, et al., 1991). In a recent study conducted in the US, Rathus and

Miller (in press) were the first to apply a modified form of DBT to the out-patient treatment of suicidal adolescents with features of borderline personality disorder. Despite having more severe pre-treatment symptomatology than the control group receiving treatment as usual, the adolescents allocated to the DBT group had significantly fewer psychiatric hospitalisations during treatment and demonstrated significant pre-post reductions in suicidal ideation and psychopathology. The treatment group also made fewer suicide attempts during the treatment, although this trend was non-significant.

Whilst Rathus and Miller's findings are promising, the evidence base to support the application of DBT to parasuicidal adolescents remains very slim. Indeed, it has been argued that the widespread popularity of DBT in the treatment of adult clients, for which it has been more extensively evaluated, continues to outweigh its empirical base (Scheel, 2000). Clearly, further investigation is needed to determine the efficacy and effectiveness of DBT for specific client groups.

Although the randomised controlled trial (RCT) is often held up as the gold standard in research design for psychotherapy outcome research, the limitations associated with this methodology have prompted arguments for qualitative research to supplement the data generated by RCTs and other quantitative approaches (McLeod, 2000). Whereas quantitative methodologies aim to provide the researcher with objective data, qualitative approaches seek to uncover the meanings associated with the phenomena under investigation. Thus, the use of the latter methodologies can reveal important insights into the experience and outcome of therapy from the client's perspective.

This project proposes to use a qualitative approach to evaluate an in-patient DBT programme for adolescents from the client's perspective and thereby broaden current knowledge regarding the effectiveness and experience of DBT for this client group. The DBT programme is currently being evaluated using a quantitative methodology, and the proposed study will usefully supplement and inform the interpretation of findings from the former research project.

See Appendix 1 for full research protocol.

### References

- Bohus, M., Haaf, B., Stiglmayr, C., Pohl, U., Bohme, R., & Linehan, M. (2000). Evaluation of inpatient dialectical-behavioral therapy for borderline personality disorder - a prospective study. *Behaviour Research and Therapy*, 38, 875-887.
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- Linehan, M. M. (1993). *Cognitive-behavioural treatment of borderline personality disorder*. New York: Guilford Press.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioural treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48, 1060-1064.

McLeod, J. (2000). The contribution of qualitative research to evidence-based counselling and psychotherapy. In N. Rowland & S. Goss (Eds.), Evidence-based counselling and psychological therapies: Research and applications (pp. 111-126). London: Routledge.

Scheel, K. R. (2000). The empirical basis of dialectical behavior therapy: Summary, critique, and implications. Clinical Psychology: Science and Practice, 7, 68-86.

## **8. Study design (incorporating randomisation and placebo details) :**

A qualitative approach, namely interpretative phenomenological analysis (IPA; Smith, 1996), will be employed to evaluate the DBT programme from the perspectives of former clients. A semi-structured interview (conducted in English) will be used to elicit a detailed account of participants' beliefs and perceptions regarding the effectiveness of the DBT that they received, helpful and unhelpful aspects of therapy, and difficulties with compliance to therapy. Each interview will be audiotaped and subsequently transcribed verbatim.

The analysis stage will begin with the detailed analysis of the first transcribed interview. This involves the researcher attempting to understand the meanings of the interviewee's responses by repeatedly reading the text and engaging in a process of interpretation. Significant or interesting findings in the text are noted in one margin of the transcript, while emerging theme titles are noted in the other margin. Through a cyclical process, connections between the emerging theme titles are sought and a list of master or superordinate themes, along with instances of them from the text, is generated. At each stage of the analysis, the researcher returns to the transcript to ensure that the themes and their connections are apparent in the text. As a process of verification, a second interview may be requested in which the participant is asked to comment on the researcher's interpretation of the transcript.

This process of analysis and verification will be repeated for each transcript and a new list of master themes produced for the group. Again, new emerging themes will be tested against earlier transcripts. The nature of the themes that emerge during analysis will determine the level of explanation of the results (e.g., a typology of responses, or the development of a theory to explain interviewees' answers). Only at the writing up stage will the themes be considered in relation to the existing literature.

As this is a naturalistic study examining clients' perceptions of DBT as it is ordinarily offered by the Adolescent Service, there will be no exclusion criteria. Young people will be recruited to the study within 18 months of completing their DBT programme.

Interviews will be conducted, transcribed and analysed by the principal investigator.

**9. Have you had statistical advice in preparing your protocol? If so, from whom?**

Being a qualitative study, there will be no statistical analysis of the data. Advice regarding qualitative analysis has been sought from Dr Robert Jones, Research Co-ordinator for the North Wales Clinical Psychology Course, who has experience of supervising qualitative studies.

**10. What are the possible benefits and hazards of this research?**

There are unlikely to be any benefits to participants of taking part. It is possible that as a result of being interviewed for the study participants may become more aware of their personal difficulties. As stated in the information sheet/consent form, they will be able to talk to any member of staff at about any negative feelings thus evoked. In addition, the telephone numbers of helplines (NSPCC, Samaritans) are provided.

**11. Participants :**

**11.1 type of participant**

Former patients.

**11.2 method of recruitment**

A list of former patients who completed their DBT programme within the past 18 months and who still had informal contact with the Adolescent Service will be generated by Dr. Swales. The young people identified will be sent a letter by the principal investigator inviting them to participate in the study. This Recruitment Letter will be accompanied by an Information Sheet and a Research Consent Form (see Appendix 3).

**11.3 numbers of participants involved**

It is anticipated that approximately 6 young people will be recruited into the study.

**11.4 age groups involved**

The participants will be young people aged over 16.

**11.5 do you intend to recruit 'vulnerable' participants? (if yes, please explain)**

Yes. Participants will be vulnerable in that they are young people with serious psychological problems. Although they will not be in a dependent position to either investigator, they will be assured that their right to future treatment will not be affected by their compliance with the research programme.

**11.6 will consent be written or oral, or both?**

Consent to participate in the study and to allow the interview(s) to be audiotaped will be written (see Research Consent Form and Audio Tape Recording Consent Form, Appendix 3). A copy of both consent forms will be retained by each participant.

**11.7 are participants competent to give informed consent?**

Yes

**11.8 how much time will be allowed between explaining the research and requesting consent?**

One week

**11.9 who will witness the consent?**

All participants will be aged over 16 and will not require their parent/guardian's consent in order to take part.

**11.10 will individuals already participating in other research be excluded?**

No

**11.11 will participants be inconvenienced in any way as a result of taking part in the study?**

Participants will only be inconvenienced in terms of the time it will take them to complete the interview(s).

**11.12 will participants receive payment or reward for taking part? If so, please give details.**

No

**12. Disclosure of payment or reward to investigators :****12.1 will any payment be made to the investigators or department / unit in respect of this trial?**

No

**12.2 if yes, will the payment be a block grant, or will it be based on the number of participants recruited?**

N/A

**12.3 if a block grant, please state amount awarded and explain how monies received will be spent.**

N/A

**12.4 if payment is based on number of participants recruited, please state total sum payable per capita, and number of participants agreed.**

N/A

**12.5 will participants be informed if the investigator / department is receiving payment, and if so, will they be told the name of the sponsor?**

N/A

**12.6 do any of the investigators have a personal involvement in the sponsoring company? If so, please give details.**

N/A

**13. Consent of others clinically involved :**

**13.1 will the participant's GP be informed of their involvement in the project?**

Yes (see Appendix 4).

**13.2 will the consent of others clinically involved be obtained?**

All mental health professionals closely involved in the care of each participant will be informed of the young person's participation in the project (see Appendix 4).

**14. Resource / service implications :**

**14.1 will your research have resource / service implications for the NHS?**

No

**14.2 if yes, please indicate the applicable areas**

N A

**14.3 have you discussed any additional workload and / or financial consequences of your project with the departments and budget holders concerned?**

N/A

**15. Extra substances to be given to the participants :**

**15.1 additional drugs**

None

**15.2 dosage form and presentation of these drugs**

N/A

**15.3 route of administration of these drugs**

N/A

**15.4 amount**

N/A

**15.5 frequency**

N/A

**15.6 desired effect**

N/A

**15.7 possible side effects**

N/A

**15.8 precautions**

N/A

**15.9 does the study medicine to be used have a marketing authorisation (product licence)?**

N/A

**15.10 if yes, will the medicine be used in accordance with, and for the indications specified in, the licence?**

N/A

**15.11 if the medicine does not have a product licence, or it will not be used in accordance with a product licence, does it have a clinical trial certificate (CTC) or an exemption under either the CTX or DXX schemes?**

N A

**15.12 is the clinical trial randomisation code to be held by the pharmacy?**

N A

**15.13 what procedures will be followed if the codes are to be broken in an emergency?**

N A

**15.14 please give full details of any extra (non-drug) substances to be given to participants**

N/A

**16. Extra interventions :**

**16.1 will the project involve any extra venous samples? If so, please give details.**

No

**16.2 will the project involve any extra arterial samples? If so, please give details.**

No



**16.3 will the research involve extra x-rays, radiation, ultrasonics, scanning, ecg or other tests? If so, please give details.**

No

**16.4 will the research involve extra biopsies? If so, please give details.**

No

**16.5 will the research involve extra local or general anaesthesia? If so, please give details.**

No

**16.6 will the research involve any other extra invasive procedures such as cannulae, probes, catheters, internal examinations, endoscopies or lumbar punctures? If so, please give details.**

No

**16.7 will the research involve extra psychological tests? If so, please give details.**

No

**16.8 will the research involve extra questionnaires? If so, please give details.**

Participants will not complete any formal questionnaires but will be required to answer questions and talk about their experiences of receiving DBT during a semi-structured interview. Specifically, they will be asked to express their beliefs and perceptions regarding the effectiveness of the DBT that they received, helpful and unhelpful aspects of therapy, and difficulties they experienced with compliance. The questions outlined on the interview schedule (see Appendix 2) will be used to guide each interview, but the researcher will also pursue areas of interest or concern that are raised by the interviewee within the context of the topic under investigation. Each interview, which will take approximately 1½ hours, will be audiotaped and subsequently transcribed verbatim.

**16.9 will the research involve any other extra procedures not mentioned above, such as those using heat or electricity etc.? If so, please give details.**

No

**16.10 will the research necessitate any treatments or procedures being withheld which would otherwise be administered? If so, please give details.**

No

**17. Ionising radiation :**

**17.1 will subjects be exposed to ionising radiation as part of this study?**

No

**17.2 if so, specify the procedures which will be performed, and state the total effective dose in msv which will be received.**

N/A

**18. What problems may hinder successful completion of this study?**

Although potential participants will no longer be in a dependent position to the second investigator, Dr Swales's involvement in the project may lead them to feel uncomfortable about expressing negative views that they hold about the DBT programme. Thus, recruitment and/or full co-operation during interviews may hinder successful completion of this study. To overcome this potential problem, Dr Swales will not have access to recordings or transcripts of the interviews, or to discussions with the principal investigator regarding individual participants' responses where such information may reveal the identity of the participant. These measures are made explicit in the Recruitment Letter and Information Sheet.

**19. What steps will be taken to safeguard confidentiality of the research records?**

All research data will be identifiable only by ID numbers. Recordings of interviews will be erased as soon as they have been transcribed.

**20. Please explain any arrangements made for indemnity cover for participants.**

N A

**21. Does the project comply with the requirements of the data protection act?**

Yes

**22. Please state the anticipated start and end dates for your study.**

Recruitment of participants is anticipated to begin in October, 2001. Interviewing, transcribing of interviews, and analysis of transcripts will take place over the following 4 months. Four further months will be devoted to writing up the research findings. The project will finish at the end of June, 2002.

**23. Investigator's declaration :**

**The information provided above is to the best of my knowledge accurate. I fully understand my obligations and the rights of the participant, particularly with regard to freely given informed consent.**

**Signed:****Print name:****Date:****24. Head of Department's endorsement :**

**I hereby endorse this research proposal with my approval.**

**Signed:****Print name:****Date:**

## **APPENDIX 1. RESEARCH PROTOCOL**

### **Evaluation of a dialectical behaviour therapy service for adolescents: A qualitative study of clients' experiences**

#### **Summary**

Parasuicidal behaviour, or deliberate self-harm, is a major health concern in the UK and is particularly common in adolescents. Individuals engaging in such behaviour often have significant mental health problems and are at increased risk of completed suicide. Although considered a high priority group, there are at present no empirically validated treatments for adolescents presenting with these complex difficulties. Dialectical behaviour therapy (DBT) is a cognitive-behavioural intervention which has been shown to decrease parasuicidal behaviour in adults with borderline personality disorder. Recently this approach has been applied to parasuicidal adolescents, and although a small body of research has indicated its utility with this population, further research is required to determine both its efficacy and its effectiveness in clinical practice.

This study proposes to expand the evidence base for DBT with parasuicidal adolescents. Qualitative methodology will be employed to evaluate an existing in-patient DBT programme (provided by the Adolescent Service) from the perspectives of individuals aged 16 and over who completed the treatment programme up to 18 months prior to their participation in the study. In addition to assessing the perceived effectiveness of the DBT that they received, the study will examine participants' views regarding helpful and unhelpful aspects of therapy and difficulties they experienced with compliance to therapy. Such qualitative data would provide an important adjunct to the more traditional quantitative outcome data and should inform the development and delivery of psychotherapeutic interventions for this population.

#### **Introduction and rationale**

The term "parasuicide" is used to describe non-fatal, deliberate self-injurious behaviour, or the ingestion of drugs or other substances in excess of any prescribed or generally accepted therapeutic dosage with the intention of causing bodily harm or

death (Kreitman, 1977). Rates of parasuicide in the UK appear to be among the highest in Europe (Kerkhof, 2000), and this problem is particularly common in adolescents (Hawton, Fagg, Simkin, et al., 2000). A recent audit of UK hospital records estimated the prevalence of parasuicidal behaviour in 12-24 year olds to be 800 per 100,000 (Hurry & Storey, 2000). However, medical attention is often not sought following an episode, and estimates derived from community surveys suggest that actual rates of adolescent parasuicide may be much higher than indicated by hospital presentations (De Wilde, 2000). A significant proportion of young people who engage in parasuicidal behaviour will self-harm on more than one occasion, with estimates of the repetition rate varying between 12 and 40% (Hawton, 1986). Furthermore, longitudinal research has indicated an upward trend in rates of adolescent parasuicide and repetition over recent years (Hawton et al., 2000). These findings are particularly worrying in light of the elevated suicide risk presented by individuals who have previously self-harmed (Goldacre & Hawton, 1985). It has been estimated that 10-14% of young people with a history of parasuicide may die by suicide (Diekstra, 1989).

As with completed suicide, parasuicide often occurs in the context of significant psychological problems, particularly depression, anxiety, drug or alcohol abuse, behaviour disturbance and personality disorders (e.g., Beautrais, 2000; Kerfoot, 1988; Lewinsohn, Rohde, & Seeley, 1996). Comorbidity of psychopathology is common, and there is a positive relationship between degree of comorbidity and both frequency and lethality of self-harm in adolescents (Frances & Blumenthal, 1989, cited in Miller & Glinski, 2000). Other psychological factors associated with parasuicide in young people include increased hopelessness, impulsivity and anger, and decreased self-esteem and problem-solving ability (Hawton, Kingsbury, Steinhardt et al., 1999). Problems with interpersonal relationships, particularly with family members, and difficulties associated with education or employment are common precursors to episodes of self-harm in this population (Hawton et al., 2000).

Due to the level of concern generated by young people who engage in parasuicidal behaviour, they have been identified as a high priority group by the All Wales Strategy for Child and Adolescent Mental Health. However, in clinical practice, this client group is commonly associated with high treatment drop-out rates

and poor outcomes (e.g., Trautman, Stewart, & Morishima, 1993). Importantly, attempts to address their needs have been hampered by the absence of empirically validated interventions for adolescents who self-harm. Of the few controlled treatment studies conducted with this client group, the intervention under investigation - e.g., intensive home-based family problem-solving sessions (Harrington, Kerfoot, Dyer, et al., 1998), or the provision of tokens to parasuicidal adolescents allowing hospital readmission if they felt actively suicidal (Cotgrove, Zirinsky, Black, & Weston, 1995) - in addition to routine care has typically failed to demonstrate a significant reduction in parasuicidal behaviour compared with routine care alone.

In the absence of evidence-based guidelines for the management of parasuicidal adolescents, a number of clinicians working with this client group have turned their attention to advances made in the treatment of adults who repeatedly self-harm. Since its development a decade ago, dialectical behaviour therapy (DBT; Linehan, 1993) has been the only intervention with demonstrably positive outcomes in the latter field, and as such it has been widely embraced by clinicians in the USA and the UK. In this psychotherapeutic approach, behavioural skills training, contingency management and cognitive modification are balanced with supportive techniques such as empathy and acceptance. Originally designed for the treatment of adult women meeting criteria for a diagnosis of Borderline Personality Disorder with a history of chronic self-harm, DBT has been associated with reduced frequency and lethality of suicidal behaviours, fewer hospital admissions and lower treatment drop-out in this group (Linehan, Armstrong, Suarez, et al., 1991). It has also been associated with reduced substance misuse in drug-dependent suicidal women with borderline personality disorder (Linehan, Schmidt, Dimeff, et al., 1999). Additionally, DBT has been associated with reduced psychopathology and frequency of parasuicidal behaviour in an in-patient setting (Bohus, Haaf, Stiglmayr, et al., 2000).

Following its apparent efficacy with adult clients, Rathus and Miller (in press) applied a modified form of DBT to adolescents. In a quasi-experimental design, adolescents with borderline features who were also suicidal received twice weekly therapy consisting of individual therapy and a multi-family skills training group run in accordance with DBT principles. These adolescents were compared with a group

receiving treatment as usual (TAU), which consisted of weekly individual therapy and weekly family sessions. Both treatments lasted for 12 weeks. Allocation to treatment group was not random but based on clinical need, with the DBT group having more severe pre-treatment symptomatology. Despite this difference, the DBT group had significantly fewer psychiatric hospitalisations during treatment and a higher rate of treatment completion than the TAU group. In addition, the DBT group made fewer suicide attempts during treatment, although this trend did not reach statistical significance. Within the DBT group, there were significant pre-post reductions in suicidal ideation, general psychiatric symptoms and symptoms of borderline personality disorder.

