

**Bangor University**

## **PROFESSIONAL DOCTORATES**

**Evaluation of the DBT-Steps A (DBT-SA) programme when delivered by School-based Counsellors to a targeted population.**

Ramage, Graeme

*Award date:*  
2019

*Awarding institution:*  
Bangor University

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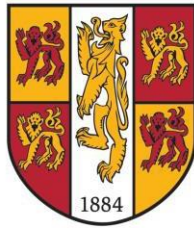
Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy.

Evaluation of the DBT-Steps A (DBT-SA) programme when  
delivered by School-based Counsellors to a targeted population.

Graeme Ramage,

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North Wales Clinical Psychology Programme



PRIFYSGOL  
**BANGOR**  
UNIVERSITY

Submitted in partial fulfilment for the degree of  
Doctorate in Clinical Psychology

June 2019

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Word count without references	4466
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Total word count with references	20,200
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For Ian Ramage  
11/07/44 – 30/11/18  
Thanks Dad.

With compassion, wisdom and love, you taught me how  
to be a man.



## **Thesis Abstract**

*Evaluation of the DBT-steps A (DBT-SA) programme when delivered by School-based Counsellors to a targeted population.*

A systematic review was carried out looking into the presence of suicide related imagery and its impact on suicidal ideation and resulting suicide. The review highlighted the complex, varied and idiosyncratic nature of images relating to suicide. However, the quality and availability of papers was moderate to weak and further research is required.

This thesis looks at the Dialectical Behavioural Therapy Skills Training for Emotional Problem Solving for Adolescents (DBT-SA) Programme. This programme is designed to be delivered as both a universal and targeted intervention. An empirical study was carried out to establish the feasibility and effectiveness of this programme when delivered by school-based counsellors to a targeted group of young people. A mixed methods approach was applied which illustrated the positive impact of this intervention on emotional regulation skills and general functioning. Qualitative analysis provided further evidence of impact through skills use and functioning after the group.

The final chapter reviews the empirical paper and systematic review and applies both to a model of suicide before making recommendations as to how DBT-SA can impact on factors that lead to suicide and ways in which the model's interpretation of images needs to be expanded to reflect the review's findings.

## **CHAPTER 1 SYSTEMATIC REVIEW**

# **A systematic review of the relationship between suicide related imagery and suicide**

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This paper will be submitted to Suicide and Life Threatening Behavior and as such will follow  
the publishing guidelines of this journal.

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## **SYSTEMATIC REVIEW ABSTRACT**

### **A systematic review of the relationship between suicide related imagery and suicide**

Imagery has been identified as a key feature in a range of mental health presentations. There has been increased awareness of the role of suicide related imagery in relation to suicide. This systematic review aims to: *(i)* provide a description and analysis of the available research into imagery and suicide; and *(ii)* highlight areas for further research. A search of literature was carried out using PsycINFO, Web of Science, PubMed and Medline were searched to identify relevant papers and ten papers were identified. All papers provided evidence of the presence of suicide related imagery. However, the quality of the papers was moderate to low and there is a limited field of researchers examining this area.

## **INTRODUCTION**

Suicide is a significant public health concern and is a leading cause of death; worldwide, more than 800,00 people will die by suicide annually. In 2014, the global prevalence rate was estimated to be 11.4 per 100,000 head of population (Klonsky, May, & Saffer, 2016). In the United Kingdom, the male suicide rate was 15.5 deaths per 100,000 of population and the rate for females was 4.9 per 100,000. Men aged 45-49 had the highest rate of death by suicide at 24.8 per 100,000. Scotland has the highest suicide rate in the UK with 13.9 deaths per 100,000 of population. There are also specific groups that are more at risk of dying by suicide e.g. people who identify as gay, lesbian or transgender (Klonsky, May, & Saffer, 2016).

To understand the mechanisms that underly suicide, a number of models have been put forward, but these earlier models lack empirical research and practical applications (Barzilay & Apter, 2014). However, suicide research has undergone a paradigm shift in understanding these processes. Suicide is increasingly understood in the context of ideation to action models to formulate why someone who is thinking about suicide then goes on to die/attempt to die by suicide. The three main models in this field are the Three Steps model (3-ST); (Klonsky & May 2015), The Interpersonal Theory of Suicide (IPTs); (Joiner 2005) and the Integrated Motivational-Volitional model (IMV); (O'Connor 2011; O'Connor & Kirtley, 2018).

The 3-ST model identifies the role of pain i.e. psychological or emotional pain and hopelessness as key factors in the development of suicidal ideation. The role of connectedness in its broadest sense i.e. lack of a job, community role and purpose for living is hypothesised as an integral step in the progression from ideation to action with the final step in this model being the person acquiring the capability to die by suicide.

Joiner's IPTS model (Joiner, 2005) describes the role and function of two interpersonal processes i.e. thwarted belongingness and perceived burdensomeness which when combined with acquired capability, increase the risk of death by suicide. Capability for death can be acquired due to the repeated exposure to distressing and emotionally arousing experiences (Ribiero & Joiner 2009) i.e. the process of habituation (Van Orden et al., 2010). There is support for this model and particularly the role of acquired capability when applied to adolescence (Stewart, Eaddy, Horton, Hughes, & Kennard, 2017).

The IMV model, which is an expanded iteration of the above models has identified pre-motivation, motivational and volitional phases as integral to the ideation to action model. These are the processes by which someone moves from being at risk of death by suicide, to being motivated to carry it out and then to act. Suicide attempters have been shown to present differently from suicidal ideators on the volitional factors but were similar in the motivational factors. Significant relationships have been identified between entrapment, thwarted belongingness, goal disengagement and suicidal ideation. Suicide attempts were related to self-injurious behaviour in others, fearlessness about death and previous suicide attempts (Dhingra, Boduszek, & O'Connor, 2016). Adolescents who were exposed to self-harm in others and had a mental health problem, were more likely to move from ideation to action in this model (Mars et al., 2019). A further iteration of the IMV model, added imagery relating to suicide as a volitional factor (O'Connor & Kirtley, 2018). They write,

*“There is growing interest in the role of mental imagery of suicide and suicidal flash forwards where an individual has a mental image of being dead or dying. We hypothesise that mental imagery increases the likelihood of enactment as it acts as a form of cognitive rehearsal for the behaviour.” (O’Conner & Kirtley 2018, p. 4)*

## **IMAGERY**

Data from a cross sectional study of 3,508 18-34-year olds in the Scottish Wellbeing Survey, (Wetherall, Clearea, Eschlea, Ferguson, O'Connor, O'Carroll, & O'Connor, 2018) established that mental imagery had the highest positive predictive value in identifying volitional phase variables in participants who had made a suicide attempt compared to those who had thought about it. The absence of volitional variables, of which imagery was one, were seen as key indicators in identifying who had not attempted suicide i.e. the absence of images was a protective factor. Regression analysis established that the presence of imagery was a highly statistically significant predictor in differentiating between the suicide attempters and suicide ideation group.

The presence of imagery in suicide is not unique and the phenomenon of imagery-based thinking can be seen in a range of mental health presentations. Depressed individuals are more prone to two types of intrusive negative imagery i.e. negative imagery about past events and imagery related to suicide in the future (Holmes, Blackwell, Bennet Heyes, Renner, & Raes, 2016). Weßlau, Cloos, Höfling, and Steil (2015) put forward evidence that participants in a large-scale online study scored higher on depression measures when they experienced fewer positive images and more negative images that were vivid and frequent. People who are grieving and have intrusive thoughts of the manner of the death, re-enactment fantasies and negative images of the future, had higher levels of complicated grief symptoms, depression and anxiety (Boelen & Huntjens, 2008). Depressed people are more likely to experience vivid and intrusive images with a negative impact (Hallford, 2019). Adolescents with more negative images and fewer positive images had higher levels of depression (Pile & Lau, 2018). Visual imagery has also been shown to influence moods of people with Bi-Polar disorder (O'Donnell, Di Simplicio, Brown, Holmes, & Burnett Heyes, 2018). Images about future events and past events have been identified in

people with emetophobia where there was a significant relationship between the level of phobia and the vividness of the imagery. In social anxiety, intrusive images were found to be more distressing (Homer & Deeptose, 2017). Malcolm, Picchioni, and Ellett (2015) described how people with schizophrenia have reported increased intrusive visual images about the future as well as the past; it is the interpretation of these images that can be attributed as influencing schizophrenic symptomatology. In a small study of people with body dysmorphic disorder (BDD) it was identified that people with BDD experienced more negative and recurrent images (Osman, Cooper, Hackman, & Veale, 2004). Future orientated negative images and resulting behaviours e.g. checking behaviours have also been identified in people with significant health anxiety (Muse, McManus, Hackmann, Williams, & Williams, 2010). The phenomenon of intrusive images has also been identified in people with social phobia (Hackmann, Clark, & McManus, 2000).

In non-suicidal self-injury (NSSI) there is also some evidence of the presence and function of images. In a study of 154 undergraduates with a history of NSSI, 74% of the participants who experienced images and had then self-injured, described seeing images of injuries prior to the act (McEvoy, Hayes, Hasking, & Rees, 2017). In a qualitative study examining the role of mental imagery and self-injury, images that were intrusive and externally stimulated were regarded as more distressing and could lead to stronger and less manageable urges to self-harm. All participants spoke about self-harm images being from a first-person perspective i.e. a field perspective (Dargan, Reid, & Hodge, 2016). Imagery has also been identified as a moderating factor in the relationship between affect and NSSI (Hasking, Di Simplicio, McEvoy, & Rees, 2018).