Whilst Rathus and Miller's findings are promising, the evidence base to support the application of DBT to parasuicidal adolescents remains very slim. Indeed, it has been argued that the widespread popularity of DBT in the treatment of adult clients, for which it has been more extensively evaluated, continues to outweigh its empirical base (Scheel, 2000). Clearly, further investigation is needed to determine the efficacy and effectiveness of DBT for specific client groups. Although the randomised controlled trial (RCT) is often held up as the gold standard in research design for psychotherapy outcome research, there are significant limitations associated with this methodology. For example, it has been argued that the use of treatment manuals and homogeneous client groups restricts the generalisability of RCT findings to everyday clinical practice (e.g., Bower & King, 2000). Both RCTs and more naturalistic quantitative outcome studies utilise standardised psychometric self-report measures, but the influence of factors such as social desirability and response shifts can lead to difficulties in interpreting the results of such research (McLeod, 2000). Furthermore, the use of self-report measures may fail to capture the range of outcomes and experiences of therapy that are considered important and meaningful to the client. For example, the absence of a demonstrable pre-post reduction in psychopathology - the most common measure of treatment effectiveness in quantitative studies - may not necessarily reflect a poor outcome from the perspective of the client. Other factors, such as gaining insight into personal difficulties, may be perceived as very helpful by the client but are not considered important measures by the researcher.

The main alternative to quantitative designs are qualitative methodologies. While the former aim to provide the researcher with objective data, the latter seek to uncover the meanings associated with the phenomena under investigation. There is a notable dearth of qualitative studies published in the psychotherapy outcome literature, and McLeod (2000) has argued that their absence has limited the usefulness of existing outcome data. Qualitative methods have the potential to uncover a diversity of client experiences, both positive and negative, which are not accessible through quantitative evaluation, but which supplement the more objective data generated by the latter type of research. In addition to assessing treatment effectiveness on the basis of client-relevant outcome factors, qualitative evaluation may help to identify specific aspects of therapy that differentially contributed to individual outcomes. Furthermore, this methodology can be used to investigate clients' experiences of receiving therapy, helping to identify, for example, aspects of therapy that clients found difficult to comply with. Although the small sample sizes typically associated with qualitative studies limit the generalisability of their findings, such research can lead to the generation of important hypotheses regarding the effectiveness of a particular treatment approach which may subsequently be tested using quantitative methodologies.

This project proposes to use a qualitative approach to evaluate an in-patient DBT programme for adolescents from the client's perspective and thereby broaden current knowledge regarding the effectiveness and experience of DBT for this client group. The Adolescent Service is a Tier 4 in-patient service for adolescents with mental health problems. Since its implementation at the unit in the late 1990's, the DBT programme has offered a structured intervention to adolescents presenting with multiple impulsive behaviours (including parasuicidal behaviour, substance misuse and binge eating) in the context of psychiatric disorder. The proportion of young people referred to the service who meet these criteria is substantial and has increased in recent years. Within the programme, adolescents participate in twice weekly individual DBT psychotherapy and a twice weekly skills training group. Generalisation of the skills taught in therapy occurs to the therapeutic milieu of the in-patient unit by nursing and teaching staff and also to the home environment by the setting of homework tasks and family therapy sessions. Adolescents also have access to skills coaching over the telephone at the weekend or



in the evenings (for adolescents receiving day-patient treatment). The length of treatment varies from case to case, with an average duration of approximately 20 weeks. Decisions regarding the need to continue treatment are made following 6-weekly case reviews.

The DBT programme is currently being evaluated using a quantitative methodology, and the proposed study will usefully supplement and inform the interpretation of findings from the former research project.

### **Aims of proposed project**

The proposed study will be a qualitative evaluation of an in-patient DBT programme for adolescents with multiple presenting problems, including parasuicidal behaviour. It aims to provide preliminary evidence regarding the effectiveness of the treatment programme as it is ordinarily delivered in the clinical setting from the perspectives of former clients. Thus, it will examine how the receipt of DBT affected participants (e.g., cognitively, affectively, behaviourally, socially), both during and after treatment. In addition, the study will explore aspects of therapy that participants believed to be helpful or unhelpful, and those that were perceived to be most difficult to comply with. Being a qualitative study, it will not set out to test specific hypotheses. Rather, the use of this methodology will allow the treatment and outcome issues deemed as important to participants to emerge from the interviews.

### **Plan of Investigation**

#### Participants

The participants will be young people aged 16 years or over who have participated in the Adolescent Service Dialectical Behaviour Therapy Programme and have completed this programme within 18 months of being interviewed. As this is a naturalistic study, there will be no exclusion criteria. It is envisaged that approximately six adolescents will participate in the study.

#### Design, method and analysis

A qualitative approach, namely interpretative phenomenological analysis (IPA; Smith, 1996), will be employed to evaluate the DBT programme from the perspectives of former clients. IPA is an appropriate methodology to investigate

these issues since it is concerned with participants' personal accounts of a particular topic and does not seek to generate objective statements about the topic itself. Furthermore, IPA does not set out to test specific hypotheses, but rather allows themes relevant to individual participants to emerge during the course of data collection (e.g., via interviews). The approach is concerned with understanding what participants believe about the topic, with the researcher engaging in a process of interpretation of individuals' verbal reports in an attempt to make sense of their personal experiences.

The procedures to be employed in the proposed study for data collection, analysis and writing up will follow those advocated by Smith and colleagues (Smith, 1995; Smith, Jarman, & Osborn, 1999) for conducting IPA research.

Semi-structured interviewing. A semi-structured interview will be used to elicit a detailed account of participants' beliefs and perceptions regarding the effectiveness of the DBT that they received, helpful and unhelpful aspects of therapy, and difficulties with compliance to therapy. The questions outlined on the interview schedule (see Appendix 2) will be used to guide each interview, but the researcher will also pursue areas of interest or concern that are raised by the interviewee within the context of the topic under investigation. Each interview, which will take between 1 and 1½ hours, will be audiotaped and subsequently transcribed verbatim.

Qualitative analysis. The analysis stage will begin with the detailed analysis of the first transcribed interview. This involves the researcher attempting to understand the meanings of the interviewee's responses by repeatedly reading the text and engaging in a process of interpretation. Significant or interesting findings in the text are noted in one margin of the transcript, while emerging theme titles are noted in the other margin. Through a cyclical process, connections between the emerging theme titles are sought and a list of master or superordinate themes, along with instances of them from the text, is generated. At each stage of the analysis, the researcher returns to the transcript to ensure that the themes and their connections are apparent in the text. As a process of verification, a second interview may be requested in which the participant is asked to comment on the researcher's interpretation of the transcript.

This process of analysis and verification will be repeated for each transcript and a new list of master themes produced for the group. Again, new emerging

themes will be tested against earlier transcripts. The nature of the themes that emerge during analysis will determine the level of explanation of the results (e.g., a typology of responses, or the development of a theory to explain interviewees' answers). Only at the writing up stage will the themes be considered in relation to the existing literature.

### **Potential Benefits**

The proposed study will provide preliminary evidence regarding the effectiveness of DBT for adolescents delivered in an in-patient setting in the UK. It is anticipated that the findings of the study will reveal client, therapist and treatment factors that differentially contributed to positive and negative client outcomes. Such information would be invaluable in terms of shaping future service provision. Furthermore, the identification of factors deemed relevant to treatment outcome by former clients will inform the selection of measures to be employed in the future evaluation of the DBT programme.

### **Timetable**

The proposed timetable for the study is as follows:

October 2001 - November 2001: Recruitment of participants

November 2001 - February 2002: Interviews with adolescents, transcription of interviews and analysis of transcripts

March 2002 - June 2002: Write-up of findings

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## APPENDIX 2. INTERVIEW SCHEDULE

### Rapport-building

- Tell me about yourself / about life at [the Unit].

### (A) Helpful and unhelpful aspects of therapy

- **What do you think have been the most helpful things about the DBT that you received?**

Prompt: helped you most during and/or after therapy, including therapist factors. How have they been helpful? (give examples)

- **What do you think have been the most unhelpful things about the DBT that you received?**

Prompt: during/after therapy, including therapist factors. In what way have they been unhelpful? (give examples) If nothing unhelpful, what was least helpful?

- **In general, how helpful do you think DBT has been for you?**

### (B) Compliance with therapy

- **How did DBT fit in with the rest of the care you received at [the Unit]?**

Prompt: including medication, other therapies/counselling, general staff attitudes

- **Were there any aspects of DBT that you didn't always stick to or follow?**

Prompt: If yes, what were they, and why?

- **Were there any times when you felt like dropping out of the DBT programme?**

Prompt: If yes, what was it that made you feel like dropping out? Why did it make you feel like dropping out? What stopped you from dropping out?

- **Were there any other aspects of DBT that you found difficult?**

Prompt: If yes, what were they, and why?

### (B) Effectiveness/outcome/impact on sense of self

- **What difficulties were you having at the time leading up to you starting DBT?**

- **How did you view yourself before you had DBT?**

Prompt: how would you have described yourself at that time?

- **What were you hoping would change for you as a result of having DBT?**

- **To what extent do you think these changes have happened?**

Prompt: what has got better, got worse, not changed? (give examples)

- **To what extent do you think having DBT was responsible for these changes?**

- **Do you think anything else has changed for you as a result of having DBT?**

Prompt: got better/got worse; emotionally, cognitively, behaviourally, ability to cope, relationships

- **How do you view yourself now?**

- **Is there anything else about your experience of DBT that we've not talked about but has been important to you?**

#### Debrief

- How did/do you feel about the interview?

### **APPENDIX 3. PARTICIPANT INFORMATION AND CONSENT FORMS**

On the following pages are blank copies of the information sheets and consent forms for the proposed study:

- Recruitment letter
- Information sheet (version 1)
- Research consent form
- Audio tape recording consent form



## RECRUITMENT LETTER

[Name]  
[Address]

[date]

Dear [name],

### Evaluation of a Dialectical Behaviour Therapy Service for Adolescents: A qualitative study of clients' experiences

I am writing to invite you to take part in a research study investigating what young people think about the Dialectical Behaviour Therapy (DBT) that they have received at . The research is being carried out by myself and Dr Michaela Swales, Consultant Clinical Psychologist and Director of the Centre for the Study of Adolescence ( Adolescent Service). I am a Trainee Clinical Psychologist on placement at for 12 months from October 2001, and I am working there under Dr Swales's supervision.

The study will involve interviewing young people about their experiences of receiving DBT (both positive and negative), and about how much they feel they have been helped by the treatment programme. Staff at value the experiences and views of the young people who receive treatment there, and this type of information can help to identify ways of improving the service offered. This study is being carried out with a view to improving the DBT service at .

Further details about the research study are given in the enclosed Information Sheet. Please take time to read the Information Sheet and to decide whether or not you would like to take part. Please note that if you decide to take part, all information that you give in the interview will be kept strictly confidential and will not be disclosed to anyone involved in your past or present care (including Dr Swales).

Thank you for reading this.

Yours sincerely,

Dr Helen Ross  
Trainee Clinical Psychologist

Dr Michaela Swales  
Consultant Clinical Psychologist  
and Director of the Centre for the Study  
of Adolescence

Version 1, [date]

**INFORMATION SHEET****Evaluation of a Dialectical Behaviour Therapy Service for Adolescents:  
A qualitative study of clients' experiences**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives and your GP if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

***Who is conducting this research study?***

This study is being conducted by **Dr Helen Ross**, Trainee Clinical Psychologist (University of Wales, Bangor) and **Dr Michaela Swales**, Consultant Clinical Psychologist and Director of the Centre for the Study of Adolescence (Adolescent Service, ). The study forms part of the work that Dr Ross is carrying out for her Doctorate in Clinical Psychology.

***What is the purpose of the study, and why have I been chosen?***

This is a research project which aims to find out what young people think about the Dialectical Behaviour Therapy (DBT) that they received at . In order to do this, we are asking young people who received DBT at and who completed their therapy within the last 18 months if they would be willing to take part in the study. It is expected that over the course of the study (October - June, 2002) approximately 6 young people will take part.

***Do I have to take part?***

It is up to you to decide whether or not to take part in the study. If you decide to take part, please complete and sign the attached Research Consent Form and send it to Dr Ross in the pre-paid enveloped enclosed. Keep this Information Sheet. You will also be given a copy of the signed Research Consent Form to keep.

**If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect the standard of care you receive, now or in the future. Similarly, if you decide not to take part, the care you receive will not be affected in any way.**

*please turn over →*

***If I take part in the study, what will I be expected to do?***

If you agree to take part, you will be interviewed (in English) by Dr Ross, who will ask:

- what you found to be helpful/unhelpful about the DBT programme;
- what aspects of the treatment programme you found to be most difficult;
- how much you feel you have been helped by the treatment programme.

The interview can be carried out at your home, at \_\_\_\_\_, or at any other Health Service premises, and should take approximately 1½ hours. On the day of the interview you will be asked to sign an Audio Tape Recording Consent Form giving your permission to a tape-recording being made of the interview. You may be asked for a second interview to help clarify any points that you raised in the first interview. However, you are free to refuse a second interview.

As a result of talking about your experiences of and views about receiving DBT, you may become more aware of your personal difficulties. If so, you will be able to discuss these with Dr Ross and/or any member of staff at \_\_\_\_\_. You can also use the following helplines: NSPCC - 0808 100 2524; Samaritans - 0845 790 9090.

***Will my taking part in this study be kept confidential?***

All information which is collected about you during the course of the research will be kept strictly confidential. Audio tapes of the interviews will be kept securely and will be erased as soon as the content has been typed up. In the written copy of your interview(s), any details that might identify you (e.g. your name) will be changed to make it anonymous. The content of your interview(s) will not be discussed with, or shown to, anyone involved in your past or present care (including Dr Swales).

***What will happen to the results of the research study?***

The results of the study will be written up as a report. They may also be published in a psychological journal and/or presented at a psychological conference. You will not be identified in any report, publication or conference presentation. You will be sent a summary of the results of the research project when these are available. If you wish, you will be able to discuss these results with Dr. Swales.

***Who do I contact if I want to know more about the research?***

If you have any queries about this research or would like further information, please contact: **Dr. Helen Ross**, Trainee Clinical Psychologist, North Wales Clinical Psychology Course, School of Psychology, University of Wales, Bangor, Gwynedd LL57 2DG **OR** **Dr. Michaela Swales**, Consultant Clinical Psychologist, Adolescent Service,

***What if I have any complaints about the study?***

If you have any complaints about the way in which this research is being conducted, these should be addressed to Professor C.F. Lowe, Head of School, School of Psychology, University of Wales, Bangor, Gwynedd LL57 2DG. Complaints should also be addressed to the Chief Executive, Conwy & Denbighshire NHS Trust, Glan Clwyd Hospital, Bodelwyddan, LL18 5UJ.

***Thank you for considering taking part in this study.***

**RESEARCH CONSENT FORM**

**Evaluation of a Dialectical Behaviour Therapy Service for Adolescents:  
A Qualitative Study of Clients' Experiences**

*Please complete the whole of this sheet, crossing out as necessary.*

Have you read the Information Sheet? ..... YES / NO

Have you had the opportunity to ask questions and discuss this study? ..... YES / NO

Have you received satisfactory answers to your questions? ..... YES / NO

Have you received enough information about the study? ..... YES / NO

Do you understand that you are free to withdraw from the study:

- at any time
- without having to give a reason
- and without affecting your future psychological and medical care? ..... YES / NO

Do you agree to take part in this study? ..... YES / NO

If YES, how would you like to be contacted to arrange an interview? (*please cross out as necessary*):

BY TELEPHONE (*please insert your telephone number* \_\_\_\_\_)

OR

BY LETTER

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

NAME (in block letters): \_\_\_\_\_

Signature of Investigator: \_\_\_\_\_

**AUDIO TAPE RECORDING CONSENT FORM**

**Evaluation of a Dialectical Behaviour Therapy Service for Adolescents:  
A Qualitative Study of Clients' Experiences**

As a participant in this research study, you are being asked if you agree to your interview with Dr Ross being audio-tape recorded.

If you agree:

- Audio tapes of your interview will be kept securely and will be erased as soon as the content has been typed up.
- In the written copy of your interview, any details that might identify you (e.g. your name) will be changed to make it anonymous. The content of your interview will not be discussed with, or shown to, anyone involved in your past or present care (including Dr Swales).
- If at any time during the interview you wish recording to stop, you can request this.
- If at the end of the interview you wish the tape to be erased immediately, you can request this.
- Refusal to consent to recording will not affect your future treatment in any way.

I have read and understood the above and I am happy to agree to this interview being audio-tape recorded. I understand this is only for the purposes of the above research project.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

NAME (in block letters): \_\_\_\_\_

I, Helen Ross, undertake to maintain proper care of this recording which will be used only for the purposes of the above research project. The contents of the tape will be erased as soon as possible, immediately after the interview has been typed up.

Signature of Investigator: \_\_\_\_\_

**APPENDIX 4. TYPICAL LETTER TO GP / MENTAL HEALTH  
PROFESSIONAL**

[Unit address]

[GP/mental health professional address]

[Date]

Dear [GP/mental health professional name]

*Re: [Patient name, d.o.b. and address]*

I am writing to inform you that this young person has recently agreed to participate in a research study evaluating the effectiveness of the Adolescent Service Dialectical Behaviour Therapy (DBT) Programme. This will entail [patient name] being interviewed about her experiences of receiving DBT and the extent to which she feels that she has been affected by the treatment programme. I have enclosed a copy of the patient information sheet which provides further details about the study.

Please do not hesitate to contact me if you have any queries or would like further information.