There is strong evidence of the relationship between images and a range of mental health problems. In addition, there is increasing evidence of the relationship between images and suicide. Therefore, the objective of this systematic review is to appraise the evidence for



the presence of images in people who are suicidal and the resulting impact on the individuals who are experiencing them.

## **METHOD**

Four psychological and medical databases; PsycINFO, Web of Science, PubMed and Medline were searched to identify relevant papers. The following search terms were used-  
Suicide OR Suicidal AND

1. Mental images
2. Flash forwards
3. Intrusive images
4. Mental imagery
5. Daydreaming
6. Ideation to action

The criteria for inclusion were i) The papers had to be original and in published journals; ii) the research must relate to the relationship between images in whatever form, and suicide and iii) the study had to be published in English.

This initial search resulted in 1,277 papers, of which 10 were eligible for review. The process for study selection is illustrated in detail in Figure 1 in line with PRISMA guidelines (Moher et al., 2015).

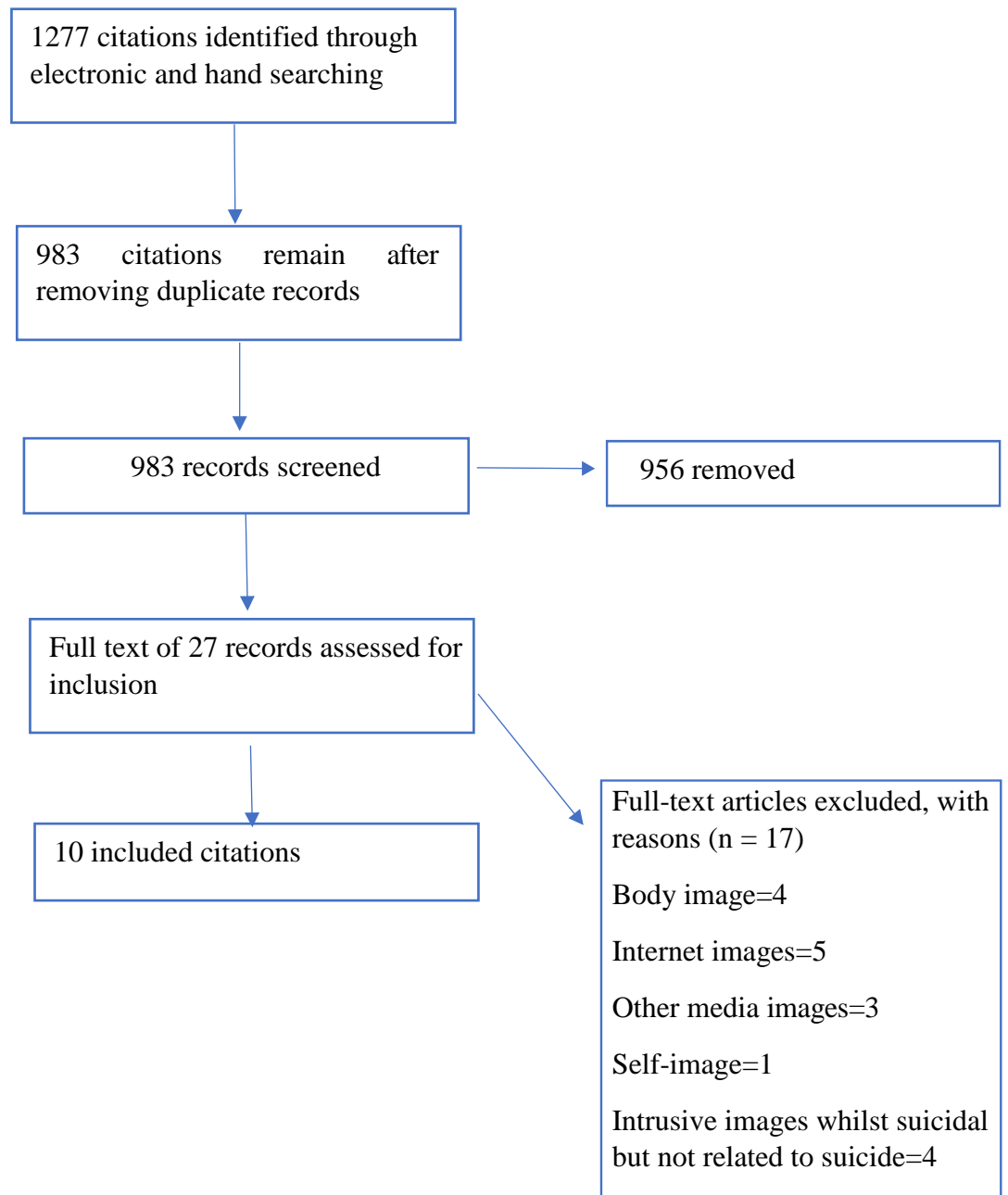


Figure 1. *PRISMA Flow Diagram of Study Selection Process*

## RESULTS

The studies included in this review looked at both non-clinical (5) and clinical samples (5). For further reference *see figure 2* The papers were assessed using the Effective Public Health Practice Project (EPHPP); (Appendix 8) Quality Assessment Tool (Evans et al., 2015); *see figure 3*.

### Non-clinical studies

Five of the studies Wetherall et al., 2018; Chu, Podlogar, Rogers, Buchman-Schmitt, Negley, & Joiner, (2016); Selby, Anestis, & Joiner, (2007); Chu, Rogers, Gai, & Joiner, 2018; and Holaday & Brausch, (2015) were conducted with non-clinical samples.

Building on the IMV model of suicide and using data from the Scottish Wellbeing Study of 3,508 18-34 young people, Wetherall et al., (2018) examined a number of motivational and volitional factors relating to increased risk of death by suicide. Of interest to the present review the participants were asked eight questions to identify the occurrence of death related imagery when “down” or feeling depressed. History of suicidal ideation and suicide attempts was established using the two items from the Adult Psychiatric Morbidity Survey (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2009) which was then used to create three categories within the sample i.e. no history of suicide (n=2470;74.6%); suicidal ideation but not attempted (n=481;14.3%) and attempted suicide in the past (n=379;11%). Mental images related to areas such as experiencing images of oneself planning to make a suicide attempt had the highest positive predictive value in identifying those participants who had made a suicide attempt. This is hypothesised as a key factor in the transition from someone thinking about dying by suicide to attempting to die by suicide. This sample was a representative sample of the age group in that 49.4% were female and 27.9% were economically inactive with a mean

age of 25.7 years. This cross-sectional study looked at the presence of suicide related imagery having a positive predictive value in identifying those who had attempted to die by suicide, but it did not establish the nature, content and interpretation of these images. In addition, it is not clear if the images directly precipitated an attempt to die by suicide.

Holoday and Brausch (2014) examined the relationship between death by suicide and imagery with a focus on acquired capability being a mediating factor in a person's attempt to die by suicide. This is based on the IPTS model of suicide with acquired capability being the final component in the process of ideation to action in suicide. Suicidal imagery was established using a modified version of the Social Cognitions Interview (Hales, Deeptrose, Goodwin, & Holmes, 2011) where only the 16 questions relating to mental images were included. The Acquired Capability for Suicide Scale (ACSS); (Bender, Gordon, Bresin, & Joiner 2011) was used to establish participants attitudes towards suicide. History of suicidality was assessed using the Self Harm Behaviour Questionnaire (SHBQ); (Guitierrez, Osman, Barrios, & Kopper, 2001). Suicidal imagery was positively correlated with SHBQ scores with 85% of those reporting some form of either suicide attempt, suicide threat or suicidal ideation, experiencing images related to suicide. Almost three quarters of this group experienced images which were described as vivid. This study provided brief qualitative data related to the types of image experienced which, despite its limitations, illustrated a wide variation in images. They ranged from the reactions of others following death; these were both positive and negative. Other participants experienced images of what they imagined an "after life" to be whilst others saw themselves committing an act that would cause their death by suicide e.g. driving a vehicle into a tree or the person seeing them themselves hanging. This study was limited as it was an undergraduate sample of 237 participants with a mean age of 20 and 59% female and there was no mediating relationship found for the role of acquired capability.

However, this study clearly established that there was a relationship between imagery and suicide. It has provided further information about the nature of images related to death by suicide and the multiple functions of imagery relating to suicide.