Yours sincerely,

Dr. Helen Ross  
Clinical Psychologist in Training

Dr. Michaela Swales  
Consultant Clinical Psychologist &  
Director of the Centre for the Study of  
Adolescence

## **APPENDIX 5. ETHICAL APPROVAL LETTERS**

On the following pages are ethical approval letters from the following committees:

- School of Psychology Research Ethics Committee
- North Wales Health Authority Research Ethics Committee (Central Sub-Committee)

c.c. Dr. Michaela Swales



September 17, 2001

Dr. Helen Ross  
 Trainee Clinical Psychologist  
 North Wales Clinical Psychology Course  
 University of Wales  
 Bangor  
 Gwynedd LL57 2DG

YSGOL SEICOLEG  
 Prifysgol Cymru, Bangor  
 Adeilad Bngantia  
 Ffordd Penrallt  
 Gwynedd LL57 2AS  
 Ffôn Bangor (01248) 382211  
 Ffacs (01248) 382599

SCHOOL OF PSYCHOLOGY  
 University of Wales, Bangor  
 Adeilad Bngantia  
 Penrallt Road  
 Gwynedd LL57 2AS  
 Tel Bangor (01248) 382211  
 Fax (01248) 382599

E-mail [psychology@bangor.ac.uk](mailto:psychology@bangor.ac.uk)  
<http://www.psych.bangor.ac.uk>

Dear Colleague

**Evaluation of a Dialectical Behaviour Therapy Service for Adolescents: a qualitative study of clients' experiences**

Your research proposal (referred to above and on the attached sheet) has been reviewed by the School of Psychology Research Ethics Committee and they are satisfied that the research proposed accords with the relevant ethical guidelines. If you wish to make any substantial modifications to the research project please inform the committee in writing before proceeding. Please also inform the committee as soon as possible if research participants experience any unanticipated harm as a result of participating in your research.

You should now forward the proposal to the appropriate Research Ethics Committees of the North Wales Health Authority. They expect one of the investigators to make an oral presentation in support of the proposal at their meeting. You will be contacted by their committee with details as to the date and place of the meeting at which your proposal will be considered

You may not proceed with the research project until you are notified of the approval of the NWA research ethics committee.

Yours sincerely

Kath Chitty  
 Coordinator - School of Psychology Research Ethics Committee



North Wales Health Authority Research Ethics Committee  
(West, Central & East Sub-Committees)

.....  
**CENTRAL SUB - COMMITTEE**

All correspondence and enquiries to: Mrs. Julie Whitmore, Gweinyddwraig Etheg / Ethics  
Administrator at Glan Clwyd Hospital, Ystafell 1038 / Room 1038, Ysbyty Glan Clwyd, Rhyl,  
Denbighshire. LL18 5UJ

☎ Direct Line: 01745-534132 Ffacs / Fax: 01745 583143

Website: [www.conwy-denbighshire-nhs.org.uk](http://www.conwy-denbighshire-nhs.org.uk) E-Bost/ E-Mail: [Julie.Whitmore@cd-tr.wales.nhs.uk](mailto:Julie.Whitmore@cd-tr.wales.nhs.uk)

Thursday, 18 October 2001

Dr. Helen Ross,

Dear Dr. Ross,

**Re: Evaluation of a dialectical behaviour therapy service for adolescents: A qualitative study of clients' experiences**

Thank you for attending the recent meeting of the NWA Central Research Ethics Committee held on 4th October 2001. The Committee always find an explanation of the nature and purpose of the study by the Investigator helpful.

The Committee have some observations and comments:

- i) The Recruitment Letter is expressed in the first person, but signed by two signatories, yourself and Dr. Swales. You explained that it is your normal practice to do this.
- ii) Only selected parts of transcriptions will be used in the study findings and patients will not be identifiable as a result. Only you will have access to the full transcription.

The Committee are happy to grant full ethical approval for the study to proceed on condition that:

- the protocol is followed as agreed
- the project commences within 3 years of the date of this letter
- the committee is notified of all protocol amendments and serious adverse events as soon as possible
- the committee receives annual progress reports and/or a final report within 3 months of completion of the project.

Approval from host institutions must be sought separately.

The Committee reserves the right to audit local research records relating to the above study. Ethics approval is granted on this basis.

Continued ...

The Committee aims to be fully ICH/GCP compliant. Please find attached a copy of our working constitution and a list of members, for your information and retention.

Yours sincerely,

A handwritten signature in black ink, appearing to read "Archard". The signature is written in a cursive style with a large initial "A".

Dr. N. P. Archard,  
Secretary,  
NWA Central Research Ethics Committee

Cc Dr. M. Swales,

Enc.

**APPENDIX 6. AMENDMENTS TO RESEARCH PROTOCOL AND**  
**ETHICAL APPROVAL FOR AMENDMENTS**

On the following pages are:

- Application for amendments to the research protocol
- Reminder letter
- Reply from the Chairman of the North Wales Health Authority Research Ethics Committee (Central Sub-Committee)
- Amended Information Sheet (version 2)
- Letter granting ethical approval for the amendments from the North Wales Health Authority Research Ethics Committee (Central Sub-Committee)

Dr T. D. Yuille (Chairman)  
 c/o Mrs Julie Whitmore, Administrator  
 North Wales Health Authority Research  
 Ethics Committee (Central)  
 Room 1038  
 Ysbyty Glan Clwyd  
 Rhyl  
 Denbighshire LL18 5UJ

30 November, 2001

Dear Dr Yuille

**Title of Project: Evaluation of a dialectical behaviour therapy service for adolescents: A qualitative study of clients' experiences**

I have recently started the above research project which was given full ethical approval by the North Wales Health Authority Research Ethics Committee (Central) in a letter dated 18th October 2001. However, I am experiencing difficulties in recruiting participants due to the small number of adolescents who have both received dialectical behaviour therapy (DBT) from [redacted] and finished treatment there within the last 18 months (as specified on the protocol). I am therefore writing to ask for ethical approval to extend the original research proposal to include the following:

- 1) a Reminder Letter (see attached sheet) to be sent to young people who have not responded to their initial invitation to take part in the research study. This would be issued 4-5 weeks after the date of mailing the initial Recruitment Letter, and would be accompanied by a copy of the original Information Sheet and Research Consent Form.
- 2) recruitment to be extended to include young people who have received DBT from [redacted] as day- or in-patients within the last 18 months but who continue to receive DBT as out-patients. Although this would change the nature of the subject pool, it would enable additional information to be collected regarding the perceived value of extending the DBT programme on an out-patient basis. Such information is likely to have important implications for the future development of the DBT service.

I hope that these amendments to the project meet with your approval, and I look forward to hearing from you.

Yours sincerely,

Dr. Helen Ross  
 Trainee Clinical Psychologist

**REMINDER LETTER**

[Name]  
[Address]

[Date]

Dear [name],

**Evaluation of a Dialectical Behaviour Therapy Service for Adolescents: A qualitative study of clients' experiences**

A few weeks ago I wrote to you inviting you to take part in a research study investigating what young people think about the Dialectical Behaviour Therapy (DBT) that they have received at . As I have not yet had a reply from you, I am writing to you again to ask you to consider whether or not you would like to take part in the study. If you have already decided not to take part, please disregard this letter and accept my apologies for contacting you again. If, however, you are interested in the research study, I would be grateful if you could take time to read the enclosed Information Sheet and decide whether or not you would like to take part.

The research is being carried out by myself and Dr Michaela Swales, Consultant Clinical Psychologist and Director of the Centre for the Study of Adolescence ( Adolescent Service). I am a Trainee Clinical Psychologist on placement at for 12 months from October 2001, working under Dr Swales's supervision.

The study involves interviewing young people about their experiences of receiving DBT (both positive and negative), and about how much they feel they have been helped by the treatment programme. Staff at value the experiences and views of the young people who receive treatment there, and this type of information can help to identify ways of improving the service offered. This study is being carried out with a view to improving the DBT service at .

Thank you for reading this.

Yours sincerely,

Dr Helen Ross  
Trainee Clinical Psychologist

Dr Michaela Swales  
Consultant Clinical Psychologist  
and Director of the Centre for the Study  
of Adolescence



Ymddiriedolaeth GIG Siroedd Conwy a Dinbych  
Conwy & Denbighshire NHS Trust

Dr Helen Ross  
Trainee Clinical Psychologist

Ein cyf/Our ref: TDY/TAW/G  
Eich cyf/Your ref:  
Dyddiad/Date: 4 January 2002  
Wrth ffonio gofynnwch am/if telephoning ask for  
Mrs Julie Whitmore  
Llinell Uniongyrchol/Direct Line:  
01745 - 534132  
E-Mail Address

Dear Dr Ross

Re: **Project: Evaluation of a dialectical behaviour therapy service  
for adolescents**

I regret to say that Mrs Whitmore, the LREC Administrator, has been on sick leave for some weeks and her work has not been adequately covered. I only received your letter of 30.11.01 just before Christmas. I have now had the opportunity to look through the original application and protocol, and your proposed amendments.

1. I see no ethical objection to the proposed reminder letter.
2. I do not see any ethical objection to recruitment being extended to young people who are continuing to receive DBT as long as the clinician involved in delivering the treatment is agreeable. It may be the clinician involved is Dr Swales for all patients. However, I would wish to have reassurance from Dr Swales and any colleagues involved that they are agreeable to the evaluation taking place concurrently with the therapy itself. I note that there would need to be a minor change to the patient information sheet under "What is the purpose of the study and why have I been chosen?" to cover this recruitment extension.

If you could let me have the approval of Dr Swales and the amended patient information sheet I can provide Chairman's approval for the amendments, to be confirmed at the next meeting of the Local Research Ethics Committee on 07.02.02.

Yours sincerely

T D Yuille  
Chairman of NWA Research Ethics Committee (Central)

cc Mrs Julie Whitmore, Committee Services Secretary, YGC

**AMENDED INFORMATION SHEET**

Version 2, [date]

**INFORMATION SHEET**

**Evaluation of a Dialectical Behaviour Therapy Service for Adolescents:  
A qualitative study of clients' experiences**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives and your GP if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

***Who is conducting this research study?***

This study is being conducted by **Dr Helen Ross**, Trainee Clinical Psychologist (University of Wales, Bangor) and **Dr Michaela Swales**, Consultant Clinical Psychologist and Director of the Centre for the Study of Adolescence ( Adolescent Service, ). The study forms part of the work that Dr Ross is carrying out for her Doctorate in Clinical Psychology.

***What is the purpose of the study, and why have I been chosen?***

This is a research project which aims to find out what young people think about the Dialectical Behaviour Therapy (DBT) they have received at . In order to do this, we are asking young people who have completed their DBT at within the last 18 months or who are currently receiving DBT as an outpatient if they would be willing to take part in the study. It is expected that over the course of the study (October - June, 2002) approximately 6 young people will take part.

***Do I have to take part?***

It is up to you to decide whether or not to take part in the study. If you decide to take part, please complete and sign the attached Research Consent Form and send it to Dr Ross in the pre-paid enveloped enclosed. Keep this Information Sheet. You will also be given a copy of the signed Research Consent Form to keep.

**If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect the standard of care you receive, now or in the future. Similarly, if you decide not to take part, the care you receive will not be affected in any way.**

*please turn over →*

***If I take part in the study, what will I be expected to do?***

If you agree to take part, you will be interviewed (in English) by Dr Ross, who will ask:

- what you have found to be helpful/unhelpful about the DBT programme;
- what aspects of the treatment programme you have found to be most difficult;
- how much you feel you have been helped by the treatment programme.

The interview can be carried out at your home, at \_\_\_\_\_, or at any other Health Service premises, and should take approximately 1½ hours. On the day of the interview you will be asked to sign an Audio Tape Recording Consent Form giving your permission to a tape-recording being made of the interview. You may be asked for a second interview to help clarify any points that you raised in the first interview. However, you are free to refuse a second interview.

As a result of talking about your experiences of and views about receiving DBT, you may become more aware of your personal difficulties. If so, you will be able to discuss these with Dr Ross and/or any member of staff at \_\_\_\_\_. You can also use the following helplines: NSPCC - 0808 100 2524; Samaritans - 0845 790 9090.

***Will my taking part in this study be kept confidential?***

All information which is collected about you during the course of the research will be kept strictly confidential. Audio tapes of the interviews will be kept securely and will be erased as soon as the content has been typed up. In the written copy of your interview(s), any details that might identify you (e.g. your name) will be changed to make it anonymous. The content of your interview(s) will not be discussed with, or shown to, anyone involved in your past or present care (including Dr Swales).

***What will happen to the results of the research study?***

The results of the study will be written up as a report. They may also be published in a psychological journal and/or presented at a psychological conference. You will not be identified in any report, publication or conference presentation. You will be sent a summary of the results of the research project when these are available. If you wish, you will be able to discuss these results with Dr. Swales.

***Who do I contact if I want to know more about the research?***

If you have any queries about this research or would like further information, please contact: **Dr. Helen Ross**, Trainee Clinical Psychologist, North Wales Clinical Psychology Course, School of Psychology, University of Wales, Bangor, Gwynedd LL57 2DG **OR** **Dr. Michaela Swales**, Consultant Clinical Psychologist, Adolescent Service,

***What if I have any complaints about the study?***

If you have any complaints about the way in which this research is being conducted, these should be addressed to Professor C.F. Lowe, Head of School, School of Psychology, University of Wales, Bangor, Gwynedd LL57 2DG. Complaints should also be addressed to the Chief Executive, Conwy & Denbighshire NHS Trust, Glan Clwyd Hospital, Bodelwyddan, LL18 5UJ.

***Thank you for considering taking part in this study.***



North Wales Health Authority Research Ethics Committee  
(West, Central & East Sub-Committees)

.....  
**CENTRAL SUB - COMMITTEE**

All correspondence and enquiries to: Mrs. Julie Whitmore, Gweinyddwraig Etheg / Ethics  
Administrator at Glan Clwyd Hospital, Ystafell 1038 / Room 1038, Ysbyty Glan Clwyd, Rhyl.

Denbighshire. LL18 5UJ

☎ Direct Line: 01745-534132 Ffacs / Fax: 01745 583143

Website: [www.conwy-denbighshire-nhs.org.uk](http://www.conwy-denbighshire-nhs.org.uk) E-Bost/ E-Mail: [Julie.Whitmore@cd-tr.wales.nhs.uk](mailto:Julie.Whitmore@cd-tr.wales.nhs.uk)

Friday, 08 February 2002

Dr. Helen Ross  
Trainee Clinical Support Psychologist

Dear Dr. Ross

**Re: Evaluation of a dialectical behaviour therapy service for adolescents**

Further to our letter of 4th January 2002 confirming Chairman's approval for the above mentioned study and following a meeting of the North Wales Health Authority Research Ethics Committee (Central) on 7th February, I can now provide full ethics approval for this study, on condition that:

- the protocol is followed as agreed
- the project commences within 3 years of the date of this letter
- the committee is notified of all protocol amendments and serious adverse events as soon as possible
- the committee receives annual progress reports and/or a final report within 3 months of completion of the project.

Approval from host institutions must be sought separately.

The Committee reserves the right to audit local research records relating to the above study. Ethics approval is granted on this basis.

The Committee aims to be fully ICH / GCP compliant. Please find attached a copy of our working constitution and a list of members for your information and retention.

Yours sincerely



Dr. N. P. Archard,  
Secretary,  
NWA Research Ethics Committee (Central)

Encs

## **SECTION TWO - LITERATURE REVIEW**

Running head: REPETITION OF DELIBERATE SELF-HARM IN  
ADOLESCENTS

Repetition of Deliberate Self-Harm in Adolescents: Issues of Conceptualisation  
and Intervention

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University of Wales, Bangor

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### **Abstract**

**Purpose.** The aim of this review paper is to provide an overview of the current status of research into the repetition of deliberate self-harm (DSH) in adolescents.

**Methods.** Five issues are addressed within the context of the broader literature on DSH in young people: terminology; prevalence rates; correlates and risk factors; association with features of borderline personality disorder; and clinical

interventions. **Results.** Despite a growing volume of literature on adolescent DSH, little has specifically targeted the significant problem of repetition in this age group.

Moreover, the clinical implications of the available evidence remain unclear. In large part, this can be traced to the following factors: a lack of consensus regarding the definition of DSH; methodological inconsistencies between studies hindering the comparability and interpretation of findings; a dearth of theoretical frameworks for conceptualising DSH repetition in young people; and a paucity of treatment efficacy research for adolescent DSH. **Conclusions.** In order to facilitate progress in meeting the complex mental health and psychosocial needs of adolescents who repeatedly self-harm, a number of recommendations are indicated. These include the need for well-defined and universally adopted nomenclature for DSH, reliable and valid measures of DSH in adolescents, longitudinal studies of both clinical and community samples, and a greater focus on the development and rigorous evaluation of interventions for this population. It is argued that research into possible mechanisms underlying DSH repetition is likely to prove most fruitful in informing clinical practice.

## **Repetition of Deliberate Self-Harm in Adolescents: Issues of Conceptualisation and Intervention**

Deliberate self-harm is a growing problem among adolescents and presents a significant challenge to mental health professionals working with this age group. However, substantial gaps in current knowledge have hindered the development of guidelines to facilitate the clinical management of this complex phenomenon. Notably, little research has been directed at those young people who repeatedly engage in this behaviour, a population known to be at high risk for subsequent suicide (Kotila & Loennqvist, 1987).

The aim of this paper is to provide an overview of the current status of research into the repetition of deliberate self-harm in adolescents. Five issues are addressed within the context of the broader literature on self-harm in this population: terminology; prevalence; correlates and risk factors; association with features of borderline personality disorder; and clinical interventions. Throughout the paper, factors that have impeded progress in this area are highlighted. Finally, recommendations for future research are proposed.

### **Terminology**

The first obstacle to making sense of the available research on self-harming behaviour in adolescents (and indeed in all age groups) is the lack of consensus around the language used to describe such behaviour. The issue of terminology is important because it is inextricably linked to the conceptualisation of this phenomenon. Thus, it has implications for assessment and case identification and, in turn, for the interpretation and comparability of research findings.

In the literature, non-fatal self-injurious behaviour has most commonly been referred to as attempted suicide, a term which implies serious intent to die. By far the

most common method associated with attempted suicide in adults and adolescents is self-poisoning, occurring in approximately 90% of episodes requiring medical attention (Hawton, Fagg, Simkin, Bale, & Bond, 1997, 2000; Vajda & Steinbeck, 2000). Conversely, the term self-mutilation has been coined to describe the deliberate destruction or alteration of bodily tissue in the absence of a conscious intent to die (Favazza, 1999; Herpertz, 1995). Typically of low lethality, self-mutilation includes skin cutting, burning and self-hitting, and is often highly repetitive (e.g., DiClemente, Ponton, & Hartley, 1991). However, difficulties arise in categorising behaviours on the basis of lethality, as this is often not strongly correlated with suicidal intent. For example, although it can be difficult to determine an individual's motives, evidence suggests that in the majority of acts often classified as attempted suicide, intention to die is either ambivalent or absent (Hawton, Cole, O'Grady, & Osborn, 1982).

Perhaps more importantly, distinctions drawn between attempted suicide and self-mutilation have encouraged the development of two discrete areas of enquiry. However, research findings suggest a substantial overlap between the populations who engage in these behaviours. A history of self-mutilative behaviour has been identified in 55% of adolescents presenting to a general hospital following attempted suicide by overdose (Guertin, Lloyd-Richardson, Spirito, Donaldson, & Boergers, 2001), and in 87% of adolescent suicide attempters in a psychiatric in-patient setting (Zlotnick, Donaldson, Spirito, & Pearlstein, 1997). As asserted by Zlotnick and colleagues (1997), it is likely that self-mutilation and suicidal behaviour occurs on a "continuum of self-inflicted acts of bodily harm of increasing severity and lethality" (p. 796).

To avoid inferring motivation behind the behaviour, some researchers have chosen to adopt the more inclusive term parasuicide, defined as non-fatal, deliberate self-injurious behaviour, or the ingestion of drugs or other substances in excess of any prescribed or generally accepted therapeutic dosage with the intention of causing bodily harm or death (Kreitman, 1977). Others have preferred to label this broad range of behaviours as deliberate self-harm (Morgan, 1979), thereby avoiding any reference to suicidality. Although criticised for implying that bodily harm always occurs (Hawton & Catalan, 1987), the term deliberate self-harm (DSH) is adopted here as a general descriptor that encompasses both deliberate self-poisoning and deliberate self-injury (including self-mutilation).

### **Prevalence Rates**

#### Adolescent DSH

Rates of DSH in the UK appear to be among the highest in Europe (Schmidtke et al., 1996), and this problem is particularly common in adolescents and young adults (Hawton et al., 1997). However, the accurate identification of the prevalence of DSH in this population is problematic for several reasons. Importantly, there are no central registries for recording its occurrence, and therefore there is an over-reliance on estimates derived from local studies (Hurry, 2000). Known variations in the prevalence of DSH between countries (e.g., Schmidtke et al., 1996) suggest that there may also be regional differences within the UK. However, between-study comparisons have been confounded by the employment of different inclusion criteria (e.g., age range and definition of self-harm), methods and duration of data collection, and methods of reporting results. Finally, the reliance of British studies on hospital presentations to gauge the prevalence of DSH in young people (e.g., Hawton et al., 1997; Hurry & Storey, 2000) is problematic because medical

attention is often not sought following an episode of self-harm (Hawton, Fagg, & Simkin, 1996). Thus, whereas a recent audit of case notes in 18 English hospitals estimated the prevalence of DSH in 12-24 year olds to be 800 per 100,000 (Hurry & Storey, 2000), estimated rates of adolescent DSH derived from community surveys in Western Europe and the USA have ranged from 2.2 to 20% (De Wilde, 2000; Diekstra, Kienhorst, & De Wilde, 1995). Despite methodological variations between community surveys, their findings suggest that actual rates of adolescent DSH in the UK are considerably higher than indicated by hospital presentations. It is likely that the extent of deliberate self-injury, which accounts for only approximately 10% of hospital presentations of DSH (Hawton et al., 2000), will have been particularly under-estimated.

### Repetition

Given the difficulties ascertaining the prevalence of DSH in adolescents and a dearth of prospective longitudinal studies, it is unsurprising that data regarding its repetition is scant. Nevertheless, available evidence suggests that a significant proportion of young people who engage in DSH will self-harm on more than one occasion (Diekstra et al., 1995). Furthermore, as with the prevalence of DSH in this population, research has indicated an upward trend in repetition rates over recent years. Between 1991 and 1994, 14% of under 20-year-olds referred to the general hospital in Oxford following DSH repeated within a year of an episode, compared with 10.5% for 1985-1989 (Hawton et al., 2000). Furthermore, 30% of those who received a psychiatric assessment following an episode of self-harm between 1991 and 1995 had a prior history of DSH, compared with 24% for 1985-1990.



### Association with Suicide Rates

Aside from the personal distress associated with DSH, this phenomenon places high demands on general medical and adolescent mental health services. However, of greatest concern is the known association between DSH and suicide. Hawton and colleagues (1997) found a positive correlation between rates of DSH in Oxford and suicide in England and Wales, which was highest for individuals (especially males) in the 15-24 year age range. Although estimates vary, the suicide risk presented by adolescents who have self-harmed is believed to be several times higher than that expected for adolescents in general (Goldacre & Hawton, 1985; Sellar, Hawton, & Goldacre, 1990). The apparent increase in repetition rates in adolescents is particularly worrying as DSH 'repeaters' are most vulnerable for completing suicide (Kotila & Loennqvist, 1987). Taken together, these findings have prompted fears of a future increase in suicide rates (Hawton et al., 1997).

### **Correlates of DSH and its Repetition in Adolescents**

#### Deliberate self-harm

A substantial body of research has identified a number of psychopathological, socio-demographic, social and psychological factors associated with DSH in adolescents. These have been reviewed elsewhere (Beautrais, 2000; De Wilde, 2000; Diekstra et al., 1995; Grosz, Zimmerman, & Asnis, 1995; Miller & Glinski, 2000) and are only briefly summarised here. DSH is rare in children under the age of 12 years, but thereafter prevalence rates appear to increase steadily with increasing age (Hawton et al., 2000). Unlike completed suicide, this behaviour is more common among female than male adolescents, although the female:male ratio decreases with increasing age (Hawton et al., 2000). As with completed suicide, DSH often occurs in the context of significant mental health problems, particularly depression, anxiety,

drug or alcohol abuse, behavioural problems and personality disturbance (Gould et al., 1998; Kerfoot, 1988; Lewinsohn, Rohde, & Seeley, 1996). Of these, depressive disorders are the most prevalent, although comorbidity is common (Andrews & Lewinsohn, 1992; Kerfoot, Dyer, Harrington, Woodham, & Harrington, 1996).

Compared with depressed or otherwise psychiatrically diagnosed non-suicidal adolescents, those who engage in DSH are more likely to have a history of physical and sexual abuse and have experienced a greater number of stressful life events (De Wilde, Kienhorst, Diekstra, & Wolters, 1992). Relative to adolescents in the general population, they are also more likely to come from socially deprived backgrounds, have a non-intact family composition (through divorce, separation or death), and have a family history of DSH or suicide (Kerfoot, 1988; Kerfoot et al., 1996). Young people who self-harm tend to perceive their families as dysfunctional, characterised by inadequate communication, problem-solving and emotional support (King, Segal, Naylor, & Evans, 1993). Furthermore, they often report poor and/or conflictual relationships with their parents, particularly with their mothers (Hurd, Wooding, & Noller, 1999; Tulloch, Blizzard, & Pinkus, 1997). Indeed, arguments or problems with family members (especially parents) are most often cited as precipitating episodes of self-harm in this population (Hawton et al., 2000). Other common precursors include study- or work-related difficulties and problems with partners and friends.

A number of studies have attempted to distinguish young people who have self-harmed from those who have not on a range of psychological variables, including hopelessness, self-esteem, impulsivity, anger and social withdrawal. Although some differences have been identified, these have largely disappeared after controlling for level of depression (Diekstra et al., 1995). Similarly, many of the

familial factors outlined above are common among depressed, non-self-harming adolescents (Miller & Glinski, 2000). Clearly, depression in itself is not a sufficient explanation for DSH, and it is likely that DSH occurs in the presence of multiple risk factors, both predisposing and precipitating (e.g., a stressful life event). However, the relative importance of such factors is not well understood, and the cross-sectional nature of most studies has precluded the identification of causal mechanisms (Diekstra et al., 1995).

### DSH repetition

Relatively little attention has been specifically directed at delineating the factors associated with repetition of DSH in adolescents. Based on hospital presentations, it appears that males who have self-harmed are more likely than females to re-engage in such behaviour. Between 1990 and 1994, a yearly mean of 16.1% of adolescent males referred to the general hospital in Oxford following an episode of DSH self-harmed within the subsequent year, compared with 13.3% of young females (Hawton et al., 2000). However, in absolute numbers, there were approximately twice as many female than male 'repeaters', and increases in repetition rates since 1985 were somewhat higher for females than males.

Attempts to identify clinical and social factors that differentiate 'repeaters' from 'first-timers' (or 'non-repeaters') have largely revealed similar risk factors to those associated with adolescent DSH per se. Risk factors for repetition include number of prior episodes of DSH, presence of psychopathology, depressive symptoms, drug and/or alcohol abuse, history of sexual abuse, previous psychiatric treatment, family psychiatric history, not living with both parents, parental conflict, and chronic medical conditions (Brown, Cohen, Johnson, & Smailes, 1999; Gilliland, 1995; Goldston et al., 1999; Kotila & Loennqvist, 1987; Vajda & Steinbeck, 2000).

Regarding the development of interventions for adolescents at risk of repetition, Hawton and colleagues (Hawton, Kingsbury, Steinhardt, James, and Fagg, 1999) have argued that the identification of psychological characteristics are likely to be more informative than clinical, social and socio-demographic factors. To date, however, research findings have been limited and inconclusive. Of adolescents presenting to a general hospital following an episode of self-poisoning, Guertin et al. (2001) found greater levels of depression, anger expression and loneliness in those who had self-injured within the previous year. In a study by Hawton et al. (1999), adolescents admitted to a general hospital following an episode of self-poisoning were assessed using a range of standardised psychological measures. Those who had a prior history of at least one overdose, and/or who engaged in further self-harm (self-poisoning or self-injury) which resulted in a hospital referral within the following year were identified as 'repeaters', and the remaining young people were termed 'non-repeaters'. Compared with the non-repeaters, the repeaters were found to have higher depression, hopelessness and trait anger scores, and lower scores for self-esteem and self-rated problem-solving. However, when level of depression was controlled for, these differences were no longer significant. While noting the limitations associated with their small sample size, Hawton et al. (1999) concluded that "depression was an overwhelming factor associated with repetition" (p.375). This was supported by the fact that repeaters were three times more likely than non-repeaters to receive a diagnosis of Major Depressive Disorder. Furthermore, it has been shown that repetition of DSH is often associated with episodes of depression (Pfeffer et al., 1993).

Taken together, the research on adolescent DSH and its repetition suggests that self-harm usually occurs in the presence of depressive symptomatology, and the

more complex and long-standing a young person's difficulties are, the more likely he or she is to repeatedly engage in DSH. This contention is supported by the findings of Hawton, Osborn, O'Grady, and Cole (1982), who devised a classification system based on the duration and problem characteristics of adolescents who had taken overdoses. Fifty percent of those whose difficulties had persisted for at least one month and included behavioural problems (the 'chronic with behaviour disturbance' group) took another overdose within the following year, compared with only 3% of those whose problems were either 'acute' (i.e., present for less than one month) or 'chronic' but without behavioural disturbance. In addition, a positive relationship has been found between degree of psychopathological comorbidity and both frequency and lethality of DSH in adolescents (Frances & Blumenthal, 1989, cited in Miller & Glinski, 2000).

Due to the diversity and complexity of problems associated with DSH repetition in young people, progress in conceptualising this behaviour to inform clinical intervention has been limited. However, such developments have been noted within the adult literature pertaining to a specific client population, namely those with borderline personality disorder. As outlined below, recent research suggests that following similar lines of enquiry with adolescents may prove fruitful in constructing a conceptual framework for DSH repetition in this age group.

### **DSH Repetition, Borderline Personality Disorder and Affect Dysregulation**

Evidence suggests that a large proportion of adults who self-harm fulfil criteria for at least one personality disorder (Haw, Hawton, Houston, & Townsend, 2001). Of these, borderline personality disorder (BPD) is by far the most common and is associated with the highest frequency of repetition of DSH (Söderberg, 2001). BPD is characterised by a pervasive instability in mood, interpersonal relationships

and self-image, impulsivity, and attempts to avoid abandonment. Furthermore, self-mutilation and suicidal behaviours are included in the diagnostic criteria (American Psychiatric Association, 1994). Söderberg (2001) found that in self-harming adults with BPD, an Axis I disorder was not always present and concluded that the instability associated with BPD predisposes individuals for DSH.

The importance of personality disturbance in DSH and its repetition in adolescence is less clearly understood. The relative dearth of research in this area is due in large part to the on-going disagreement regarding the validity of a diagnosis of personality disorder in this age group (Braun-Scharm, 1996). Some have argued that adolescence is a time of fluid personality development and as such this population cannot be said to have the rigid and enduring patterns characteristic of personality disorders. In addition, objections have been raised regarding the labelling of adolescents with this chronic and stigmatising diagnosis. Others assert that personality disorders are unlikely to appear only after the age of 18. Indeed, in adults with BPD who repeatedly self-harm, this behaviour usually begins in adolescence (Favazza & Conterio, 1989; Simeon et al., 1992). The complex issues surrounding this debate have been discussed elsewhere (e.g., Bleiberg, 1994). Nevertheless, both anecdotal and research findings suggest that features of BPD may be common among adolescent psychiatric in-patients who self-harm (Braun-Scharm, 1996; Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen, & Helenius, 1998). As such, biological, psychological and social mechanisms believed to be associated with repetition of DSH in adults with BPD may prove useful in helping to understand the same phenomenon in adolescents.

One promising area of research concerns the concept of affect dysregulation. According to Linehan's (1993) biosocial theory, the characteristics of BPD

(including DSH) are consequences of a primary dysfunction of the emotion regulation system. This dysfunction is purportedly due to both high emotional vulnerability and deficits in emotion modulation, which in turn are consequences of biological predispositions and being raised in emotionally invalidating environments. Furthermore, it has been contended that recurrent self-injurious behaviour characteristic of this population has the effect of changing or reducing intense, overwhelming emotional arousal (Favazza, 1999; Herpertz, 1995).

Recent research has indicated that affect dysregulation may also be an important factor in adolescent DSH. In a study of adolescent psychiatric inpatients, Zlotnick and colleagues (1997) found higher levels of affect dysregulation among those who had recently engaged in DSH with intent to die ('suicide attempters') than among those reporting suicidal ideation. Additionally, in the suicide attempters there was a significant positive correlation between degree of affect dysregulation and number of types of self-mutilative acts in the year prior to hospitalisation. In light of their findings, the authors suggested that "adolescent suicide attempters may engage in a variety of self-inflicted assaults on their bodies in search of an effective method to modulate their affect. Perhaps a suicide attempt is a final attempt to adapt to intense negative emotions" (Zlotnick et al., 1997, p. 796). Importantly, the identification of mechanisms underlying DSH repetition in adolescents, such as poor affect regulation, are likely to have significant implications for the development of effective interventions for this population.

### **Clinical Management**

Despite the level of concern generated by young people who repeatedly engage in DSH, it remains unclear as to how this problem should be managed. In clinical practice, this client group is commonly associated with high treatment drop-

out rates and poor outcomes (e.g., Trautman, Stewart, & Morishima, 1993). Notably, there have been few rigorous studies of the efficacy of psychosocial and pharmacological interventions for DSH, and of these, only a small proportion have specifically targeted adolescents (Arensman et al., 2001; Hawton et al., 1998). Furthermore, although repetition of DSH is typically included as a measure of outcome, most intervention studies have failed to distinguish between those at high and low risk of repetition.

In developing effective interventions for adolescents who repeatedly self-harm, it would seem appropriate to target those factors most strongly associated with repetition in this group. However, to date there have been very few controlled studies that have shown promise in this regard. Although not specifically addressing the issue of repetition, Harrington and colleagues (Harrington et al., 1998) evaluated a brief home-based family intervention designed to target difficulties such as impaired problem-solving and poor communication that are characteristic of the families of adolescents who self-harm. The study failed to reveal any significant benefits of receiving the family intervention plus routine care over routine care only in terms of primary outcomes (i.e., suicidal ideation, hopelessness and family functioning) or rates of DSH repetition. Although the family intervention resulted in a reduction of suicidal ideation in the non-depressed adolescents, this population are known to be at lower risk of repetition than those who are depressed (Hawton et al., 1999).

Due to the strong association between depression and DSH repetition in young people, it has been suggested that interventions developed to treat adolescent depression may be beneficial for this group (Hawton et al., 1999). However, studies of the efficacy of psychotherapeutic and pharmacological interventions for



depression have typically excluded adolescents who self-harm and have not used rates of DSH as an outcome variable (Miller & Glinski, 2000; Weisz & Hawley, 2002).

As outlined earlier, there is evidence to suggest that affect dysregulation may be an important characteristic of adolescents who repeatedly self-harm. It follows that interventions which facilitate the utilisation of adaptive emotion regulation strategies may be beneficial for this population. One psychotherapeutic approach, namely dialectical behaviour therapy (DBT; Linehan, 1993), incorporates this objective. DBT is the only intervention for adults at high risk of DSH repetition which has been empirically validated, and as such it has been widely embraced by clinicians in the USA and the UK. Based on Linehan's (1993) biosocial model of BPD, it is primarily a cognitive-behavioural approach which incorporates elements of Eastern philosophy and meditation, as well as components of other psychotherapeutic approaches. DBT balances behavioural skills training, contingency management and cognitive modification with supportive techniques such as empathy and acceptance during a one-year programme of individual therapy, group skills training, and telephone coaching. Originally designed for the outpatient treatment of adult women meeting criteria for a diagnosis of BPD with a history of chronic self-harm, DBT has been shown to be significantly superior to routine treatment in reducing frequency and lethality of DSH, number of hospital admissions, treatment drop-out rate, depression, suicidal ideation, hopelessness and anger and in improving social adjustment in this client group (Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993). Additionally, this intervention has been associated with reduced psychopathology and frequency of DSH among adult women with BPD in an in-patient setting (Bohus et al., 2000).

Following its apparent efficacy with adult clients, Miller and colleagues (Miller, Rathus, Linehan, Wetzler, & Leigh, 1997) developed a modified form of DBT for adolescents (DBT-A), a 12-week programme of twice weekly therapy consisting of individual therapy and a multi-family skills training group run in accordance with DBT principles (with an optional 12- to 24-week follow-up consultation group). Although not yet subjected to rigorous evaluation, preliminary data are promising. Compared with a control group receiving 12 weeks of twice-weekly supportive-psychodynamic individual and family therapy, suicidal adolescents with borderline personality features receiving 12 weeks of DBT-A had significantly fewer psychiatric hospitalisations during treatment and a higher rate of treatment completion (Rathus and Miller, 1999, cited in Miller & Glinski, 2000). Although the tendency towards fewer subsequent episodes of DSH was not significant, it should be noted that the DBT-A group was at higher pre-treatment risk for repetition. In addition, there were significant pre-post reductions in suicidal ideation, general psychiatric symptoms and symptoms of borderline personality disorder in the DBT-A group.