### “Violent Daydreaming”

Three of these papers (Chu et al., 2016); (Selby, Anestis & Joiner, 2007); (Chu, Rogers, Gai, & Joiner, 2016) took a slightly different interpretation of imagery and reviewed the connection between violent daydreaming and suicide. These papers have been included as the authors of these papers see violent daydreaming as imagery based and it is therefore felt by the authors of this paper that they are appropriate for inclusion in this review. Violent daydreaming in relation to suicide is seen as the process by which suicidal individuals report seeing their death by suicide very clearly in their visual imagination (Selby, Anestis, & Joiner, 2007). This can often take the form of enduring and vivid emotional thoughts (Chu et al., 2016) and are frequently visual images about the act of suicide and the aftermath of death by suicide (Selby et al., 2007). It is seen as different to active ideation as it may involve a daydream or fantasy that occurs spontaneously (Chu et al., 2016). All three of the above papers have used the Thoughts of Revenge subscale of the Anger Rumination Scale (ARS); (Sukhodolsky, Golub, & Cromwell, 2001) as the main predictor variable to assess the level of violent daydreaming. Whilst this subscale looks at thoughts of revenge it does not directly ask about the presence of images. All three papers have used this scale as a proxy for violent daydreaming (Chu et al., 2018). The Beck Depression Inventory (BDI); (Beck Steer, & Garbin, 1988) and the Beck Suicide Scale (BSS); (Beck, Steer, & Ranieri, 1988) were used in all three studies. Chu et al., (2016) used the Everyday Memory Questionnaire (Royle & Lincoln 2008) to assess everyday memory functioning and the Schedule of Imagined Violence (Grisso, Davis, Vesselinov, Appelbaum, & Monahan, 2000) to measure daydreams about violence to

others. Chu., et al (2018) utilised the Interpersonal Needs Questionnaire (Van Orden, Cukrowicz, Witte, & Joiner, 2012) to look at thwarted belongingness and perceived burdensomeness as these are two main components of the IPTS model of suicide. Using the thoughts of revenge subscale of the ARS as indicative of violent daydreaming, Selby et al., (2007) found that there was a significant interaction between high levels of violent daydreaming, high scores on the BDI and increased scores on the BSS. However, this study did not specifically utilise a measure that assessed the presence of violent daydreaming and it may be the case that violent daydreaming may not result in the increased risk of death by suicide. Selby et al., (2007) speculate that violent daydreaming or images related to suicide may serve two main functions. Firstly, they increase a person's ability to die by suicide as it increases habituation to pain. Secondly, daydreaming about suicide becomes a means of escape from pain, a method of revenge and an increase in ability to enact the visualised act. Chu et al., (2016) further reviewed the impact of violent daydreaming and suicide and its connection with memory in a non- clinical sample of 512 young adults. Memory retrieval and encoding in relation to overgeneralised autobiographical memories had been hypothesised as having a relationship with increased suicidality. Violent daydreaming was found to have a mediating effect on suicidal ideation through impairments in memory retrieval and encoding. These results can be interpreted as individuals who engage in suicidal ideation may experience increased memory encoding and retrieval difficulties due to engaging in violent daydreaming, resulting in overgeneralised autobiographical memories with a resulting impact on their mood. This study of 512 participants was a largely female (64.3%) and white (81.8%) undergraduate psychology sample with 89% reporting no history of mental health problems. To further expand the role of violent daydreaming and its relationship with two key factors on the IPTS model of suicide, Chu et al., (2018)

carried out research on 818 undergraduates from a non-clinical sample. Outcomes indicated there was a significant and positive relationship between violent daydreaming and thwarted belongingness, perceived burdensomeness and levels of suicidal ideation. These results could be interpreted as violent daydreaming instilling and reinforcing harsh and critical attitudes towards oneself and others; and increasing a sense of alienation from and to others which may then increase the risk of death by suicide. This study was carried out using self-reported online measures and the sample was primarily white, female undergraduates with an average age of 18.9 years.

### *Clinical studies*

Five of the papers used participants from clinical or formerly clinical groups. These included depressed and formerly suicidal patients (Holmes, Crane, Fennell, & Williams, 2007); bipolar and unipolar disorder (Hales, Deeproose, Goodwin, and Holmes, 2011); formerly suicidal and depressed participants (Crane, Shah, Barnhofer, & Holmes, 2012); suicidal patients (Ng, Di Simplicio, McManus, Kennerley, & Holmes, 2016) and people with borderline personality disorder and major depressive disorder (Schultebraucks, Duesenberg, Di Simplicio, Holmes, & Roepke, 2019).

Using a sample of 15 depressed and formerly suicidal patients who were in remission, Holmes et al., (2007) identified the concept of “flash forwards images” i.e. images relating to a future suicide. This study utilised Mini International Neuropsychiatric Interview (MINI); (Sheehan et al., 1998); the BDI II; the BSS (worst ever version) and a further suicidal cognitions interview which required participants to identify the most significant image they experienced when they were at their most suicidal and/or despairing. All participants reported images related to suicide when in crisis. These images related to methods of suicide and/or death; experiences of what may occur after

death and the impact on others. Images were described as distressing as well as comforting with a number of participants reporting preoccupation with images and the vividness of images being associated with higher levels of suicidal ideation. Participants interpreted images in various ways. Some saw the image as a means of escape from present problems; others saw their images as a means of appraising options whilst one participant interpreted their image as a warning sign about the implications of death by suicide. Although this was a small sample size, all participants had a history of depression with a range of co-morbid mental health problems. The mean age of the sample was 41.1 years and nine of the participants were female. This study looked at the co-occurrence of suicide related images when participants were at their most despairing. Although there is evidence that images did occur at this point it is not clear what the causal relationship was. As the images were related to the worst ever episode, it is unclear if participants were experiencing frequent images but found them more powerful and overwhelming when in crisis situations.

Crane et al., (2012) carried out research with a group of 27 formerly depressed participants to establish the relationship between imagery and suicidality. Using the same methods of assessment as the Holmes et al., (2007), study they were able to identify that all participants with a history of a suicide attempt experienced images relating to suicide. Five of the participants declined to describe their images and three did not report any images. Nine of the participants described images related to future suicidal behaviour whilst other participants reported images of past episodes. However, other participants conveyed images which were comforting and reduced their desire to die by suicide. A shortcoming of this research was the lack of a very detailed history of the exact relationship and timing of images and behaviour related to suicide. Although all participants who had a history of suicide attempt experienced images, the causal



relationship between these two processes is unclear. Furthermore, the roots, history, duration, ruminative processing, spontaneity and level of intrusion of these images are unclear.

Hales et al., (2011) utilised a quasi-experimental comparative study to look at the presence of images and suicidality in a split sample of 40 participants who had been diagnosed with unipolar and bi-polar depression respectively (mean age of 38.3; 50% female). This study used the same methods of assessment as the Holmes et al., (2007) study with the addition of the Spontaneous Use of Imagery Scale (Reisberg, Person & Kosslyn, 2003) to establish use of imagery in everyday life; the Impact of Future Events Scale (Deeprrose, Malik, & Holmes, 2011) to assess the level of intrusion of future orientated imagery and premorbid intelligence was assessed using the National Adult Reading Test (Nelson & Wilson, 1991). All participants in this study reported experiencing images related to suicide that were intrusive and were more pre-occupying than verbal cognitions when at their most suicidal. In the bi-polar group, 13 out of 20 of the participants reported that their flash forward suicide images made them want to act on their images. Within the bi-polar group it was also reported that the images increased resistance to suicide and could be seen as a warning sign of crisis. The bi-polar group scored statistically significantly higher on the measures related to use of imagery as a trait, which may indicate why they experienced more suicide images but also felt more compelled to act on these images.

The concept of flash forwards suicidal imagery has also been identified in non-Caucasian participants. Using a sample of 82 suicidal (mean age 45.9; 29.3% male) and 80 control participants (mean age 45.6; 27.5% female) in Hong Kong, Ng, et al., (2016) reviewed the relationship between flash forwards imagery and suicide. This study used the BSS (worst ever version) and the Impact of Events Scale with images rated as suicidal or non-

suicidal. The Defeat Scale and The Entrapment Scale (Gilbert & Allan 1998) were also used. At the initial timepoint over a third (30/82) of the participants with flash forwards suicide images had more severe suicidal ideation than those participants who were suicidal but did not experience images. There was a significant reduction in the level of flash forwards images in the previously suicidal participants who were non-suicidal at 7 weeks follow up. This study also looked at entrapment and feelings of defeat which are key motivational components in the IMV model of suicide. It is hypothesised that the combination of feelings of entrapment, defeat and the presence of flash forwards images can increase suicidal ideation.

Suicide related imagery has been found in people with borderline personality disorder (BPD) (Schultebraucks et al., 2019). This study used the MINI interview schedule; The Structured Clinical Interview for DSMIV Axis II Disorders (Fydrich, Renneberg, Scmitz & Wittchen, 1997); the Childhood Trauma Questionnaire (Wingenfield et al., 2010) and BPD symptoms were assessed using the Borderline Symptom List (Bohus et al., 2007). Suicidal ideation was assessed using the BSS (worst ever version) and the Social Cognitions Interview. All participants in this study reported both mental images and verbal thoughts relating to suicide. These images were primarily related to an act of suicide and in contrast with other studies, did not identify images relating to the impact on others. Almost all of the participants with BPD had a behavioural response of wanting to enact these images. Severity of suicidal ideation was associated with mental imagery with more vivid images being consistent with higher suicidal ideation. The level of distress from images was related to the previous number of suicide attempts and traumatic experiences in childhood. As this study used the BSS (worst ever version) to assess level of suicidal ideation, it was unclear when exactly suicide attempts occurred in relation to experiences of imagery.

## **Discussion**

Using a quality assessment tool, the quality of the papers discussed were moderate to weak and reflects the complexity of carrying out the research in this area (*appendice 1*). Despite differences in the manner of description of suicide-based imagery i.e. images and violent daydreaming, all the studies identified the presence of imagery related to suicide. However, there were a number of differences between the papers.

### *Assessing Suicide*

There were a number of different measures used for the assessment of suicide risk. The Beck Suicide Scale (BSS; Beck, Kovacs & Weissman, 1979) was used by (Chu et al., 2018; Chu et al., 2016; Ng et al., 2016 and Selby et al., 2007). Although this is a widely used tool in clinical practice, it has been identified as lacking in sensitivity (Runeson et al., 2017) although (de Beurs, Fokkema, de Groot, de Keijser, & Kerkhof, 2015) assessed this tool as having good longitudinal properties. The Beck Suicide Scale (Worst Ever Version) was used by (Schultebrasucks et al., 2019); (Holmes et al., 2007) and (Hales et al., 2011). This is an adaptation of the BSS and identifies the worst-ever suicide attempt and is an important marker of future suicide risk (Joiner et., 2003). Holaday and Brausch (2015) used the Self Harm Behaviour Questionnaire (Gutierrez, Osman , Barrios, & Kopper, 2001). Wetherall et al., (2018) used sample questions to assess levels of suicidality.