More recently, Wood and colleagues (Wood, Trainor, Rothwell, Moore, & Harrington, 2001) conducted the first (and to date, only) randomised controlled trial of an intervention for adolescents who repeatedly engage in DSH. The intervention, termed 'developmental group psychotherapy', was specifically designed for this population, and included techniques from a range of psychotherapeutic approaches including cognitive-behavioural therapy, DBT, and psychodynamic group psychotherapy. It comprised of an initial assessment phase followed by six 'acute' group sessions, then weekly 'long-term' group therapy which continues until the adolescent felt ready to leave. Six themes were targeted in the acute group

(relationships, school problems and peer relationships, family problems, anger management, depression and self-harm, and hopelessness), these being suggested by previous research as important issues in this population. Adolescents who had self-harmed on at least two occasions within the previous year were allocated to group therapy plus routine care or routine care only. At seven-month follow-up, adolescents receiving group therapy were less likely to have self-harmed (particularly on more than one occasion), had better school attendance and a lower rate of behavioural disorder, and were less likely to have used routine care than those receiving routine care only. There were no differences between groups on levels of depression, suicidal ideation, rates of most mental disorders and global outcome. The authors concluded that while their results were encouraging, adolescents at higher risk of DSH repetition may require longer treatment. This proposition was supported by their finding of an inverse association between number of group sessions received and probability of subsequent DSH.

The limited available evidence appears to highlight the necessity of tailoring treatment to the individual needs of adolescents who self-harm. Given the complexity of the difficulties experienced by many young people who repeatedly engage in this behaviour, it is perhaps not surprising that brief interventions have shown limited success.

### **Conclusions and Recommendations for Future Research**

Despite a growing volume of research on adolescent DSH, little has specifically targeted the problem of repetition in this age group. Furthermore, the clinical implications of the available evidence remain unclear. In large part, this can be traced to several factors: a lack of consensus regarding the definition of DSH (including its behavioural and motivational constituents); methodological

inconsistencies between studies hindering the comparability and interpretation of findings; a dearth of theoretical frameworks for conceptualising DSH repetition in young people; and a paucity of treatment efficacy research for adolescent DSH (and indeed for adolescent mental health problems per se; Weisz & Hawley, 2002). Based on the current status of research into adolescent DSH repetition, a number of recommendations are indicated in order to facilitate progress in meeting the needs of these high-suicide-risk young people.

### Terminology

Firstly, there is a need for well-defined and universally adopted nomenclature for DSH, including both a generic term and specific descriptors that encompass the full range of self-harming behaviours. Due to the often poor correlation between lethality and degree of suicidal intent, it would seem most appropriate to develop a separate set of terms for the latter, which could then be used in conjunction with behavioural descriptors if motivation is ascertainable. Clearly, further investigation is required to determine the nature of the relationship between DSH with and without intent to die. This issue is particularly pertinent to the study of DSH repetition because many repeaters engage in both suicidal and non-suicidal self-harming behaviours which often fall within non-overlapping areas of research.

### Measures of DSH

Given agreed terminology, there is a need for reliable and valid measures of DSH in adolescents that can be utilised in both clinical and research settings and are sensitive to an individual's history of self-harm. Such tools have been developed for adult populations (e.g., the Parasuicide History Interview; Linehan, Wagner, & Cox, 1989), but have not been validated for use with adolescents. The assessment of DSH in research studies has therefore relied on a range of methods including clinical

interviews, unvalidated measures and hospital records, typically with differing criteria for defining an episode and for identifying repetition. The widespread use of a well-developed measure would therefore facilitate both case-identification and comparability between studies.

### Research Design

Another factor that has contributed to difficulties interpreting available data is the over-reliance of research on cross-sectional designs. Firstly, such designs preclude the identification of causal relationships between DSH and its correlates. Secondly, in studies comparing 'repeaters' with 'non-repeaters/first-timers', it is possible (indeed likely) that many of the latter will go on to self-harm again. Thus their findings may mask important differences between the characteristics of repeaters and 'true' non-repeaters. The difficulties associated with cross-sectional investigations, particularly in the study of DSH repetition, underscore the importance of prospective, longitudinal studies. Although such research programmes are currently underway, they typically rely on those adolescents whose acts of DSH result in hospital presentations. Thus, research tends to focus on more serious or lethal acts of self-harm. However, available evidence suggests that young people who repeatedly self-harm may initially engage in relatively minor acts of DSH that do not require medical attention (Hawton et al., 1996). Since many adolescents are already repeaters by the time they first present at hospital, difficulties arise in attempting to estimate repetition rates, identify risk factors and underlying mechanisms associated with repetition, delineate patterns of DSH repetition over time, and identify possible subgroups of repeaters. This suggests the need for longitudinal community-based research to supplement that from hospital-based programmes, thereby providing a more comprehensive picture of DSH repetition in adolescents. Particular focus is

required in identifying psychological, social and biological factors implicated in DSH repetition that will facilitate assessment of risk and that may be amenable to intervention. In addition, further research is required in understanding the relationship between adolescent DSH and functioning in adulthood (Kerfoot, 2000).

### Treatment Research

Finally, there is an urgent need to develop effective interventions for adolescents who repeatedly self-harm. Whilst Rathus and Miller's (1999) DBT-A appears promising, further outcome data are clearly warranted. Indeed, it has been argued that the widespread popularity of DBT in the treatment of adult clients, for which it has been more extensively evaluated, continues to outweigh its empirical base (Scheel, 2000). Although it may be useful to draw from the adult literature, research is needed to determine the elements of adult interventions that are helpful for adolescents and the modifications required to ensure developmental appropriateness. Wood et al.'s (2001) group therapy, which also demonstrated some success, specifically emphasised developmental issues. However, it is unclear as to the theoretical underpinnings of their intervention. Progress in the adult literature suggests that interventions informed by evidence-based conceptual models of DSH repetition in adolescents are likely to prove most fruitful. This reinforces the need for further research into possible mechanisms (such as affect regulation) underlying this behaviour.

One of the difficulties in conducting randomised controlled trials with people who self-harm is that large sample sizes are required to demonstrate reliable effects of treatment on repetition (Arensman et al., 2001). Consequently, others have suggested that alternative methodologies should be considered (Goldney, 1998). One possible avenue concerns the use of qualitative methods, which have been proposed

as a useful adjunct to more traditional quantitative approaches to outcome research (McLeod, 2000). Qualitative studies have the potential to identify factors associated with both positive and negative outcomes, as well as identifying outcome variables perceived by clients themselves as important. In a client group associated with poor treatment retention (Trautman et al., 1993), gaining the adolescent's perspective may prove invaluable in promoting the development of effective and acceptable interventions.

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## APPENDIX 1. NOTES FOR CONTRIBUTORS

### **British Journal of Clinical Psychology - Notes for Contributors**

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited :

- Papers reporting original empirical investigations;
- Theoretical papers, provided that these are sufficiently related to the empirical data;
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- Brief Reports and Comments (see below).

#### **1. Circulation**

The circulation of the Journal is worldwide. There is no restriction to British authors; papers are invited and encouraged from authors throughout the world.

#### **2. Length**

Pressure on Journal space is considerable and papers should be as short as is consistent with clear presentation of the subject matter. Papers should normally be no more than 5,000 words, although the Editor retains discretion to publish papers beyond this length.

#### **3. Refereeing**

The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be made aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to a removable front page (and the text should be free of such clues as identifiable self-citations ('In our earlier work...')).

#### **4. Submission requirements**

(a) Four copies of the manuscript should be sent to the Editor (Professor Karin Mogg/ Professor Brendan Bradley, BPS Journals Department, St. Andrews House, 48 Princess Road East, Leicester, LE1 7DR, UK). Submission of a paper implies that it has not been published elsewhere and that it is not being considered for publication in another journal. Papers should be accompanied by a signed letter indicating that all named authors have agreed to the submission. One author should be identified as the correspondent and that person's title, name and address supplied.

(b) Contributions must be typed in double spacing with wide margins and on only one side of each sheet. All sheets must be numbered.

(c) Tables should be typed in double spacing, each on a separate piece of paper with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

(d) Figures are usually produced direct from authors' originals and should be



presented as good black or white images preferably on high contrast glossy paper, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Paper clips leave damaging indentations and should be avoided. Any necessary instructions should be written on an accompanying photocopy. Captions should be listed on a separate sheet.

(e) For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusion. Review articles should use these headings : Purpose, Methods, Results, Conclusions (more details on Structured Abstracts can be obtained by contacting the Journals Department).

(f) Bibliographic references in the text should quote the author's name and the date of publication thus: Smith (1994). Multiple citations should be given alphabetically rather than chronologically: (Jones, 1998; King, 1996; Parker, 1997). If a work has two authors, cite both names in the text throughout: Page and White (1995). In the case of reference to three or more authors, use all names on the first mention and et al. thereafter except in the reference list.

(g) References cited in the text must appear in the list at the end of the article. The list should be typed in double spacing in the following format:

Herbert, M. (1993). Working with children and the Children Act (pp. 76-106). Leicester: The British Psychological Society.

Moore, R.G., & Blackburn, I.M. (1993). Sociotrophy, autonomy and personal memories in depression. *British Journal of Clinical Psychology*, 32, 460-462.

Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

(h) SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses (see The British Psychological Society Style Guide at:

<http://www.bps.org.uk/publications/jAuthor.cfm>).

(i) Authors are requested to avoid the use of sexist language.

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### **6. Brief reports and comments**

These allow rapid publication of research studies, and theoretical, critical or review comments with an essential contribution to make. Case studies are normally published only as Brief Reports. They should be limited to two printed pages with the text, including references and a 100 word abstract set at 150 lines. Abstracts should also be structured under these headings: Purpose, Methods, Results, Conclusions (more detailed guidelines on structured abstracts are available from the Journals Department). Figures and tables should be avoided. Title, author and name and

address for reprints and data of receipt are not included in the allowance. However, deduct three lines from the text each and every time any of the following occur:

- a) title longer than 70 characters
- b) author names longer than 70 characters
- c) each address after the first address
- d) each text heading (these should normally be avoided).
- e) A character is a letter or space. A punctuation mark counts as two characters (character plus space) and a space must be allowed on each side as a mathematical operator.

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### **8. Supplementary data**

Supplementary data too expensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

### **9. Proofs**

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- Double spacing with wide margins
- Tables/figures at the end
- Complete reference list in APA format
- Four good copies of the manuscript (or an e-mail attachment)

**SECTION THREE - RESEARCH PAPER**

Running head: DIALECTICAL BEHAVIOUR THERAPY FOR ADOLESCENTS

Evaluation of a Dialectical Behaviour Therapy Service for Adolescents:

A Qualitative Study of Clients' Experiences

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### **Abstract**

This study employed a qualitative methodology to evaluate an existing inpatient dialectical behaviour therapy (DBT) programme for adolescents with multiple presenting problems including deliberate self-harm. Semi-structured interviewing was used to elicit detailed accounts of the experience and impact of receiving DBT from the perspectives of four female adolescents. Transcripts were analysed for significant and recurrent themes using interpretative phenomenological analysis. Overall, the results supported the use of DBT with this client group. Application of DBT skills helped to gain a sense of control over internal experiences and overt behaviours, although marked individual differences were apparent. Furthermore, for most participants, the effective use of DBT skills was at least partially dependent upon the continued receipt of therapy. Motivation to engage in and comply with therapy appeared to be significantly influenced by participants' perceptions of staff and peers within the inpatient unit. Additionally, social comparison emerged as an important means of evaluating changes since entering DBT. The findings are discussed in relation to the existing literature, with particular emphasis on the extent to which therapeutic processes deemed important by DBT theory were concordant with participants' experiences. Implications for clinical practice are highlighted and directions for future research suggested.

## **Evaluation of a Dialectical Behaviour Therapy Service for Adolescents:**

### **A Qualitative Study of Clients' Experiences**

Deliberate self-harm (i.e., self-poisoning and self-injury) is a major health concern in the UK and is particularly common in adolescents (Hawton, Fagg, Simkin, Bale, & Bond, 1997). It has been estimated that 30% of young people who engage in such behaviour may do so on more than one occasion, and it appears that rates of self-harm and repetition in this age group are rising (Hawton, Fagg, Simkin, Bale, & Bond, 2000). Adolescent self-harm typically occurs within the context of significant mental health problems, most notably depression, anxiety, drug or alcohol abuse, behavioural problems and personality disturbance (Gould et al., 1998; Kerfoot, 1988; Lewinsohn, Rohde, & Seeley, 1996). Comorbidity is common and is associated with more frequent and lethal acts of self-harm (Frances & Blumenthal, 1989, cited in Miller & Glinski, 2000). Of particular concern is the increased risk of subsequent suicide presented by adolescents who self-harm, especially those who do so repeatedly (Goldacre & Hawton, 1985; Kotila & Loennqvist, 1987; Sellar, Hawton, & Goldacre, 1990). Other associated psychosocial problems include multiple, stressful life events (including physical and sexual abuse), perceived family dysfunction and conflictual relationships with parents (De Wilde, Kienhorst, Diekstra, & Wolters, 1992; King, Segal, Naylor, & Evans, 1993; Hurd, Wooding, & Noller, 1999).

Despite the level of concern generated by adolescents who self-harm, it remains unclear as to how this problem should be managed. In clinical practice, this population is commonly associated with high treatment drop-out rates and poor outcomes (e.g., Trautman, Stewart, & Morishima, 1993). Importantly, attempts to address their often complex needs have been hampered by the absence of empirically

validated interventions for this age group (however, see Wood, Trainor, Rothwell, Moore, & Harrington, 2001, for promising results of a preliminary randomised trial of group therapy for self-harm 'repeaters'). In the adult domain, dialectical behaviour therapy (DBT; Linehan, 1993) is the only evidence-based intervention for individuals at high risk of repetition. Primarily a cognitive-behavioural approach, DBT balances behavioural skills training, contingency management and cognitive modification with supportive techniques such as empathy and acceptance. Originally designed for the treatment of adult women with borderline personality disorder and a history of chronic self-harm, DBT has been shown to be significantly superior to routine treatment in reducing psychopathology and frequency of self-harm in this client group in both inpatient and outpatient settings (Bohus et al., 2000; Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993).

Following its apparent efficacy with adult clients, Rathus and Miller (1999; cited in Miller & Glinski, 2000) recently investigated the utility of a modified form of DBT for adolescents (DBT-A; Miller, Rathus, Linehan, Wetzler, & Leigh, 1997). Compared with a control group receiving individual and family therapy, suicidal adolescents with borderline personality features receiving DBT had significantly fewer psychiatric hospitalisations during treatment and a higher rate of treatment completion. There was also a non-significant tendency towards fewer subsequent episodes of self-harm, despite the DBT-A group being at higher pre-treatment risk for repetition. In addition, there were significant pre-post reductions in suicidal ideation, general psychiatric symptoms and symptoms of borderline personality disorder in the DBT-A group.

Although preliminary findings are promising, further evidence is required to support the application of DBT to adolescents who self-harm. Since large sample sizes are required in efficacy research to demonstrate reliable effects of treatment on repetition of self-harm (Arensman et al., 2001), it has been suggested that alternative methodologies should be considered (Goldney, 1998). The aim of the present study was to expand the evidence base for DBT by employing a qualitative methodology to evaluate an existing in-patient DBT programme for adolescents with multiple presenting problems including self-harm. Specifically, it sought to explore the experience and impact of receiving DBT from the clients' perspective. Although rarely employed in psychotherapy effectiveness research, McLeod (2000) has argued for the potential utility of qualitative methods in this domain as an important adjunct to traditional quantitative approaches. Clearly, it is not only important to know if a therapy works, but also how and for whom it works.

## **Method**

### **Participants**

All young people who had participated in the DBT programme of a Tier 4 inpatient adolescent mental health service and had been discharged or changed to outpatient status within the previous 18 months were invited to take part in the study. Of the 10 young people approached (all of whom were female), five consented to participate. One participant withdrew from the study, resulting in a final sample size of four.

For confidentiality purposes, only minimal participant details are provided here and their names have been changed. At the time of data collection, participants were aged between 16 and 18 years and all were attending school or college. Upon entry to the DBT programme, all fulfilled at least three criteria for borderline



personality disorder as specified by the Diagnostic and Statistical Manual of Mental Disorders (4th ed., American Psychiatric Association, 1994) and had a prior history of repeated deliberate self-harm (including self-injury and overdoses). In addition, they had a range of mental health and psychosocial problems. Their ages ranged from 14 to 17 years at the start of therapy.

Within the DBT programme, adolescents attended twice weekly individual therapy and group skills training. Katie and Rachel each received DBT for 7-8 months. Therapy had ended upon their discharge from the inpatient unit, 6-12 months prior to entering the study. Natalie and Jade continued to receive DBT at the unit as outpatients following their discharge from day-/inpatient status 9-12 months earlier. In total, they had each been in therapy for 2-2½ years.

#### Procedure

Interpretative phenomenological analysis (IPA; Smith, 1996) was employed to evaluate the DBT programme from the adolescents' perspective. This methodology was chosen because it is concerned with understanding what participants believe about a particular topic. It does not seek to generate objective statements about the topic or test specific hypotheses. Rather, IPA allows themes relevant to individual participants to emerge during the course of data collection, with the researcher engaging in a process of interpretation of their verbal reports in an attempt to make sense of personal experiences.

The procedures employed for data collection and analysis followed those advocated by Smith and colleagues (Smith, 1995; Smith, Jarman, & Osborn, 1999) for conducting IPA research.

Data collection. Semi-structured interviewing was used to elicit a detailed account of participants' beliefs and perceptions regarding the effectiveness of the

DBT that they received, helpful and unhelpful aspects of therapy, and difficulties with compliance to therapy. An interview schedule was used for guidance, but the researcher also pursued areas of interest or concern raised by the participant within the context of the topic under investigation. Each interview, which lasted between 1 and 1½ hours, was audiotaped and subsequently transcribed verbatim.

Analysis. This stage began with the detailed analysis of the first transcribed interview. This involved the researcher attempting to understand the meanings of the participant's responses by repeatedly reading the text and engaging in a process of interpretation. Significant or interesting findings in the text were noted in one margin of the transcript, while emerging theme titles were noted in the other margin. Through a cyclical process, connections between the emerging theme titles were sought and a list of superordinate (or major) and associated subordinate themes was generated. At each stage of the analysis, the researcher returned to the transcript to ensure that the themes and their connections were apparent in the text.

The above process was repeated for each transcript, with new emerging themes being tested against earlier transcripts and a revised list of superordinate and subordinate themes produced for the group. As an initial process of verification, a second interview was requested from the first two participants (Katie and Rachel) in which they were asked to comment on the researcher's interpretation of their initial interview, as well as to clarify areas of ambiguity. These additional interviews were similarly transcribed and included in the analysis. Analysis and revision of the *master list of themes continued during the writing-up phase, and only then were the results considered in relation to the existing literature.*

All interviews were conducted and analysed by the first author (HR), who had a fundamental understanding of and interest in the principles of DBT. Attempts were

made to minimise these influences on the interpretative process. As a credibility check, the results were fed back to and discussed with the participants.

### Results

Analysis of the interviews resulted in the emergence of four superordinate themes (see Table 1). Using interview extracts for illustrative purposes, each superordinate theme is discussed in turn with reference to the subordinate themes of which it comprised.

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Insert Table 1 about here

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#### Evaluating change through social comparison

The first theme concerned participants' use of social comparison in trying to make sense of the changes they perceived since entering DBT.

Comparison with prior self. One index of change reflected the difference between their present perception of self and that prior to receiving treatment. This was most clearly articulated in relation to overt behaviours. Compared with pre-treatment levels, self-harming behaviour had decreased in frequency and/or severity for all participants, albeit to varying degrees: 'it used to be a complete self-mutilation a few times a day, and now it's like once a month or something I'd give it a good go' (Natalie). For Rachel, the reduction had been so dramatic that she felt self-harming was a 'past life kind of thing', occurring 'hardly ever' and being 'superficial' in nature. Only Katie failed to identify such changes as significant: 'I don't [overdose] as often as I did then, but it still happens and that'. All participants also talked about

improvements in their ability to interact with others: 'I wasn't a person who was interpersonally effective, but now I'm, I can deal with anybody' (Jade).

Change in internal experiences was most strongly expressed by Rachel, who noted a significant increase in mood and decrease in urges to self-harm. For the other participants, it was difficult to evaluate such change since it had occurred very gradually and/or had fluctuated over time. When asked if her mood had altered since entering DBT, Natalie replied 'probably, yeah, but with it's being over so long, I can't really put my finger on it'. For Jade, continuing mood fluctuations impeded her ability to maintain a stable evaluation of progress: 'on some days I think I'm just the same. On other days I think no, I have come far because I'm not [self-harming] any more, so. I do think I've come far today, but tomorrow if you ask me I'd probably say the opposite'.

Comparison with 'normality'. A second frame of reference for evaluating change concerned participants' perceptions of themselves in relation to others. Most described wanting to be or to appear 'normal'. Natalie commented 'everyone used to call me weird, so I just wanted to be normal. I didn't really know what it was ... I just knew it wasn't what I was'. Although she had subsequently accepted being different, she acknowledged that the first sign of change in herself was 'people actually wanting to speak to me'. The ability to 'fit in', particularly within their peer group, appeared to be a significant indicator of a successful outcome for others: 'when I told [my teachers about the Unit], they couldn't believe it 'cos there's other people from places like [the Unit] and they don't do well and you can tell that they've got problems, but they couldn't tell' (Rachel). Returning to mainstream education, however, served to reinforce Katie's negative view of herself: 'I just wanted to

concentrate on like trying to be normal like everybody else ... [but] I'm not normal so I didn't feel normal'.

Comparison with perception of self by others. All participants commented on changes that other people had noticed in their presentation. For Rachel, this confirmed her belief in having attained desired change: 'it's definitely nice when people say that "oh, you're much happier than you used to be and you're much more like outgoing" ... 'cos that's like how I've always wanted to be but I'm like that now'. However, for most participants there was a mismatch between the views of others and their self-perception, with the former being considered an over-estimation of the extent to which positive changes had occurred: 'well I don't see much changes but other people say I've changed a lot' (Katie). The wider the discrepancy, the more difficult it seemed to be for participants to make sense of and articulate the changes in themselves: Jade stated 'I feel that [DBT] is benefiting me, but I can't see that, but other people can. And it's quite difficult because I think I'm going round in circles, but other people think that I'm y'know, going down the right road now'.

#### Control as a route to change

This theme referred to the emphasis participants placed on gaining control as an explanation for changes in self since entering therapy.

Control through skills application. Gaining control was typically mentioned within the context of applying DBT skills and was most apparent in relation to the prevention of self-harming behaviour. One domain of control concerned their response to urges to self-harm: 'although I still have the urges that hit the roof ... I'm not acting upon it half as much as I used to' (Natalie). For Katie, considering 'pros and cons' had reduced the likelihood of her impulsively buying tablets when experiencing urges to overdose. Rachel and Jade had been able to 'fulfil the urge'

(Jade) to self-harm by engaging in alternative, non-harmful behaviours. A second area of control was in reducing the likelihood of experiencing urges to self-harm. The occurrence of adverse events was universally cited as a trigger for such urges. Thus, the ability to deal effectively with difficult situations appeared significant in further engendering a sense of control. Improved interpersonal skills had helped Rachel and Jade to get 'out of crises' (Jade) and 'not end up in situations which you're more likely to self-harm' (Rachel).

In comparison with their overt behaviour, the perceived extent and direction of change in control over internal experiences was more variable across participants. Mood remained very unstable for Katie, Natalie and Jade, although the use of mindfulness skills had enabled Natalie to gain some degree of control in this domain: 'my emotions go all over the place ... I'm either on top of the world or I'm six foot under, all the time, and almost immediately mindfulness kind of levels me that little bit more'.

Mindfulness had also been instrumental in gaining a degree of control over cognitive processes, helping Rachel and Jade to focus attention on their studies. Further control over cognitions had been achieved by Rachel through challenging negative self-judgements. However, others continued to struggle with their thoughts, and Katie felt that receiving DBT had diminished her trust in her own judgement: 'DBT made that little old positive voice in my head get stronger, and I don't like that now ... 'cos I've got like big arguments in my head going on between the little negative person and the little positive person'. Unable to reconcile opposing viewpoints, she felt somewhat out of control: 'the positive seems to be winning quite a lot recently ... but then I don't know whether that's good or bad, 'cos like the other

side of me, it's still as strong on the negative side, and it keeps like thinking I'm doing wrong'.

Context dependency. The extent to which participants had gained a sense of control appeared to be closely associated with their degree of dependency on the structure and support provided by the treatment setting in order to effectively implement the skills learned. In turn, this seemingly reflected how far they had moved along the continuum from understanding the skills to internalising them. Rachel, who reported gains in control in several domains, talked about using the skills 'subconsciously': 'sometimes I forget I'm doing [a skill] because I've done it so much it's just natural now'. When she did self-harm, she would analyse why it happened and identify what she could have done differently in an attempt to prevent its reoccurrence. Support from the Unit was sought only on an infrequent and informal basis.

Natalie and Jade felt knowledgeable about the skills and were able to use many of them to good effect. However, continuation in the DBT programme as out-patients provided needed reminders, incentive and structure within which to practice the skills: 'you might know the stuff, but it slips to the back of your mind ... if you're in the group[s], then it's bringing it to the fore all the time' (Natalie). Katie similarly reported having benefited while in the programme from staff prompting her to use her skills when she felt low and unmotivated. Further structured practice, she felt, would have helped her to remember and integrate them into her 'pattern of living'. No longer receiving the service, Katie lacked motivation to apply the skills and rarely thought about them, largely resorting to old coping strategies.

### Personal and interpersonal influences on the change process

This theme referred to the impact of personal and interpersonal or social factors on participants' engagement in the process of change, predominantly through their influence on motivation to comply with treatment.

Goal setting and self-belief. The development of goals (both concrete and abstract) and the belief that such attainment was possible emerged as an important influence on the change process. On entering DBT, personal goals or expectations were typically vague (e.g., to 'just feel better' (Katie) or 'not to be scared' (Natalie)). This appeared in part to reflect ambivalence about the implications of change: 'sometimes it's hard to change and I didn't wanna just change all of a sudden and start like dealing with all my problems ... just 'cos I'm scared of change' (Katie). Rachel's initial resistance was further expressed as a desire to maintain her sense of self: 'I used to sit on my hands and I didn't want to get better, because I was like this crazy girl and I liked it'.

Goal setting and self-belief appeared closely interlinked, both being mood-dependent and reflecting hopefulness about the future. Katie stated 'when my mood had lifted and then I would start thinking that there was a life ... I started like setting myself goals [but] I only set little ones 'cos I was still feeling negative ... and didn't see myself like to be alive in five years'. She was unable to remember what those goals were and to what extent she had met them. Katie remained strongly influenced by others in making decisions about her future.

For Rachel, formulating a sense of direction in life (initially through a desire to return to education) provided a strong motivation to change: 'it was like I was still at [the Unit] in this one place and everything else was moving past me, and I just wanted to jump on the train'. Achievement of goals reinforced her self-belief and



encouraged further goal-setting: 'I know that I can try my best at anything and it should work'. Jade similarly expressed determination in her desire to 'cope better', encouraged by her successful fight against urges to self-harm in recent months.

Nurturing relationships. The perceived supportiveness of interpersonal relationships, both within and outside the treatment environment, appeared to play a significant role in facilitating change and maintaining gains. Both Jade and Rachel likened the Unit community to a large close-knit family. The emphasis on 'getting better and feeling good about yourself' was identified by Rachel as the initial trigger for her motivation to change: 'you can't really be resistant to not helping yourself because everyone's behind you and like trying to help you get better all the time'. The consequences of developing supportive relationships, however, were not entirely experienced as positive. Katie reported feeling more guilty after overdosing: 'before I just didn't care. But I do feel bad now 'cos I think oh, I've wasted people's time ... [because] they've tried like so long to like help me get better'. Rachel also talked about increased guilt after self-harming, but harnessed this as a source of motivation to apply skills.

Two features of supportive relationships appeared particularly salient for participants. Firstly, most mentioned how helpful they had found the attunement and responsiveness of staff to their emotional distress or needs. For Natalie, this responsiveness had increased in the home environment since her therapist had started teaching her mother DBT skills: 'my Mum's really got the hang of it, which helps 'cos now if I'm down, my Mum knows what to say when I'm home ... that'll help me'. A second factor concerned the degree to which participants felt safe with others and was related to a willingness to talk about themselves and their feelings. Fear of being judged by her peers impeded Katie's participation in the groups: 'I thought if I

said something people would think it was stupid'. Perceived safety was associated with trust, and both were typically greatest in the relationship with participants' individual DBT therapist.

Sense of connection with others. A sense of connection with others appeared to have a significant impact on the experience of treatment and the process of change. The DBT groups played a prominent role in this regard. Identification with peers served to normalise the difficulties they were experiencing: 'I liked hearing other, like listening to what other people had to say because, like if they said something I'd think oh, I'd feel like that ... stuff like that, and it was nice to know that other people like felt the same way' (Katie). For Rachel, peers provided a source of learning and inspiration to apply skills and work towards change: 'you think well, I'm living with these people and they can use their skills and they're helping themselves, and I can do the same thing ... it's I guess maybe because they've actually experienced what I've been through in a sort of way that I could be like them and use my skills'.

Natalie also expressed having a sense of connection with her therapist, which similarly served to increase motivation to apply skills: 'I find [my therapist] a lot more easy to talk to, but she's a lot more like me, er, which is really weird 'cos I hate myself ... when you talk to [her] she makes skills sound fun. She actually makes me want to do skills'. The wider the perceived differences between herself and others, the less Rachel felt understood and consequently helped: 'I think it's because I learn more from people who have experienced the same things as me'.

#### Pervasiveness of DBT within the treatment setting

The final theme referred to participants' perception of DBT as pervasive within the context of the wider treatment experience at the Unit: Katie said 'it's always mentioned, DBT, like with everything really'. Most noted a degree of overlap

between DBT skills and those taught in other groups, such as anxiety management and social skills. The greatest blurring of boundaries, however, was between DBT and the counselling sessions with nursing staff that all participants received. All participants talked about their counsellors prompting them to use DBT skills during discussions of day-to-day hassles: ‘they’d always remind me of DBT whoever I was having a session with at the moment, y’know DBT skills are at hand’ (Jade). Despite the challenging nature of DBT and the personal discomfort it had at times aroused, the pervasiveness of the approach throughout the Unit was generally perceived as helpful. For Katie, prompting by the staff to use her skills helped to reduce the mood-dependency of their application: ‘when you’re upset you don’t think of [the skills] really. But then you do need that someone telling you to think of it when you’re like upset’. However, according to Natalie, the helpfulness of prompting by staff appeared conditional upon their relative expertise in DBT: ‘I often start talking to [staff] and I’m thinking I know this stuff, I know it better than you. I could teach you more than you could teach me about DBT!’.

### **Discussion**

This study aimed to explore the experience and outcome of receiving DBT in a naturalistic setting from the perspectives of a small number of adolescents. As such, the findings do not claim to be representative of young people’s experiences of DBT in general. However, the prominence of and interrelationships between the emergent themes appear to provide important indicators regarding the utility of this psychotherapeutic approach with adolescents.

At a fundamental level, the results support previous data indicating that young people who repeatedly self-harm and have a diversity of mental health and psychosocial needs can benefit from DBT (Miller, Wyman, Huppert, Glassman, &

Rathus, 2000; Rathus & Miller, 1999). The emphasis placed by participants on the application of DBT skills to gain a sense of control over internal experiences and observable behaviours (including self-harm) is consistent with the aims of DBT, namely to improve emotion regulation and facilitate behavioural, interpersonal, self, and cognitive stability (Linehan, 1993). However, most participants reported limited change in internal experiences (e.g., mood, cognitions, urges to self-harm) relative to overt behaviours. This finding is perhaps understandable in view of the fact that reducing self-harming behaviours is the highest priority target in DBT. Furthermore, the overarching focus of DBT on increasing dialectical behaviour patterns may help to explain the reportedly adverse impact of therapy on Katie's thought processes. It appeared that her cognitive style had shifted from one of rigid negativity to a recognition of opposing viewpoints, but had not progressed to an ability to integrate these polarities to achieve a more balanced (i.e., dialectical) stance. Given that she reported few perceived gains from therapy, these findings suggest that the ability to think dialectically may be an essential prerequisite to achieving behavioural control. Further research is required to test this hypothesis.

Notably, the effective use of DBT skills for most participants was at least partially dependent upon the continued receipt of therapy. Katie's reflections suggested that treatment ended prematurely, resulting in poor maintenance of gains primarily through a loss of structure, prompting and motivation. The most 'successful' outcome appeared to have been achieved by Rachel, who reported having internalised the skills and become more proficient at analysing situations and problem-solving. In effect, she had become her own therapist. This underscores the necessity of generalisation beyond the treatment environment, an aim of all skills-based psychotherapeutic interventions. In accordance with Natalie's experiences,

teaching DBT skills to parents may facilitate this process, a hypothesis worthy of further investigation. Together with the reported benefits derived by Jade and Natalie from on-going outpatient DBT, the above findings suggest that therapy (at least in terms of duration) should be tailored to the specific needs of the individual. Furthermore, they support the contention that brief interventions are likely to be of limited effectiveness for this client group (Wood et al., 2001). However, the potential for achieving further gains through longer-term DBT remains to be determined.

As indicated earlier, treatment compliance is frequently problematic in this client group (Trautman et al., 1993). This study identified a number of factors that seemingly enhanced participants' motivation to engage in and comply with therapy. In relation to the wider treatment environment, these included the consistency of the approach to care and the perceived support and responsiveness of staff. Such findings highlight the value of providing DBT in an inpatient setting. However, peers also appeared to play an important role in facilitating participants' progress in therapy. The lack of a strong self-concept or sense of identity characteristic of adolescents with mental health problems purportedly makes them susceptible to identification with others. In turn, the latter is believed to underlie contagion of deliberate self-harm among adolescent in-patients (Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen, & Helenius, 1998). The present findings suggest that identification with others can also serve to inspire and normalise the problems of young people who self-harm, thus supporting the use of group therapy for this population. The apparently strong link between motivation and outcome indicates the need for further clarification of sources of motivation that can be harnessed in future treatment programmes.

Finally, this study highlighted the difficulties for some participants in making sense of changes in themselves since entering therapy. For Jade and Katie, there was a lack of consistency between their self-perception and a view of self through feedback from others. This finding may have indicated continuing instability of self-concept. Moreover, it raises questions regarding the validity of observer-rated or 'objective' measures of outcome, which may overestimate the positive impact of therapy (and perhaps underestimate negative outcomes). It would seem reasonable to suppose that the meaning of change to a client is of paramount importance in evaluating the success of an intervention. Although a reduction in self-harming behaviour and psychopathology are clearly important from a clinical point of view, this study suggests that both a sense of life moving on (e.g., through the achievement of personal goals) and the perceived ability to fit in with one's peer group may be key indicators of a positive outcome from the client's perspective. Further research is required to determine the breadth and consistency of client-generated indices of outcome, as well as their relationship to more traditional, objective measures.

Although this study supported the use of DBT for adolescents who self-harm, the methodology and small sample size precluded an evaluation of the long-term impact of DBT or its effectiveness in relation to other interventions. Similarly, there remain many outstanding questions regarding the influence of specific therapist, client, treatment and environmental characteristics on outcome. Nevertheless, the study hopes to have demonstrated the value of qualitative research in furthering knowledge of adolescents' experiences of receiving DBT, generating hypotheses regarding the links between process and outcome, and highlighting directions for future investigation.

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Table 1.

Superordinate and subordinate themes

Superordinate Themes	Subordinate Themes
Evaluating change through social comparison	Comparison with prior self Comparison with 'normality' Comparison with perception of self by others
Control as a route to change	Control through skills application Context dependency
Personal and interpersonal influences on the change process	Goal setting and self-belief Nurturing relationships Sense of connection with others
Pervasiveness of DBT within the treatment setting	

**APPENDIX 1. EXTRACTS FROM PARTICIPANTS' INTERVIEWS**  
**ILLUSTRATING THEMES**

**Theme 1. Evaluating change through social comparison**

**Comparison with prior self**

(Katie, i1p17) 'I don't [overdose] as often as I did then, but it still happens and that.'