### *Assessment of Images*

Selby et al., (2007); Chu et al., (2016) and Chu et al., (2018) used the Anger Rumination scale (Sukhodolsky, Golub, & Cromwell, 2001) to assess imagery. However, this scale primarily looks at the presence of anger and only asks one specific question about the presence of imagery in the form of daydreams and fantasies about others, which these

studies have taken as a proxy for the presence of images. The Schedule for Imagined Violence (Grisso et al., 2000) was used by (Chu et al., 2016) although this does not explicitly ask about the presence of images. Crane, Shah, Barnhofer & Holmes (2012); Wetherall et al., (2018); Schultebrucks et al., (2019); and Holmes et al., (2007) utilised the scale from (Holmes et al., 2007) which is an eight-item questionnaire based on the presence of images related to suicide at a time when the participant was at their most despairing or suicidal. Despite the lack of any further analysis into the validity or reliability of this measure, it has a significant impact on a very small field and is used by almost half of the papers examined. The Impact of Future Events Scale (Deeprrose & Holmes, 2010) which was used by (Hales et al., 2011; Ng et al., 2016) looks at the presence of intrusive images that are relevant to the person. Crane et al., (2014) used a scale for measuring images based on an unpublished piece of research and (Holaday & Brausch, 2015) used a suicidal cognitions and flash forwards interview previously used in research by (Hales et al., 2011). The lack of a standardised, well validated and robust tool for assessing imagery related to suicide is a cause for concern and undermines the impact of this review. Any further research into this field has to address this deficit to ensure that the relationship between suicide and images can be further established.

### Participants

Despite the highest rate of suicide being in the male 45-49 category, four of the studies in this review have used a non-clinical sample of predominately female undergraduate participants (Chu et al., 2016); (Selby et al., 2007); (Chu et al., 2018); and (Holaday & Brausch, 2015). Although this is standard practice, it further lessens the validity of this review.

### Theoretical Context

Of the ten studies in this review only four have placed their findings in a theoretical context. Wetherall et al., (2018) linked their study to the IMV model (O'Connor & Kirtley, 2018) whilst (Ng et al., 2016) has linked their findings to the entrapment and defeat component within this model. One of the papers (Chu et al., 2018) specifically looked at violent daydreaming and its relationship to thwarted belongingness and perceived burdensomeness whilst (Holaday & Brausch, 2015) looked at acquired capability which are key parts of the IPTS model of suicide (Joiner 2005). This limits the impact of the studies discussed.

### Types of Images

Only four of the studies have specifically identified the nature of participants images (Holmes et al., 2007); (Holaday & Brausch, 2015); (Hales et al., 2011) and (Crane, Shah, Barnhofer, and Holmes, 2012). However, even in this small sample there is a wide variation in the types and functions of images ranging from images of future suicide or flash forwards images e.g. jumping from a cliff; what may be experienced after death e.g. being in a coffin; an image related to a previous suicide attempt e.g. tablets or a rope. Other participants regarded imagery related to suicide as a warning indicator of actual or perceived increased risk of taking action. Although there appears to be evidence of a relationship between suicide related imagery and suicide there are a number of key differences in the results of the study that impact on this review. The nature, content and interpretation of these images is not identified, and it is not clear if the images directly precipitated an attempt to die by suicide (Wetherall et al., 2018). The role and function of images or violent daydreaming may be directed towards others and may be a contributing factor towards impaired memory encoding and critical attitudes towards self and others, thereby increasing a sense of thwarted belongingness and perceived burdensomeness (Chu et al., 2016); (Chu et al., 2018).

Images have been identified as being present at time of worst crisis but it is unclear as to the presence of images before this point (Holmes et al., 2007); (Schultebraucks et al., 2019). Images may be related to traits (Hales et al., 2011) although they became less frequent when suicidality reduced (Ng et al., 2016). There is some evidence of the role of habituation towards the idea of suicide if images are present. However, for some these images may provide comfort and a deterrent (Crane et al., 2014).

### Limitations

There are a number of very important limitations to this review. Firstly, the causal relationship between images and suicide related behaviour is yet to be established. The mechanism, processes and relationship between images and risk has yet to be fully understood. The amount of research into this field is limited and the papers described above come from a narrow field of researchers. The inclusion criteria was broadened to include violent daydreaming as this involves the use of images but may serve a different process to others that have been identified elsewhere. Half of the studies used clinical samples, and these were generally small. A range of measures were used to identify images and as such there is no standardised measure for the assessment of images. The predisposition to use images as a trait was not looked at by the majority of the research described above.

### Further Research

This is a limited field and further research is needed to understand how and why imagery impacts on levels of suicidality whether this is a flash forwards process or a trait process and how imagery impacts on attitudes towards self and others. Larger prospective studies

of at risk individuals who are actively suicidal are required although this does pose risks related to safety and risk management.

### *Clinical Implications*

There are a number of very significant clinical implications from this systematic review. Due to the increasing evidence of the presence of images and a possible relationship with suicide, it is imperative that clinicians explicitly ask patients about the presence of images and their role, function, meaning and interpretation that are idiosyncratic to that individual. Images and daydreaming about suicide can have multiple interpretations that can increase the risk of someone dying by suicide. Personalised imagery-based formulations should be created as a means of establishing baseline risk, increases in risk and promotion of recovery, which would allow for a more accurate assessment of images and their role and function. Participants across several papers described that this research was the first occasion they had been asked about suicidal imagery; despite it being a very significant, long term and ongoing cognitive process they rarely volunteered this information without prompting (Schultebrasucks et al., 2019).

Increasing awareness of the presence, role and function of images in people's lives is a key clinical outcome of this research. This will be done through the publication of this research, the dissemination of the key messages and through supporting other clinicians to start to meaningfully enquire about images related to suicide. Supporting others to expand their clinical assessment and intervention skills set is key role for a clinical psychologist. This process allows for individuals to engage with their images, normalise them, manage them and react accordingly. The presence and variety of images related to suicide has also raised further questions to be addressed by research. As can be seen in the third paper of this thesis, the IMV model of suicide has been enhanced by the inclusion of images at all stages of the model.

Further population of this model is required to fully understand the role and function of images. This will be done through individual case studies, clinical assessment and large-scale research projects.

## Conclusion

In conclusion, there are several limitations to this review; several of the studies have used female undergraduates despite the highest risk group being middle aged men, there are no specific and evaluated tools for measuring images related to suicide. However, and despite this, there is increasing evidence of the presence of images related to suicide. Causal links have yet to be established but there is strong enough evidence to warrant the inclusion of the assessment of images about suicide and violent daydreaming related to suicide in any clinical assessment. Further research into traits towards image-based rumination and intrusive images in a clinical population is required to fully establish the causal relationship and the range of roles and functions of suicide related imagery. A further aim is to place this evidence within the context of the IMV model of suicidal behaviour to further elaborate the role and function of images at all stages of this model. This will be addressed in the third paper in this thesis.



*Studies used in Review*

	Type of study	Participants	Description	Definition of images	What tools were used	Criticisms	Results
Chu., et al (2016)	Cross-sectional study.	512 young adults	Study looked at daydreaming and suicidal ideation and everyday memory.	Selby 2007 definition Study has referred to other studies that refer to images.	Everyday memory questionnaire. Anger rumination scale Schedule of imagined violence.	Did not use a specific measure on daydreaming about death and suicide.	Suicidal ideation predicted violent day dreaming. Corroborated Selby 2007. Impacts on memory functioning. Low rates of suicide and comprised of high functioning young adults in college.
Chu., et al (2018)	Two-phase cross-sectional study	1 508 undergraduates mean age 18.94 67% female 2 310 undergraduates 79.1 female	Trying to understand the mechanism underlying violent daydreaming. Relationship between thwarted belongingness and perceived burdensomeness.	Violent daydreaming about others and self may fuel negative feelings towards others and turn one away from others.	Anger rumination scale Interpersonal needs questionnaire BSS BDI	Looking at factors too early in the cycle. Moved away from imagery about suicide. Online screening retrospective.	Violent daydreaming may be reinforcing negative feelings towards others. No role for depression as a mediating factor. Mediation occurs when the relationship between an independent variable and a dependent variable is explained by a third variable.
Crane., et al (2011)	Cross-Sectional	27 participants in clinical setting.	Relationship between depression, suicide imagery and despair.	Flash forward imagery.	BSS BDI Suicidal cognitions interview,MINI	No causal relationship.	Depressed participants report vivid imagery related to suicide. For some, images can be comforting.
Hales., et al (2011)	Quasi experimental Cross sectional	40 participants who were previously. 20 of whom met the criteria for unipolar depression and 20 who met the criteria for bi-polar depression.	Cognitions in uni-polar and bi polar depression.	Flash forwards	BSS worst ever version. Suicidal cognitions and flash forwards interview. Spontaneous use of imagery scale. Impact of future events scale. Barrat impulsiveness scale.	Not clear if level of imagery was related to severity of condition of diagnosis related	Bi polar group were more preoccupied with flash forwards. All participants reported intrusive related images at times of most despair. 13/20 in bi polar group reported that the flash forwards. Imagery was also comforting. Both groups experienced flash forwards.
Holaday & Busch (2015)	Cross sectional	237 undergraduates 59% female mean age 20	Relationship between suicide related imagery and suicidality.	Holmes definition	Suicide imagery Holmes 2011 SHBQ	Retrospective correlational data.	Suicidal imagery scores were positively correlated with SHBQ scores. History of suicidality and non-suicidality also report more suicidal imagery. Higher reports of realness were related to higher scores in the SHBQ. The mediation hypothesis was not supported. Although participants described means to commit suicides or saw images there was no indication of a rise in acquired capability.