(Rachel, i1p18) 'It's not so much of a self-harming issue now, it's more just... It's not even an issue now. It's just like past life kind of thing ... Like I used to self-harm all the time, whenever I could, whenever I could find somewhere to do it, whenever I could find anything to hurt myself ... It's just like the old [Rachel]. It's the new [Rachel] now.'

(Natalie, p7) 'I was quite good at interpersonal skills before, but um, being able to say no I was always bad at ... [DBT] helped me be able to say no to things that really I should be saying no to, I've been, I've been saying yes to 'cos I didn't know what else to do.'

(Jade, p4) 'I wasn't a person who was interpersonally effective, but now I'm, I can deal with anybody, arguments with friends, arguments with people I don't know kind of in the street, just any situation, any sticky situation to do with other people, I'm better at now'

(Jade, p14) '...my chain of thoughts ... I feel I haven't got anywhere, and they're just the same as they were. But obviously if I really, I really sat down and look at it and compare it to two years ago, they probably are slightly different.'

(Katie, i1p10) 'I suppose I did start feeling better 'cos I am better now, or better than I was ... it took a while, a few months, I don't really remember ... I just went up and down all the time so I don't remember.'

(Jade, p3) 'On some days I think I'm just the same. On other days I think no, I have come far because I'm not [self-harming] any more, so. I do think I've come far today, but tomorrow if you ask me I'd probably say the opposite.'

### Comparison with 'normality'

(Natalie, p16) '[I wanted to] be normal really ... oh, everyone used to call me weird, so I just wanted to be normal. I didn't really know what it was ... I just knew it wasn't what I was ... I've never been normal ... [but it] doesn't bother me at all now ... 'cos I accepted that I was weird.'

(Rachel, i2p18) 'I don't want people seeing me as like an emotional wreck or something, I just want people to see me as [Rachel], not like, er, a weird freakish [Rachel] because like even though I've had problems, it's not, it's not for them to know about, it's just for me to know about inside.'

(Rachel, i1p19) '[My teachers] didn't know anything about [the Unit] ... When I told them, they couldn't believe it 'cos there's other people from places like [the Unit] and they don't do well and you can tell they've got problems, but they couldn't tell.'

(Katie, i1p19) 'I just felt as if I was different, like being in college, 'cos nobody else knows where I've been ... like [at the Unit]. So I just didn't wanna think about it, I just wanted to concentrate on like trying to be normal like everybody else ... [but] I'm not normal so I didn't feel normal ... I'm not the same as everybody else.'

### Comparison with perception of self by others

(Rachel, i2p19) 'It's definitely nice when people say that 'oh, you're much happier than you used to be and you're much more like outgoing' and things

like that ... 'cos that's like how I've always wanted to be but I'm like that now.'

(Katie, i2p3) 'People say that I always, um, come across good, but I don't think I do, but they say I do when I'm nervous and that ... I don't know, people say I'm more confident and changing all the time. But I don't really see it often.'

(Rachel, i1p2) 'But now [my relatives] notice that I'm more happy, and it's like I did that myself. So that's what I'm proud of.'

(Rachel, i1p19) 'Like people, they don't even know what's happened but they notice that I've changed and I'm more confident in myself and around other people.'

(Jade, p2) 'I feel that [DBT] is benefiting me, but I can't see that, but other people can. And it's, it's quite difficult because I think I'm going round in circles, but other people think that I'm y'know, going down the right road now.'

(Jade, p16) 'Lots of people have said lots of things but I've just let it go in through one ear and out the other because I kind of... no, that's not me. So, chose not to accept it.'

## **Theme 2. Control as a route to change**

### **Control through skills application**

(Rachel, i2p18) 'I still have my problems but I have ways to cope with them.'

(Katie, i1p2) 'Like with my [therapist] we wrote out all my pros and cons ... and then that helped me and I'd keep that in my purse and when I feel like buying tablets I look at it and I look at the pros and cons ... it just makes me just not do things impulsively.'

- (Jade, p13) '[I've been] using skills, trying different ways to maybe fulfil the urge and think that'll do for now, but not doing anything harmful. Erm, like say if I have an overdose urge I'd probably do something busy ... distract myself from it and then come back to it when I was able to cope with it.'
- (Rachel, i2p21) 'When you're like in the real world and you're in certain situation, if you're not skilful enough then, say if you're too anxious to exchange a skirt or something, then it can really like upset you and things, 'cos you're just too scared to talk to someone ... So with the skills it helps you not end up in situations which you're more likely to self-harm.'
- (Natalie, p7) 'My emotions go all over the place. I'm either, I'm either on top of the world or I'm six foot under, all the time, and almost immediately mindfulness kind of levels me that little bit more.'
- (Natalie, p19) 'I've got more friends than I've ever had ... I think that's a result of DBT 'cos I can actually control my emotions ... Now before, I was such an emotional wreck that there's no point in being my friend 'cos I, I could pop at any moment.'
- (Rachel, i2p17) 'When I had nothing else to think about, then I just used to judge myself ... But then I used to like challenge my judgements in my head and then it would get sorted really.'
- (Katie, i1p21) 'DBT made that little old positive voice in my head get stronger, and I don't like that now ... 'cos I've got like big arguments in my head going on between the little negative person and the little positive person. 'Cos the little positive person gets bigger and I don't like it, 'cos it's making me more indecisive about things and that ... the positive seems to be winning quite a lot recently ... But then I don't know whether that's good or bad ... 'cos like the other side of me, it's

still as strong on the negative side, and it keeps like thinking I'm doing wrong and that, I should be listening to the negative more. It's just 'cos I'm used to listening to the negative all the time.'

### Context dependency

(Rachel, i1p20) 'When I was doing [my DBT diary cards] I used to have to think all the time like what skills am I using and stuff. But now I just use my skills and I like forget their names sometimes and stuff like that, and like when I learnt them and why I learnt them, I just use them.'

(Rachel, i1p7) 'Sometimes I forget I'm doing [a skill] because I've done it so much it's just natural now.'

(Natalie, p6 7) 'It's one thing knowing [the skills], it's another being motivated to do it ... You might know the stuff, but it slips into the back of your mind. Even if you want to do it, sometimes it can slip to the back of your mind. If you're in the [skills and homework] group[s], then it's bringing it to the fore all the time ... And it kind of, it makes it more scheduled for me 'cos I practice the homework and like try and perfect things that I'm doing, whereas before I'd just say 'oh I'll try them all' and I'd get very disorganised and annoyed and I'd probably just forget the lot.'

(Jade, p4) 'It's kind of like, um, a tool box, learning DBT. Um, you can carry it round with you all day and no-one will know because it's a tool box in your brain, and you can just pick out which skill you're gonna use. Um, but obviously sometimes you can forget, so it's helpful to keep going over and over because you can think that's the skill I've forgotten, that might help me.'

(Katie, i1p1) '[DBT] helped me learn a lot about myself, so that was helpful ... it helped me realise that, um, like identify my different emotions and



things like that, and like, um, it was the coping methods and that. That kind of helped me but then it only helped me while I was doing it. It didn't help me when I wasn't in [the Unit] ... when I was at home I didn't think about it and just didn't think of doing it because there wasn't like an incentive to do it, 'cos there wasn't like a homework group to go to and things like that ... But then it's still helpful now in the sense that I learnt a lot about myself and my emotions and that. But then I don't really do the coping methods that much.'

(Katie, i1p4) 'I still think it should have carried on when I left [the Unit], I think I should have been able to come up for the groups after I left ... it was just I didn't think about it often ... I know it all, but then I still needed to practice [the skills] more to actually get it into like my routine of doing it ... The first time [through the skills programme] I just didn't know what it was about really, or anything, and it was confusing. But then the second time I understood it, and then I needed to go through it again to like, like get it into like my pattern of living. But I didn't go through it again.'

(Katie, i2p4) 'I'm gonna start doing [the DBT skills] with ... a counsellor that I'm seeing ... 'cos I told them, like about it, that I think it's helpful when you're doing it and reminding it. So they said they'll go through my [skills] folder with me and keep reminding me about it, things like that.'

### **Theme 3. Personal and interpersonal influences on the change process**

#### **Goal setting and self-belief**

(Katie, i2p2) 'Cos I knew what emotion it was I felt that I should deal with it. But like I didn't wanna 'cos sometimes it's hard to change and I didn't wanna just change all of a sudden and start like dealing with all my

problems and that. 'Cos I just wanted it to go slowly and that ... just 'cos I'm scared of change and I don't like things changing.'

(Katie, i1p20) 'When my mood had lifted and then I would start thinking that there was a life and things like that. And that was because, er, we discussed things like that in DBT. Things like your goals and things like that. I started like setting myself goals ... I only set little ones 'cos I was still feeling negative and I still didn't wanna live and that and didn't see myself like to be alive in five years.'

(Katie, i2p8) 'I don't mind other people making decisions for me, because it saved me having to do it ... but [Unit staff] agreed with me about making a decision, 'cos I'm really bad at making decisions.'

(Katie, i1p11) '[Unit staff] said it would be best for me [to go to college] ... I still think it was pointless 'cos they made me just go ... and I just didn't enjoy it and it just didn't help me at all.'

(Rachel, i2p1) 'With self-harm and things, because I was doing it for years, it's just the way that I learned to cope with things, and I didn't wanna lose it 'cos it always worked ... [and] I was so used to like that adrenaline and things afterwards, I didn't think anything could feel as good as that.'

(Rachel, i1p13) '[In the first three or four months of DBT] I was still like the little girl who didn't have a problem, and that just wanted to get away and self-harm and live in my like black world. But then it just got better when I started listening and thinking well, I'd better do something about it otherwise I'm gonna be here for ever ... it was like I was still at [the Unit] in this one place and everything else was moving past me, and I just wanted to jump on the train.'

(Rachel, i1p17) 'I wanted to be the same person as I was before but with the skills ... that I could use to cope with my emotions so I could just carry on with like my education.'

(Rachel, i1p14) 'It just felt that I was moving on so much ... everything was just becoming better and my dreams were all coming true. I know that sounds really sleazy but they were because I got good grades and I got into college, so. Like I've got like back on the path of my life and that was good.'

(Rachel, i1p18) 'I have a future now so I don't have to [self-harm], I don't need to do that.'

(Rachel, i2p18) 'Say if something goes wrong, and I feel depressed, then I can say that I've come far and I've done well ... even though sometimes [my problems] like demotivate me, but they're the reason that I carry on because I know I can come through those and like get better. I know that I can try my best at anything and it should work.'

(Jade, p2) '[I wanted] to have different skills to be able to cope better, um, to not give up so easily ... Well, I haven't given up easily on past urges [to self-harm], um, so I'm still fighting hard against that, er, and I'm getting there slowly.'

### Nurturing relationships

(Rachel, i2p2) 'The environment in [the Unit] ... everything is focused around like getting better and feeling good about yourself and all the staff are really helpful. You can't really be resistant to not helping yourself because everyone's behind you and like trying to help you get better all the time. It's not like they're pushing you to get better, but the environment is like a nice close family environment sort of thing.'

- (Jade, p1) 'When I came here it felt like a big family and, um, it was nice to settle in.'
- (Rachel, i2p9) 'It was just really nice to know that like it wasn't just a job, it was like a way of life for [the staff] and that they really did care about like their patients.'
- (Rachel, i2p7) 'I think everyone kind of have, had their one member of staff who they told everything to and they were kind of friends with. So it's, it was nice being in an environment like that. It was kind of like they were looking out for you and they knew how you were feeling, even though you didn't know how you were feeling yourself.'
- (Natalie, p4) 'I had three members of staff that I knew I could talk to, no matter how down I was, I knew that they'd always pick me up and even if they told me something that I didn't wanna hear, which they frequently did, um, I could take it better from them.'
- (Katie, i1p21) 'I feel more guilty now after I've overdosed, whereas before I just didn't care. But I do feel bad now 'cos I think oh, I've wasted people's time and things like that ... everybody at [the Unit], 'cos they've, they've tried like so long to like help me get better.'
- (Rachel, i2p15) 'Before anyone found out about my problem I was just guilty for what I had done, and I felt ashamed and things. But then like when my Mum found out, then I felt guilty 'cos I didn't want to upset her. And then when I went to [the Unit] I didn't wanna upset the staff and things.'
- (Rachel, i2p5) 'It was like it was OK for me to have problems at [the Unit] because that's why I was there, and all the staff were really helpful, like say if I even looked down they would come and talk to me and stuff. But say

if I was in the real world, people wouldn't do that so I would just feel worse about myself.'

(Natalie, p10) '[My therapist's been going through the DBT skills] with my Mum for a while now, and, um, my Mum's really got the hang of it, which helps 'cos now if I'm down, my Mum knows what to say when I'm home that'll help, that'll help me ... [and] it's helped her personally, I mean she's more relaxed, then it's easier for her to help me.'

(Rachel, i2p19) 'I've told the people who know about my self-harm to how they should act after I've done it ... [so] they're disappointed in me, so in a way they make me feel guilty for what I've done because sort of like because that's what I deserve, but because it motivates me into not doing it again ... like my Mum used to be more 'just don't do it again' and 'I'm a bit disappointed' and then we'd just leave it, but now she's like 'why did you do it? You've come a long way', and that helps a lot because they sort of help me to get out of emotional mind and stuff.'

(Katie, i1p2/3) 'I don't think the [DBT] group was that helpful 'cos I didn't like it ... just 'cos I don't like being in groups and having to talk about things with other people there. Because I thought if I said something people would think it was stupid or something ... It got easier towards the end, but I still didn't like it ... just I trusted the people more and that ... once they started saying things and then I thought well no-one is laughing and things like that. So then I just started feeling more comfortable there ... [it] was easier [with my therapist because] I trusted her.'

(Rachel, i1p5) '[Individual DBT] was helpful because you could talk more about how you were feeling and you didn't feel like stupid asking questions 'cos it was just on a one-to-one basis.'

(Natalie, p5/6) 'With [my therapist] I talk about things that are really getting to me. And, um, like with [my nurses], when I see them I talk about, um, things that are annoying me ... but I'm not about to kill myself over them ... I think it's 'cos I trust [my therapist] a lot more. I don't think they'd like me saying that, but um ... I find [my therapist] a lot more easy to talk to.'

### Sense of connection with others

(Natalie, p8) 'We decided that the group was, it was wrong to call DBT DBT, and um we wanted to call it the suicide group ... 'cos at that time there wasn't, there weren't many of us in the group ... and every single one of us wanted to die and we'd had at least once in our lives tried to kill ourselves, so we figured it should be the suicide group, which kept us all thoroughly entertained for ages. It kept us laughing.'

(Katie, i1p3) 'I liked hearing other, like, listening to what other people had to say because, like if they'd said something I'd think oh, I'd feel like that in..., stuff like that, and it was nice to know that other people like felt the same way.'

(Katie, i2p7) 'The [DBT] group was good in the sense that I heard other people talk about their emotions and that ... And that helped me feel less on my own.'

(Rachel, i2p3) 'Some of the out-patients that came back every couple of weeks or so, they seemed really happy and they were getting on with their own lives. But there must have been a problem sort of like mine for them to have been in [the Unit] and to have been like an in-patient and to go to DBT, so it worked for them.'

(Rachel, i1p5) 'You think well, I'm living with these people and they can use their skills and they're helping themselves, and I can do the same thing,

especially if they're in a lot of distress or something and they use their skills it's like yeah, I can do that. So, it's I guess maybe because they've actually experienced what I've been through in a sort of way that I could be like them and use my skills.'

- (Rachel, i1p4) 'In the homework group ... people connect skills with everyday life and how they've used them. And so that was more helpful than the actual therapy group because then you think well I could do that as well.'
- (Katie, i1p5) 'I didn't wanna read out my homework in front of everybody, 'cos you had to like put it on the board and that. But then it was helpful to see that other people like, their opinions on it, things like that, that was helpful.'
- (Natalie, p6) 'I find [my therapist] a lot more easy to talk to, but she's a lot more like me, er, which is really weird 'cos I hate myself ... when you talk to [her] she makes skills sound fun. She actually makes me want to do skills, and when, when the [other staff] say it, it's kind of like yeah, er, OK ... like I already don't know this stuff.'
- (Rachel, i1p6) 'I don't know whether [therapist] has, but she probably hasn't experienced like what the young people are going through who self-harm and things. So it's more difficult because they ask you things like 'why have you got the urges?' and stuff, and then you have to do the chain analysis, and like you're just bored or something and that's why you harm yourself. But they don't understand and they like question you all the time, like 'why were you bored? Bored of what?' and things like that. So that was quite annoying ... I think it's because I learn more from people who have experienced the same things as me.'

#### **Theme 4. Pervasiveness of DBT within the treatment setting**

- (Jade, p5) 'It all kind of interlinks with each other. There's, um, there was at one point I was in another group, social skills, and I could always see that the skills were a bit like DBT skills or very, very similar. And um, yeah, it, it all interlinks. Every group has kind of got a little bit of DBT in it.'
- (Rachel, i1p10) 'I think it had a big place at [the Unit], the DBT, because like all the staff always use the word mindful and mindfulness, like in morning meetings and everything, and even the teachers use it. I don't think the teachers understand mindfulness ... But it did have a big part. And in things like anxiety management, we used to do relaxation, and there was, that was basically mindfulness ... [In the counselling sessions] we used to talk about what I would do this weekend, and it would always be 'what new skill are you going to do today, and what skills are you gonna do'. So it did play a big role.'
- (Jade, p5) '[The nurses would] always remind me of DBT whoever I was having a [counselling] session with at the moment, y'know DBT skills are at hand. Um, y'know you don't have to put up with it on your own. And, I mean it was just like a helping hand, DBT is really.'
- (Katie, i1p5 6) 'It's always mentioned, DBT, like with everything really. It's always mentioned ... If you were upset ... [the staff would] say to you like 'oh, think of your DBT and think of doing this and that' ... I knew it was best if I did, but when you're upset you don't think of it really. But then you do need that someone telling you to think of it when you're like upset.'
- (Rachel, i2p9) 'During my counselling sessions, say if we talked about I dunno, like say me wanting my own space at home or something, then we'd go



into talking about a DBT skill ... it helped because I sort of knew which skill would help me in which situation.'