## *Studies used in Review*

Holmes., et al (2007)	Cross Sectional of patient's cognitions in most despairing or suicidal period	15 depressed and formerly suicidal patients.	Suicide related imagery and flash forwards processes to suicide.	Intrusive repetitive suicide related images when at their most distressed and despairing.	MINI BDI 2 BSS worst ever version Suicidal cognitions interview.	Small sample size. Retrospective assessment of a flash forwards phenomenon. No causal relationship. Correlational. Time from strongest urge was 10-240 months.	High scores on the clinical worst ever suicidal ideation measure were significantly associated with higher levels of image reality and increased preoccupation with suicide related images.
Ng., et al (2015)	Prospective cohort study	Chinese participants. Part of larger study Score > than 1 on two questions on BSS 82 participants Age and gender matched control group	Assessment of images once suicidality had reduced.	Flash forwards but also recognition of violent day dreaming.	Two question in BSS 4 and 5. Impact of future events scale.	Did not measure actual suicide attempts. 30 attrition rates Suicidal behaviour was not measured Self-report compared to interview	At baseline suicidal participants with higher levels of imagery had more severe suicidal ideation than suicidal participants without. Suicide flash forwards was only found in suicidal participants. Images were of the aftermath of imagined suicide and the act of suicide. Participants who became non-suicidal at 7-week follow did not report flash forwards
Selby, Anestis & Joiner (2007)	Cross sectional	83 undergraduates 78.4% female mean age 19.2	Suicide and revenge  Impact on self and impact on others	Daydreams about future suicidal plans, previous suicide attempts or the ways in which people will react after their death	Anger rumination scale BDI BSS	Not replicated in Chu 2016. No clear measures about suicide and imagery.	Thoughts of revenge had the highest correlation with BSS scores. High violent daydreaming and high depression indicated high BSS.
Schultebracks., et al (2019)	Cross sectional study	74 participants mean age 34.2 (SD=10.46) Significantly more women in BPD group.  BPD group reported higher numbers of suicide attempts	Whether BPD patients with or without PTSD experience mental images related to suicide. Patients with MDD were included as controls Whether mental imagery is associated with trauma experience. Whether the number of previous suicide attempts affects the number and quality of mental imagery after suicide.	Flash forwards	MINI BSS worst ever version Suicidal cognition interview	Several differences in age and gender across groups.	No difference in BPD with or without PTSD. Vividness of imagery did not differ. Number of suicide attempts revealed that the number of suicide attempts was significantly related to how comforting the image was. The higher the number of previous suicide attempts the less comforting the image. The mental images related to suicide did not differ across groups. Consistent with previous studies the characteristics of mental imagery are associated with the severity of mental imagery.
Wetherall., et al (2018)	Cross sectional study Based on the IMV model Scottish Wellbeing study Volitional moderators	3508 18-34-year olds in the Scottish Wellbeing Survey	Motivational and volitional factors phase factors would differentiate between controls from those who had a history of suicidal ideation /attempts. Only volitional factors would differentiate between those that who had a history of suicidal ideation and those who had attempted suicide	Death related imagery when feel down or distressed included engaging in self-harm or suicidal behaviour	Two questions: Have you ever seriously thought about taking your own life but not attempted it? Have you ever tried to take your own life? Eight questions related to imagery. Related to Holmes 2007 but not clear what they were	Not clear what the questions were  Did not use the BSS scale  Cross sectional study	Mental imagery had the highest positive predictive value.  (Positive predictive value is the probability that subjects with a positive screening test truly have the disease)

	<i><b>SELECTION BIAS</b></i>	<i><b>STUDY DESIGN</b></i>	<i><b>CONFOUNDERS</b></i>	<i><b>BLINDING</b></i>	<i><b>DATA COLLECTION</b></i>	<i><b>WITHDRAWALS</b></i>
<i><b>Chu., et al (2016)</b></i>	Weak	Moderate	Weak	Moderate	Moderate	Moderate
<i><b>Chu., et al (2018)</b></i>	Weak	Weak	Moderate	Moderate	Moderate	Moderate
<i><b>Crane., et al (2011)</b></i>	Strong	Weak	Weak	Weak	Moderate	Moderate
<i><b>Hales., et al (2011)</b></i>	Strong	Weak	Weak	Weak	Moderate	Moderate
<i><b>Holaday &amp; Busch (2015)</b></i>	Weak	Weak	Weak	Weak	Weak	Weak
<i><b>Holmes., et al (2007)</b></i>	Strong	Moderate	Weak	Moderate	Moderate	Moderate
<i><b>Selby, Anestis &amp; Joiner (2007)</b></i>	Weak	Moderate	Moderate	Weak	Moderate	Moderate
<i><b>Ng., et al (2015)</b></i>	Strong	Strong	Moderate	Moderate	Moderate	Moderate
<i><b>Schultebracks., et al (2019)</b></i>	Strong	Moderate	Moderate	Weak	Moderate	Moderate
<i><b>Wetherall., et al (2018)</b></i>	Strong	Strong	Strong	Moderate	Moderate	Moderate

## REFERENCES

- Barzilay, S., & Apter, A. (2014). Psychological Models of Suicide. *Archives of Suicide Research, 18*(4), 295–312. <https://doi.org/10.1080/13811118.2013.824825>.
- Beck, A. T., Steer, R. A., & Carbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical psychology review, 8*(1), 77-100.
- Beck, A. T., Robert A. Steer, and William F. Ranieri. (1988)"Scale for suicide ideation: Psychometric properties of a self-report version." *Journal of clinical psychology* 44, no. 4: 499-505.
- Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intention: The Scale for Suicide Ideation. *Journal of consulting and clinical psychology, 47*(2), 343.
- Bender, T. W., Gordon, K. H., Bresin, K., & Joiner Jr, T. E. (2011). Impulsivity and suicidality: The mediating role of painful and provocative experiences. *Journal of affective disorders, 129*(1-3), 301-307.
- Bohus, M., Limberger, M. F., Frank, U., Chapman, A. L., Kühler, T., & Stieglitz, R. D. (2007). Psychometric properties of the borderline symptom list (BSL). *Psychopathology, 40*(2), 126-132.
- Boelen, P. A., & Huntjens, R. J. C. (2008). Intrusive images in grief: An exploratory study. *Clinical Psychology and Psychotherapy, 15*(4), 217–226. <https://doi.org/10.1002/cpp.568>.
- Chu, C., Podlogar, M. C., Rogers, M. L., Buchman-Schmitt, J. M., Negley, J. H., & Joiner, T. E. (2016). Does Suicidal Ideation Influence Memory? A Study of the Role of Violent Daydreaming in the Relationship Between Suicidal Ideation and Everyday Memory.

*Behavior Modification*, 40(5), 731–747. <https://doi.org/10.1177/0145445515625189>.

Chu, C., Rogers, M. L., Gai, A. R., & Joiner, T. E. (2018). Role of thwarted belongingness and perceived burdensomeness in the relationship between violent daydreaming and suicidal ideation in two adult samples. *Journal of Aggression, Conflict and Peace Research*, 10(1), 11–23. <https://doi.org/10.1108/JACPR-10-2016-0255>.

Crane, C., Barnhofer, T., Duggan, D. S., Eames, C., Hepburn, S., Shah, D., & Williams, J. M. G. (2014). Comfort from suicidal cognition in recurrently depressed patients. *Journal of Affective Disorders*, 155(1), 241–246. <https://doi.org/10.1016/j.jad.2013.11.006>.

Crane, C., Shah, D., Barnhofer, T., & Holmes, E. A. (2012). Suicidal imagery in a previously depressed community sample. *Clinical psychology & psychotherapy*, 19(1), 57–69.

Dargan, P., Reid, G., & Hodge, S. (2016). Exploring the Role of Mental Imagery in the Experience of Self-injury: An Interpretative Phenomenological Analysis. *Behavioural and Cognitive Psychotherapy*, 44(1), 92–103. <https://doi.org/10.1017/S1352465814000666>.

de Beurs, D. P., Fokkema, M., de Groot, M. H., de Keijser, J., & Kerkhof, A. J. F. M. (2015). Longitudinal measurement invariance of the Beck Scale for Suicide Ideation. *Psychiatry Research*, 225(3), 368–373. <https://doi.org/10.1016/j.psychres.2014.11.075>.

Deeprase, C., & Holmes, E. A. (2010). An exploration of prospective imagery: The impact of future events scale. *Behavioural and Cognitive Psychotherapy*, 38(2), 201–209. <https://doi.org/10.1017/S1352465809990671>.

- Deepröse, C., Malik, A., & Holmes, E. A. (2011). Measuring intrusive prospective imagery using the Impact of Future Events Scale: Psychometric properties and relation to risk for bipolar disorder. *International Journal of Cognitive Therapy*, 4(2), 187-196.
- Dhingra, K., Boduszek, D., & O'Connor, R. C. (2016). A structural test of the Integrated Motivational-Volitional model of suicidal behaviour. *Psychiatry Research*, 239, 169–178. <https://doi.org/10.1016/j.psychres.2016.03.023>.
- Fydrich, T., Renneberg, B., Schmitz, B., & Wittchen, H. U. (1997). SCID II (Structured Clinical Interview for DSM-IV. Axis II: Personality Disorders. *Göttingen: Hogrefe*.
- Gilbert, P., & Allan, S. (1998). The role of defeat and entrapment (arrested flight) in depression: an exploration of an evolutionary view. *Psychological medicine*, 28(3), 585-598.
- Grisso, T., Davis, J., Vesselinov, R., Appelbaum, P. S., & Monahan, J. (2000). Violent thoughts and violent behavior following hospitalization for mental disorder. *Journal of Consulting and Clinical Psychology*, 68(3), 388–398. <https://doi.org/10.1037/0022-006X.68.3.388>.
- Gutierrez, P.M., Osman, A., Barrios, F.X. and Kopper, B.A. (2001) Development and initial validation of the Self Harm Behaviour Questionnaire. *Journal of Personality Assessment*, 77 (3) 475-90.
- Hackmann, A., Clark, D. M., & McManus, F. (2000). Recurrent images and early memories in social phobia. *Behaviour Research and Therapy*, 38(6), 601–610. [https://doi.org/10.1016/S0005-7967\(99\)00161-8](https://doi.org/10.1016/S0005-7967(99)00161-8).
- Hales, S. A., Deepröse, C., Goodwin, G. M., & Holmes, E. A. (2011). Cognitions in bipolar affective disorder and unipolar depression: Imagining suicide. *Bipolar Disorders*, 13(7–

8), 651–661. <https://doi.org/10.1111/j.1399-5618.2011.00954.x>.

Hallford, D. J. (2019). The phenomenological characteristics of autobiographical future thinking in dysphoric and non-dysphoric individuals. *Psychiatry Research*, 273 (September 2018), 481–486. <https://doi.org/10.1016/j.psychres.2018.12.100>.

Hasking, P. A., Di Simplicio, M., McEvoy, P. M., & Rees, C. S. (2018). Emotional cascade theory and non-suicidal self-injury: the importance of imagery and positive affect. *Cognition and Emotion*, 32(5), 941–952. <https://doi.org/10.1080/02699931.2017.1368456>.

Holaday, T. C., & Brausch, A. M. (2015). Suicidal imagery, history of suicidality, and acquired capability in young adults. *Journal of Aggression, Conflict and Peace Research*, 7(3), 127–138. <https://doi.org/10.1108/jacpr-10-2014-0146>.

Holmes, E. A., Blackwell, S. E., Heyes, S. B., Renner, F., & Raes, F. (2016). Mental imagery in depression: phenomenology, potential mechanisms, and treatment implications. *Annual review of clinical psychology*, 12.

Holmes, E. A., Crane, C., Fennell, M. J. V., & Williams, J. M. G. (2007). Imagery about suicide in depression-"Flash-forwards" *Journal of Behavior Therapy and Experimental Psychiatry*, 38(4), 423–434. <https://doi.org/10.1016/j.jbtep.2007.10.004>.

Homer, S. R., & Deeprose, C. (2017). Voluntary and Involuntary Imagery in Social Anxiety. *Behavioural and Cognitive Psychotherapy*, 45(03), 285–299. <https://doi.org/10.1017/s1352465817000017>.

Joiner T. "Why people die by suicide"(2005). Cambridge, MA, US: Harvard University Press.

Joiner, T. E., Steer, R. A., Brown, G., Beck, A. T., Pettit, J. W., & Rudd, M. D. (2003).

Worst-point suicidal plans: A dimension of suicidality predictive of past suicide attempts and eventual death by suicide. *Behaviour Research and Therapy*, 41(12), 1469–1480. [https://doi.org/10.1016/S0005-7967\(03\)00070-6](https://doi.org/10.1016/S0005-7967(03)00070-6).

Klonsky, E. D., & May, A. M. (2015). The three-step theory (3ST): A new theory of suicide rooted in the “ideation-to-action” framework. *International Journal of Cognitive Therapy*, 8(2), 114-129.

Klonsky, E. D., May, A. M., & Saffer, B. Y. (2016). Suicide, Suicide Attempts, and Suicidal Ideation. *Ssrn*. <https://doi.org/10.1146/annurev-clinpsy-021815-093204>.

Kovacs, M., Weissman, A., & Beck, A. T. (1979). Assessment of suicidal intention : The Scale of Suicide Ideation Assessment of Suicidal Intention : The Scale for Suicide Ideation. *Journal of Consulting and Clinical Psychology*, 47(May 1979), 343–352 <https://doi.org/10.1037/0022-006X.47.2.343>.

Malcolm, C. P., Picchioni, M. M., & Ellett, L. (2015). Intrusive prospective imagery, posttraumatic intrusions and anxiety in schizophrenia. *Psychiatry Research*, 230(3), 899–904. <https://doi.org/10.1016/j.psychres.2015.11.029>.

Mars, B., Heron, J., Klonsky, E. D., Moran, P., O’Connor, R. C., Tilling, K., ... Gunnell, D. (2019). What distinguishes adolescents with suicidal thoughts from those who have attempted suicide? A population-based birth cohort study. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 60(1), 91–99. <https://doi.org/10.1111/jcpp.12878>.

McEvoy, P. M., Hayes, S., Hasking, P. A., & Rees, C. S. (2017). Thoughts, images, and appraisals associated with acting and not acting on the urge to self-injure. *Journal of Behavior Therapy and Experimental Psychiatry*, 57, 163–171. <https://doi.org/10.1016/j.jbtep.2017.05.010>.



- McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E., & Jenkins, R. (2009). *Adult psychiatric morbidity in England, 2007: results of a household survey*. The NHS Information Centre for health and social care.
- Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., & Stewart, L. A. (2015). Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Systematic reviews*, 4(1), 1.
- Muse, K., McManus, F., Hackmann, A., Williams, M., & Williams, M. (2010). Intrusive imagery in severe health anxiety: Prevalence, nature and links with memories and maintenance cycles. *Behaviour Research and Therapy*, 48(8), 792–798.  
<https://doi.org/10.1016/j.brat.2010.05.008>.
- Nelson, H. E., & Willison, J. (1991). *National adult reading test (NART)*. Windsor: Nfer-Nelson.
- Gilbert, P., & Allan, S. (1998). The role of defeat and entrapment (arrested flight) in depression: an exploration of an evolutionary view. *Psychological medicine*, 28(3), 585-598.
- Ng, R. M. K., Di Simplicio, M., McManus, F., Kennerley, H., & Holmes, E. A. (2016). ‘Flash-forwards’ and suicidal ideation: A prospective investigation of mental imagery, entrapment and defeat in a cohort from the Hong Kong Mental Morbidity Survey. *Psychiatry Research*, 246(August), 453–460  
<https://doi.org/10.1016/j.psychres.2016.10.018>.
- O’Connor, R. C. (2011). Towards an integrated motivational–volitional model of suicidal behaviour. *International handbook of suicide prevention: Research, policy and practice*, 1, 181-98.

- O'Connor, R. C., & Kirtley, O. J. (2018). The integrated motivational-volitional model of suicidal behaviour. *Philosophical Transactions of the Royal Society B: Biological Sciences*, 373(1754). <https://doi.org/10.1098/rstb.2017.0268>.
- O'Donnell, C., Di Simplicio, M., Brown, R., Holmes, E. A., & Burnett Heyes, S. (2018). The role of mental imagery in mood amplification: An investigation across subclinical features of bipolar disorders. *Cortex*, 105, 104–117. <https://doi.org/10.1016/j.cortex.2017.08.010>.
- Osman, S., Cooper, M. J., Hackman, A., & Veale, D. (2004). Spontaneously occurring images and early memories in people with body dysmorphic disorder. *Memory*, 12(4), 428–436. <https://doi.org/10.1080/09658210444000043>.
- Runeson, B., Odeberg, J., Pettersson, A., Edbom, T., Adamsson, I. J., & Waern, M. (2017). Instruments for the assessment of suicide risk: a systematic review evaluating the certainty of the evidence. *PLoS one*, 12(7), e0180292.
- Pile, V., & Lau, J. Y. F. (2018). Looking forward to the future: Impoverished vividness for positive prospective events characterises low mood in adolescence. *Journal of Affective Disorders*, 238(May), 269–276. <https://doi.org/10.1016/j.jad.2018.05.032>.
- Reisberg, D., Pearson, D. G., & Kosslyn, S. M. (2003). Intuitions and introspections about imagery: The role of imagery experience in shaping an investigator's theoretical views. *Applied Cognitive Psychology: The Official Journal of the Society for Applied Research in Memory and Cognition*, 17(2), 147-160.
- Ribeiro, J. D., & Joiner, T. E. (2009). The interpersonal-psychological theory of suicidal behavior: Current status and future directions. *Journal of clinical psychology*, 65(12), 1291-1299.