(Natalie, p5) '[The staff are] trying to be more DBT like with me all round now, but [the counselling and individual DBT sessions] used to be extremely different ... They're finding that DBT actually works for me so they're, um, so they're switching my other sessions around so that they keep trying to throw in 'were you being mindful?' and, um, 'I reckon you should do radical acceptance here' ... before they wouldn't throw in any skills really, you'd just talk about it. And um, now it's very skill, very skilled all over ... I think I prefer it ... because I'm more comfortable with DBT, and I like DBT.'

(Natalie, p6) 'I've been doing [DBT] longer than most of the staff [in the Unit] ... I often start talking to them and I'm thinking I know this stuff, I know it better than you. I could teach you more than you could teach me about DBT. Whereas when I talk about it to [my therapist], it's not like... Maybe it's 'cos she's been doing it longer, I don't know ... [but when] she talks about it, it's kind of like I want to try what she says. I, I want to do more.'

## APPENDIX 2. NOTES FOR CONTRIBUTORS

### **Psychology and Psychotherapy: Theory, Research and Practice (formerly the British Journal of Medical Psychology) - Notes for Contributors**

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international journal with a focus on the psychological aspects of mental health, psychological problems and their psychotherapeutic treatments. Its aim has been to bring together the psychiatric and psychological disciplines and this is reflected in the composition of the Editorial Team. Nevertheless we welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The traditional orientation of the Journal has been towards psychodynamic and interpersonal approaches, which have defined its core identity, but we now additionally welcome submissions of original theoretical and research-based papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. The Journal thus aims to promote theoretical and research developments in the fields of subjective psychological states and dispositions, interpersonal attitudes, behaviour and relationships and psychological therapies (including both process and outcome research) where mental health is concerned. Submission of systematic reviews and other research reports which support evidence-based practice is also welcomed. Clinical or case studies will be considered only if they illustrate particularly unusual forms of psychopathology or innovative forms of therapy which carry important theoretical implications.

***Counselling Psychology:*** A special section on counselling psychology has been created in the journal in recognition of the importance of this area within psychology and psychotherapy. This section aims to promote theoretical and research developments in the field of counselling psychology. Authors who wish to submit their papers for consideration in this section should state this in their covering letter.

#### **1. Circulation**

The circulation of the Journal is worldwide. There is no restriction to British authors; papers are invited and encouraged from authors throughout the world.

#### **2. Length**

Pressure on Journal space is considerable and papers should be as short as is consistent with clear presentation of the subject matter. Papers should normally be no more than 5,000 words, although the Editor retains discretion to publish papers beyond this length.

#### **3. Refereeing**

The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be made aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to a removable front page (and the text should be free of such clues as identifiable self-citations ('In our earlier work...')).

#### **4. Submission requirements**

(a) Four copies of the manuscript should be sent to the Editor (Professor Phil Richardson, Journals Department, The British Psychological Society, St. Andrews House, 48 Princess Road East, Leicester, LE1 7DR, UK). Submission of a paper implies that it has not been published elsewhere and that it is not being considered

for publication in another journal. Papers should be accompanied by a signed letter indicating that all named authors have agreed to the submission. One author should be identified as the correspondent and that person's title, name and address supplied.

(b) Contributions must be typed in double spacing with wide margins and on only one side of each sheet. All sheets must be numbered.

(c) Tables should be typed in double spacing, each on a separate piece of paper with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

(d) Figures are usually produced direct from authors' originals and should be presented as good black or white images preferably on high contrast glossy paper, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Paper clips leave damaging indentations and should be avoided. Any necessary instructions should be written on an accompanying photocopy. Captions should be listed on a separate sheet.

(e) All articles should be preceded by an Abstract of 200 words, giving a concise statement of the intention and results or conclusions of the article.

(f) Bibliographic references in the text should quote the author's name and the date of publication thus: Smith (1994). Multiple citations should be given alphabetically rather than chronologically: (Jones, 1998; King, 1996; Parker, 1997). If a work has two authors, cite both names in the text throughout: Page and White (1995). In the case of reference to three or more authors, use all names on the first mention and et al. thereafter except in the reference list.

(g) References cited in the text must appear in the list at the end of the article. The list should be typed in double spacing in the following format:

Herbert, M. (1993). Working with children and the Children Act (pp. 76-106).

Leicester: The British Psychological Society.

Neeleman, J., & Persaud, R. (1995). Why do psychiatrists neglect religion? *British Journal of Medical Psychology*, 68, 169-178.

Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

(h) SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses (see The British Psychological Society Style Guide at:

<http://www.bps.org.uk/publications/jAuthor.cfm>).

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- Complete reference list in APA format
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## **SECTION FOUR - CRITICAL REVIEW**

## **Critical Review of the Large Scale Research Project**

In this critical review, my intention is to guide the reader through the processes involved in the development, execution and writing up of the Large Scale Research Project (LSRP) presented in this thesis. Within this context, the most salient issues are highlighted and the strengths and weaknesses of the research discussed. Finally, suggestions are made for future research which follow from the findings and limitations of the present study.

### **Developing the research idea**

#### Initial interests in dialectical behaviour therapy

My interest in dialectical behaviour therapy (DBT) stemmed from my research days at Leeds University in the mid-to-late 1990's. Having been asked to become involved in evaluating a newly developed DBT service for the local NHS Trust, I attended an introductory workshop held by Marsha Linehan, the originator of DBT. There, I was drawn by the appeal of the theoretical and clinical model presented. Additionally, I was struck by Marsha's enthusiasm towards working with adults with borderline personality disorder, a client group typically labelled 'difficult to treat' and for whom the approach was originally developed (Linehan, 1993). Unfortunately, the proposed research did not take place. However, the opportunity to pursue my interest in DBT subsequently arose during clinical training. Naturally, I took this opportunity, choosing to undertake a specialist third year placement at a Tier 4 adolescent inpatient unit where DBT was being offered to young people with multiple presenting problems including deliberate self-harm. The decision to link my LSRP with this placement followed from both a desire to further my knowledge of this psychotherapeutic approach, and practical considerations (e.g., ease of access to participants and quality of supervision).

### Developing a focus for the research

Having decided upon the general research area (i.e., DBT for adolescents), the next step was to formulate a specific focus for the research. In light of the absence of empirically validated treatments for adolescents who self-harm and the promising but limited data supporting the effectiveness of DBT in this regard, an evaluation of the DBT programme within the aforementioned adolescent inpatient service was an obvious choice. However, given the low frequency of adolescents entering the DBT programme, the typically lengthy duration of therapy, and the limited time-scale within which to complete the project, a quantitative evaluation was deemed unfeasible. Furthermore, I was interested in how therapy was perceived by the clients themselves, and the ways in which they made sense of changes occurring since their entry into therapy. Consequently, I decided to conduct a qualitative evaluation of the DBT programme from the clients' perspective. In accordance with the ethos of qualitative research, the study did not set out to test specific hypotheses. Rather, it aimed to allow the process and outcome issues deemed as important to participants to emerge from their own accounts of receiving therapy.

### Rationale for employing qualitative methodology

McLeod (2000) has argued that the dearth of qualitative studies in the psychotherapy outcome literature has limited the usefulness of existing data derived from quantitative research. While the latter aims to generate objective data, qualitative research seeks to uncover the meanings associated with the phenomena under investigation. Since it is the client who has to live with the changes incurred as a result of receiving therapy, it would appear appropriate to ask clients themselves how they perceive these changes and what impact they have had on their lives, rather than impose our own, more "objective" criteria of change upon them to understand

the effectiveness of an intervention. Such an approach also allows for the emergence of individual differences in client experiences, something which tends to become lost in quantitative research. Thus, qualitative methods have the potential to uncover a diversity of client experiences, both positive and negative, which are not accessible through quantitative evaluation, but which may usefully supplement the more objective data derived from the latter type of research. In addition to assessing treatment effectiveness on the basis of client-relevant outcome factors, qualitative evaluation may help to illuminate the therapeutic processes that differentially contribute to individual outcomes. Although the small sample sizes typically associated with qualitative studies limit the generalisability of their findings, such research can lead to the generation of important hypotheses regarding the effectiveness of a particular treatment approach which may subsequently be tested using quantitative and/or qualitative methodologies.

#### Selection of qualitative methodology.

Of the various qualitative approaches to psychological research, interpretative phenomenological analysis (IPA; Smith, 1996) was deemed the most appropriate methodology for the present study. IPA is similar to discourse analysis (e.g., Potter & Wetherell, 1987) in that both approaches recognise the importance of context and language in qualitative analysis. However, whereas proponents of discourse analysis are sceptical of the relationship between verbal reports and underlying cognitions, instead focusing on verbal statements as behaviours in their own right, IPA is concerned with understanding what people think or believe about a particular topic. In terms of theoretical perspective, IPA is most closely related to the qualitative approach of grounded theory (e.g., Strauss & Corbin, 1998). Both adopt a symbolic interactionist position, stressing the importance of meanings ascribed to phenomena



by individuals. These meanings are believed to arise from social interaction and are only obtained through interpretation. Grounded theory differs from IPA in that it specifically seeks to develop a theory about the phenomenon under investigation which is 'grounded' in, or emerges from, the data. In IPA, the nature of the themes that emerge during analysis determine the level of explanation of the results.

Although it may lead to the development of a theoretical model, alternative levels or types of explanation are possible (e.g., a typology or classification of responses, or a focus on the complexity or ambiguity of participants' views on the topic; Smith, 1995). Due in part to the breadth of the topic under investigation and the small participant pool, the present study did not specifically set out to formulate a theory of adolescents' experiences of DBT. As such, IPA appeared to be the most suitable methodology for developing an understanding of the client's perspective.

### **Conducting the research**

#### **Recruitment and sample size**

As outlined in the research protocol accompanying the original ethics proposal, the initial intention was to recruit to the study only those young people who had received DBT at the unit and their therapy had terminated (for whatever reason) within the previous 18 months. The latter time limit was imposed to reduce difficulties associated with participants' ability to recall their experiences. The expectation of a sample size of approximately six was, in hindsight, unrealistic. Only five young people fulfilled the above criteria, and of these, only two agreed to participate in the study. Consequently, a decision was made to extend the study to include adolescents who had received DBT as day- or inpatients and continued to receive therapy on an outpatient basis. Upon approval from the local Trust ethics committee, five outpatients were approached and three consented to take part. One

outpatient subsequently dropped out of the study, resulting in a final sample size of four.

The small sample size was certainly a weakness of the study, further limiting the generalisability of the findings. In addition, since recruitment was on an opt-in basis, the representativeness of the sample was questionable. Since no feedback was received from those young people who chose not to take part in the study, or from the recruit who dropped out of the study after her initial interview, it remained unclear as to why only 40% of the potential recruitment pool opted into the study (despite a reminder being sent out to those who did not respond to the initial invitation to take part). It is possible that young people were discouraged by the sensitive nature of the study, that they had had negative experiences which they did not want or feel able to discuss, that they simply wanted to put their experiences of the Unit behind them, or that they were currently experiencing too many difficulties to even contemplate taking part. Although it may be expected to be biased towards those young people who had favourable experiences and outcomes, the results of the study suggested that this was not entirely the case. Finally, the inclusion of out-patients in the sample meant that two participants were unable to comment upon post-treatment outcomes. However, this could also be considered a strength of the study, since the views of outpatients facilitated an understanding of the large discrepancy in outcomes between Katie and Rachel, and highlighted the value of continuing therapy on an outpatient basis for those whose gains have not fully generalised to their lives outside the Unit.

### Interviews

Prior to conducting the interviews, I had been warned that adolescents may not be particularly forthcoming with their responses to questioning. However, my experience was very different to my expectations, and I was struck by the openness

and willingness of the participants to disclose personal experiences, many of which were of a very sensitive nature. There was also some concern that participants may be less likely to discuss negative experiences, particularly in light of my association with the Unit. Again, this did not appear to be the case. One factor which may have contributed to their comfort in talking about negative as well as positive experiences and outcome was the degree of confidentiality assured. Within the letter inviting young people to take part in the study, it was made clear that no member of staff (including their DBT therapist) would be informed as to whether or not they agreed to participate. Furthermore, I would be the only person privy to their audiotaped and transcribed interviews. The latter consequently had implications for validation of the results, an issue which is discussed later.

### Analysis and writing up

The process of analysing and writing up the data was, without doubt, the most demanding aspect of the research project. It was analogous to completing a large jigsaw with no picture for guidance. The pieces were all the same shape and size, and differed only in the small part of the picture they revealed. It is acknowledged that there were multiple ways in which the pieces could have been fitted together. In large part, their assembly was constrained by the size of the picture that could adequately be described within the word limit of the research paper. In a quantitative study, data can be summarised in tables and therefore excluded from the word count. Qualitative data (i.e., extracts of interviews) cannot be displayed in such a format, and therefore word restrictions are particularly punitive for studies employing such methodologies. Due to the interrelationships between the themes that emerged during the course of analysis, only those occurring at a high level of abstraction were discussed. Focusing in on any one aspect of the picture would have obscured the

context within which it stood. Consequently, much of the individual detail arising from participants' accounts was lost.

#### Validation of the research findings

A further limitation of the study was that assurances regarding confidentiality of the content of the interviews precluded the verification of my analyses by a second researcher. It is acknowledged that my prior interest in DBT, as well as learning more about its theoretical underpinnings and clinical applications on placement over the duration of the study, is likely to have influenced my interpretation of participants' accounts, although attempts were made at the analysis stage to dissociate myself from any theoretical allegiances. As a credibility check, the results were fed back to participants in order to validate my interpretations of their accounts. In addition, the inclusion of multiple quotes in the results section and appendix of the research paper aimed to leave my interpretations open to inspection by the reader. Due to the retrospective nature of the study and the reliance on participants' abilities to recollect and recall their experiences, the paper may have benefited from triangulation with other sources of data, such as pre- and post-therapy observer-rated or self-report measures of self-harming behaviour, psychopathology, and psychological and adaptive functioning. Although such data is now routinely collected upon admission and discharge, it was not available for the young people who participated in this study.

### **Implications of the research**

#### Strengths of the study

The findings of this study do not claim to be representative of the views of adolescents going through DBT. However, their value lies in the insights they provide into the range of factors that may influence the experience and outcome of

receiving DBT from the adolescent client's perspective. In contrast to quantitative studies, no prior assumptions were made regarding the relative importance of client, therapist, treatment, social or environmental factors in the evaluation of process and outcome. Although participants' accounts varied widely, specific themes repeatedly emerged from their stories, suggesting a degree of commonality between their diverse experiences. Furthermore, individual accounts facilitated an understanding of the experiences of other participants, and together they provided a rich picture of the processes involved in change and the maintenance of gains. For example, the results suggested that gaining control over overt and covert behaviours may be dependent upon the development of a dialectical cognitive style, and that unless generalisation and internalisation of DBT skills and problem analysis have occurred, the maintenance of control may require the continued support, prompting and structure provided by external agencies. Consequently, an important strength of the study was the generation of specific hypotheses regarding the mechanisms of change, which in turn suggest areas requiring more focused quantitative and/or qualitative research. Further evidence supporting the present findings of the benefits of offering on-going (i.e., non-time-limited) therapy and extending the teaching of DBT skills to parents or carers of adolescents would clearly have significant implications for clinical practice.

A further strength of the study was its ability to tap into the various ways in which participants made sense of changes occurring since their entry into the DBT programme. Importantly, the findings demonstrated that there may be large discrepancies between client- and observer-rated measures of outcome. This raises questions regarding the validity of so-called objective methods in the evaluation of therapy effectiveness, and emphasises the importance of gaining the client's views to

understand the meaning of change. As such, this study supports the use of qualitative methodologies in psychotherapy outcome research.

#### Directions for future research

Although the present study supported the value of DBT as an intervention for adolescents with complex mental health and psychosocial problems, including repeated deliberate self-harm, further research is required to determine the efficacy of this psychotherapeutic approach, particularly in relation to other interventions. Despite their limitations, randomised controlled trials remain most appropriate methodology for this purpose (Bower & King, 2000). Importantly, such research designs have the capacity to account or control for the possible effects on outcome of non-DBT factors (e.g., maturation, spontaneous remission or supplementary treatment), a claim that cannot be made by the present study. Due to the large numbers of participants required to demonstrate reliable treatment effects on repetition of self-harm, the need for multi-centre trials is indicated (Arensman et al., 2001). Furthermore, there is a need for long-term follow-up studies to determine the extent to which gains are maintained by adolescents (and indeed by adult clients with borderline personality disorder; Westen, 2000) beyond the termination of therapy.

In addition to proving that an intervention works, it is important to understand how it works. With the exception of a study by Shearin and Linehan (1992) with adult clients, there is a dearth of process-outcome data in the field of DBT research. Both quantitative and qualitative methodologies can be employed to examine the relationship between process and outcome, and the present study has suggested fruitful lines for further enquiry. In particular, it is important to determine whether or not the theoretical underpinnings of a psychotherapeutic approach do indeed predict outcome and facilitate an understanding of the processes involved in change. In this

study, several findings were supportive of the link between theory and clinical improvement. For example, it may be argued that the supportive and emotionally responsive environment within the Unit served to counteract the invalidating environment deemed by Linehan's (1993) biosocial theory to be one of the principle contributors to the emotion regulation difficulties characteristic of people with borderline personality disorder. However, prospective research is needed to further clarify the causal mechanisms linking specific processes with outcome. Thus, for example, while goal setting is an important component of DBT and appeared to be associated with therapeutic gains for Rachel, it was unclear as to whether this preceded or followed an improvement in her mood.

Clearly, there were also several non-specific factors that appeared to have a significant impact on the experience and outcome of therapy, particularly in terms of increasing and maintaining motivation to change. These factors included the influence of peers and more generally a sense of connection with others. Further research is required to determine the extent to which therapy-specific and non-specific factors contribute to positive (and negative) outcomes for this client group.

Finally, the present study was unable to answer questions regarding the influence on outcome of a wide range of specific therapist characteristics (e.g., professional training, expertise in DBT, treatment adherence and personality), client characteristics (e.g., gender, age and level of maturity, intellectual ability, quality of family or social support, and complexity of pre-treatment psychopathology and psychosocial problems), or treatment characteristics (e.g., setting, duration and intensity). Understanding the relationships between such variables may facilitate the tailoring of therapy to individual needs. In particular, there is an outstanding need for research examining the experience and effectiveness of DBT for young males who

self-harm, an increasingly prevalent group that may be particularly difficult to engage in treatment (Hawton, 1997).



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**SECTION FIVE - WORD COUNT**