- Royle, J., & Lincoln, N. B. (2008). The Everyday Memory Questionnaire–revised: Development of a 13-item scale. *Disability and Rehabilitation*, 30(2), 114-121.
- Runeson, B., Odeberg, J., Pettersson, A., Edbom, T., Jildevik Adamsson, I., & Waern, M. (2017). Instruments for the assessment of suicide risk: A systematic review evaluating the certainty of the evidence. *PloS One*, 12(7), e0180292. <https://doi.org/10.1371/journal.pone.0180292>.
- Schultebras, K., Duesenberg, M., Simplicio, M. Di, Holmes, E. A., & Roepke, S. (2019). Suicidal Imagery in Borderline Personality Disorder and Major Depressive Disorder. *Journal of Personality Disorders*, 1–19. [https://doi.org/10.1521/pedi\\_2019\\_33\\_406](https://doi.org/10.1521/pedi_2019_33_406).
- Selby, E. A., Anestis, M. D., & Joiner, T. E. (2007). *Behavior Modification Emotion Dysregulation in Suicidality*. 867–879. <https://doi.org/10.1177/0145445507300874>.
- Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., & Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (MINI): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *The Journal of clinical psychiatry* 59 (Suppl 20), 22-33.
- Stewart, S. M., Eaddy, M., Horton, S. E., Hughes, J., & Kennard, B. (2017). The Validity of the Interpersonal Theory of Suicide in Adolescence: A Review. *Journal of Clinical Child and Adolescent Psychology*, 46(3), 437–449. <https://doi.org/10.1080/15374416.2015.1020542>.
- Sukhodolsky, D. G., Golub, A., & Cromwell, E. N. (2001). Development and validation of the anger rumination scale. *Personality and Individual Differences*, 31(5), 689–700.
- Turner, J. R. (2013). Community Sample. *Encyclopedia of Behavioral Medicine*, 69(January 2011), 473–473. [https://doi.org/10.1007/978-1-4419-1005-9\\_1000](https://doi.org/10.1007/978-1-4419-1005-9_1000).

- Van Orden, K. A., Cukrowicz, K. C., Witte, T. K., & Joiner Jr, T. E. (2012). Thwarted belongingness and perceived burdensomeness: Construct validity and psychometric properties of the Interpersonal Needs Questionnaire. *Psychological assessment*, 24(1), 197.
- Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E. (2010). The Interpersonal Theory of Suicide. *Psychological Review*, 117(2), 575–600. <https://doi.org/10.1037/a0018697>.
- Weßlau, C., Cloos, M., Höfling, V., & Steil, R. (2015). Visual mental imagery and symptoms of depression - results from a large-scale web-based study. *BMC Psychiatry*, 15(1), 1–13. <https://doi.org/10.1186/s12888-015-0689-1>.
- Wetherall, K., Cleare, S., Eschle, S., Ferguson, E., O'Connor, D. B., O'Carroll, R. E., & O'Connor, R. C. (2018). From ideation to action: Differentiating between those who think about suicide and those who attempt suicide in a national study of young adults. *Journal of Affective Disorders*, 241(June), 475–483. <https://doi.org/10.1016/j.jad.2018.07.074>.
- Wingenfeld, K., Spitzer, C., Mensebach, C., Grabe, H. A., Hill, H. & Gast, U (2010) The German version of The Childhood Trauma Questionnaire *Psychotherapie, Psychosomatik, Medizinische Psychologie* 60 (11), 442-450.

## Chapter 2

## **Chapter 2**

### **Research Paper**

**Evaluation of the DBT-Steps A (DBT-SA) programme when delivered by School-based Counsellors to a targeted population.**

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This paper will be submitted to British Journal of Educational Psychology and as such will follow the publishing guidelines of this journal.

<https://onlinelibrary.wiley.com/page/journal/20448279/homepage/forauthors.html>

# RESEARCH PAPER ABSTRACT

## **Background**

There is clear evidence of the increase in mental health problems in children and young people. Many models of intervention are universal and preventative. DBT-Steps A is a universal transdiagnostic programme that can be delivered as a targeted intervention that has promising outcomes when delivered by school-based counsellors.

## **Aims**

This study was a feasibility study into the effectiveness of DBT-SA when delivered as a targeted intervention. To the author's knowledge this was the first time the programme had been researched in this manner.

## **Sample**

Participants (n=35) comprised selected participants aged 14-15.6 years of age (24 females) who completed the 11-week, 22 session programme.

## **Methods**

A mixed-methods design was utilised. Pre and post measures were completed using DBT Ways of Coping Checklist (DBT-WCCL; Neacsiu, Rizvi, Vitaliano, Lynch, & Linehan, 2010); Difficulties in Emotion Regulation Scale (DERS), (Gratz & Roemer, 2004); Strengths and Difficulties Questionnaire (SDQ), (Goodman, 2001); Child and Adolescent Mindfulness Measure (CAMM); (Greco Baer, & Smith 2011), Warwick Edinburgh Mental Wellbeing Scale (WEMWBS); (Tennant et al 2007). Eleven participants were interviewed, and qualitative data was analysed using thematic analysis.



## **Results**

Statistically significant effect sizes were found for improved emotional regulation (DERS) and general functioning (SDQ). Thematic analysis indicated that participants were utilising skills with resulting improvements in functioning, mindfulness, relationships and academic performance.

## **Conclusions**

DBT-SA is a promising intervention when delivered to a targeted group of young people and provides further evidence of the transdiagnostic flexibility of Dialectical Behavioural Therapy.

## INTRODUCTION

In the United Kingdom there has been a gradual increase in rates of mental health problems in 5-19-year olds from 9.7% in 2011, to over 12% in 2017. Rates for boys and girls were broadly similar (12.6% and 12.9% respectively) but almost a quarter of 17-19-year-old girls have an identifiable mental health difficulty. Access to specialist services for children and young people is inadequate with only 25.2% of this group having contact with a mental health specialist (NHS Digital, 2018). In the UK, rates of self-harm in girls aged 13-16 have risen from 45.9 per 10,000 in 2011 to 77 per 10,000 in 2014 (Morgan et al., 2017).

It is estimated that childhood psychiatric disorders cost £1.47bn to health, social care and education services with the biggest burden being placed on the education system (Snell et al., 2013). Mental health problems in childhood not only impact on development but can have lifelong implications (Patalay, Fink, Fonagy, Deighton, 2017). Mental health and academic performance have a cyclical relationship i.e. poor mental health affects educational outcomes and poor educational outcomes impacts on mental health (Paulus, Ohmann, & Popow, 2016). This may be due to school specific factors such as bullying and increased academic demands which can increase the prevalence of anxiety and depression (Fazel, Hoagwood, Stephan, & Ford, 2014). This cyclical relationship is also present in mental health difficulties and exclusion (Ford, Parker, Salim, & Goodman, 2018).

There is increasing evidence of the effectiveness of school-based interventions in the form of social and emotional learning (SEL) to help young people develop the skills that are required to negotiate a complex school environment and social and emotional challenges out with school. These skills have been described as how “children and adults effectively apply the knowledge, attitudes and skills necessary to understand and

manage emotions” (CASEL 2013) cited in (Mazza, Dexter-Mazza, Miller, Rathus, & Murphy, 2016, pp.10). These skills can be described as the development of intrapersonal and interpersonal competencies (Domitrovich, Durlak, Staley, & Weissberg, 2017) and can be subdivided into five areas i.e. self-awareness, self-management, social awareness, relationship skills and responsible decision making (Clarke, Morreale, Field, Hussein, & Barry, 2015).

A meta-analysis of 213 programmes involving approximately 150,000 participants established that children and young people who had participated in SEL programmes showed improved social and emotional skills, attitudes, behaviour, and school performance (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Moderate effect sizes for prevention programmes were found but larger effect sizes of 1.35 (Cohen’s *d*) were identified for early intervention and targeted programmes (Reddy, Newman, De Thomas, & Chun, 2009). School-based tiered interventions are advocated but indicated programmes demonstrate superior outcomes and reduction of symptoms more than universal interventions (Fazel et al., 2014); (Calear & Christensen, 2010). Universal interventions have advantages in that they are less stigmatizing, easily provided and can be delivered to larger groups of young people. However, targeted interventions tend to have larger effect sizes and can be more efficient in targeting need (Stallard & Buck, 2013); (Stallard et al., 2014). These have a more dramatic effect when they address the needs of higher risk young people. Very few interventions have been shown to have a negative impact (Weare & Nind, 2011).

As result of this increase in need and the associated challenges in supporting young people with a range of mental health presentations, there has been research into multiple interventions. Many programmes are targeted at a specific area of need such as the FRIENDS programme which aims to prevent anxiety and depression (Stallard et al 2014).

Other interventions have tackled depression (Werner-Seidler, Perry, Caelear, Newby, & Christensen, 2017) anxiety (Neil & Christensen, 2009) and suicide (Katz et al., 2013).

However, a potential treatment option in this area is Dialectical Behavioural Therapy (DBT) as clinicians have asserted it can be beneficial to all young people across a wide spectrum of functioning. Bio-social theory, which underpins all DBT programmes and is the cornerstone of DBT-SA, states that when vulnerable biology is coupled with an invalidating environment it can lead to challenges in emotional regulation, interpersonal problems, impulsive behaviours and confusion about the self (Mazza et al., 2016). Given these common precipitants in the development of mental health problems, and the innate flexibility of the core DBT philosophy, it is expected that DBT can be further adapted to yield significant benefits when it is utilised as an intervention for young people, within a school environment (Rathus, Miller & Linehan, 2015).

Delivering a modified version of the original DBT protocol (Linehan, 1993), Rathus & Miller, (2003) found that there were significant reductions in suicidal ideation, general psychiatric symptoms, and symptoms of borderline personality within the adolescent treatment group. DBT has been found to be effective in improving health related quality of life in suicidal adolescents (Swales, Hibbs, Bryning, & Hastings, 2016); reducing repeated suicidal and self-harming behaviour (Mehlum et al., 2014) and found to be promising in managing risk behaviours in certain groups of young people (Zapolski & Smith, 2017). DBT skills programmes have been shown to be effective when delivered over four weeks in an alternative education setting (Ricard, Lerma, & Heard, 2013) and in a sixteen-week modified skills training group for children and young people with oppositional defiant disorder (Nelson-Gray et al., 2006). DBT for adolescents has been adapted to address a wide range of target areas. These include: self-injury, unstable affect, deliberate self-harm, bipolar disorder, eating disorders and trichotillomania within a range of inpatient and community settings.

Results of these studies have been positive and have shown significant post treatment effects in a range of areas such as distress tolerance, depression, suicidal ideation, general functioning, anxiety, hospitalisations, violence, bingeing, purging and hair pulling (MacPherson, Cheavens, & Fristad, 2013).

DBT-SA is a further iteration of the DBT family of interventions. Sharing the same theoretical foundations and elements of skills development as standard DBT, it is intended for use within a school environment. Secondary school children are supported to gain skills to manage distress; become more interpersonally effective, manage emotions and be more mindful. The programme was designed to be delivered by teachers on a universal basis to all young people in a school setting over the course of an academic year but also allows for a more targeted intervention. Initial data collection has shown significant reductions in emotional distress scores when compared to peer controls. Young people themselves have reported favourably on the programmes with high numbers reporting they would use the skills learned and that they would be helpful for others (Mazza et al., 2016). Following a recent evaluation in Ireland, DBT-SA has identified as a potentially effective universal intervention to develop skills that promote positive mental health (Flynn et al., 2017).

As a result of increasing need, the impact of targeted programmes, the outcomes from other DBT interventions and the flexibility of the DBT-SA programme this intervention was seen by the Local Authority in question as a promising targeted programme for young people with more complex emotional difficulties.

This research looked at the effectiveness of DBT-SA when delivered by schools-based counsellors and teachers to a targeted group of young people. To the author's knowledge DBT-SA has never been delivered by this group of professionals to young people in this

manner and as such this was a feasibility study. As this was a new and novel style of delivery a mixed methods approach was utilised.

## **METHODOLOGY**

### **Study setting**

This study was a collaboration between the North Wales Clinical Psychology Programme and one local authority in the area. Working alongside the lead Educational Psychologist and the head of the schools-based counselling service, the lead author undertook a feasibility study into the effectiveness of DBT-SA when delivered as a targeted intervention by the school-based counselling service.

The programme was delivered in three mainstream high schools to targeted groups of young people i.e. highlighted as having more complex needs than the general school population. Two of the groups were taught in English and the third was delivered in Welsh. The schools were in urban, rural and semi-rural settings. The Local Authority in question has had a longstanding working partnership with the the Local CAMHS team. This relationship has been very fruitful in the past and has allowed for the development of significant interventions and processes. The local CAMHS team have been very supportive of the Educational Psychology service and Schools Counselling Service and a member of staff from the CAMHS team is part of the advisory board of the Counselling Service. This ensured that this intervention was easier to develop due to the significant development work that had been carried out by the local CAMHS team.

### **Recruitment**

Inclusion criteria for the intervention were as follows: young people who required a targeted intervention due to difficulties in (i) emotional regulation, (ii) interpersonal skills, (iii) distress tolerance and (iv) had been referred to the schools based counselling service but whose needs were not at level requiring support from tier 3 CAMHS. were integrated into the school settings and were key to the school's pastoral care system.

The broad inclusion criteria ensured this study reflected a real-world example of the types of young people who would be involved in this service (figure 1).

	n=	Mean age	Gender
Group 1	11	14.9 years; sd=0.9	7 females
Group 2	13	14.9 years; sd=0.9	8 females
Group 3	11	14.1 years; sd=0.6	9 females

*Figure 1*

### **Method of Analysis**

The quantitative measures assessed the impact of the intervention on mindfulness, general wellbeing, functioning, emotional regulation and skills use. The qualitative component was aimed at understanding the experiences of the young people who were involved in the programme.

### **Quantitative Measures**

- DBT Ways of Coping Checklist (DBT-WCCL); Neacsiu, Rizvi, Vitaliano, Lynch, & Linehan, 2010) is a 59-item self-report measure designed to assess the use of skills taught in DBT. It consists of three sub scales i.e. skills use, general dysfunction and blaming others. It has strong psychometric properties and reliability of  $\alpha = 0.8$ .
- Difficulties in Emotion Regulation Scale (DERS); Gratz & Roemer, 2004) is a 36-item, self-report questionnaire of emotional dysregulation that assesses the following areas; (i) nonacceptance of emotional responses (ii) difficulties engaging in goal directed behaviour (iii) impulse control difficulties.

- (vi) lack of emotional awareness (v) limited access to emotion regulation strategies (vi) lack of emotional clarity. Research indicates that it has promising internal consistency and validity in community samples and factors are related to externalising and internalising difficulties (Neumann, van Lier, Gratz, and Koot, 2010).
- Strengths and Difficulties Questionnaire (SDQ); (Goodman, 2001) is a brief behavioural screening questionnaire for 3-16-year olds. It looks at emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour. There is strong evidence for the discriminative and structural validity of the SDQ (Kersten et al., 2016).
- Child and Adolescent Mindfulness Measure (CAMM); (Greco Baer, & Smith, 2011) is a 10-item questionnaire designed to assess mindfulness skills in youth over the age of 9 years; it assesses lack of awareness of ongoing activity and judgmental or avoidant responses to thoughts and feelings. There are positive correlations between CAMM and academic competence, quality of life and skill but is negatively correlated with externalising problems and internalising symptoms. It has been validated across a variety of international populations (Goodman, Madni, & Semple, 2017).
- Warwick Edinburgh Mental Wellbeing Scale (WEMWBS); (Tennant et al., 2007) is a 14-item questionnaire that evaluates mental wellbeing. Analysis indicates that it is a valid, reliable and acceptable measure with good levels of responsiveness (Maheswaran, Weich, Powell, & Stewart-Brown, 2012).

## **Ethics**

Ethics approval was gained from Bangor University, School of Psychology, Ethics and Governance Committee. Research was carried out in accordance with guidelines laid



down by the British Psychological Society (2018) and the Bangor University School of Psychology guidelines on data protection as defined by the Data Protection Act (2018). Using the NHS Health Research algorithm, it was established that this study did not require NHS Research Ethics Committee approval as it was a service evaluation (Medical Research Council 2017).

### **Data Collection**

Quantitative data was collected at the beginning and end of the intervention by pastoral teachers within the respective schools. These teachers were also involved in the delivery of the programme. Qualitative data was collected by the lead researcher.

Eleven young people self-selected to be part of the qualitative interviews. All three groups were represented with three participants from group 1 and group 2 respectively and five from group 3. Following a full briefing on confidentiality and their right to withdraw at the beginning and the end of the interviews all participants gave permission for their data to be used. There were three males and eight females, from Year 8 to Year 11. All interviews were conducted in English, held on school premises and were carried out, recorded and transcribed by the lead author. (See appendix 6 for a range of interview questions) .

### **INTERVENTION**

This feasibility study followed guidance laid out in the DBT-SA manual for targeted interventions (Mazza, Dexter-Mazza, Miller, Rathus & Murphy, 2016). This specifically relates to smaller class sizes (i.e. no more than 10-15 students), the opportunity for coaching of skills and targeting the pace of the intervention to participants' needs. This intervention was carried out once a week over eleven weeks with the group running for two hours with a break in the middle of each session. Groups were facilitated

by school-based counsellors and Pastoral Care Teachers. Weekly staff meetings were facilitated by a skilled DBT therapist from a local CAMHS service to allow for consultation, co-planning and information exchange.

The following topics were delivered in the programme; See *Figure2*

1 Orientation	Orientation to the four main areas of DBT
2 Dialectics	Opposites can both be true as parts of the larger whole
3 Mindfulness Wise mind	Wise mind is the synthesis of emotional mind and reasonable mind.
4 Mindfulness What skills	Observing, describing and participating as mindfulness skills
5 Mindfulness How skills	How to practice mindfulness that is non-judgemental, one mindfully and effective
6 Distress Tolerance- Introduction to Crisis Survival Skills	Introduction to skills for distress tolerance
7 Distress Tolerance- Self Sooth and improve the moment	Self sooth using the five senses and IMPROVE the current moment
8 Distress Tolerance- TIP Skills	Using temperature, paced breathing and intense exercise to reduce intense emotions quickly
9 Distress Tolerance- Pros and cons	Pros and cons of acting or not acting on urges
10 Distress Tolerance- Radical Acceptance	Radical acceptance of present situation
11 Mindfulness-Wise Mind	Increasing awareness of different “minds” i.e. wise mind, reasonable mind and emotional mind
12 Mindfulness- What and If skills	Observing, describing and participating mindfully
13 Emotional Regulation- Goals of emotional regulation	Understanding that emotions serve important functions
14 Emotional Regulation- Describing emotions	How to observe and describe emotions
15 Emotional Regulation-Check the facts and opposite action	Revising an initial interpretation to match the facts
16 Emotional Regulation-Problem solving	A seven-step problem solving process to manage painful emotions
17 Emotional Regulation- The A of ABC PLEASE	Accumulating positives
18 Emotional Regulation- The BC of ABC PLEASE	Building mastery and coping ahead with emotional situations
19 Interpersonal Effectiveness- Goals and overview	Developing skills in how to make effective requests or say no

20 Interpersonal Effectiveness- DEAR MAN skills	How to make an effective request or deal with a demand
21 Interpersonal Effectiveness- GIVE skills	How to maintain a relationship
22 Interpersonal Effectiveness- FAST skills	How to make a request or say no in order to maintain self-respect

*Figure 2*

## RESULTS

### Methods of analysis

### QUANTATITIVE ANALYSIS

Pre and post measures for all questionnaires were analysed and can be seen below (*figure3*). Further analysis of the two statistically significant results was carried out to ascertain mixed between-within models' analysis of variance and the correlation between the DERS AND SDQ (*figure 4*); (*figure 5*).

Power calculations were carried out post hoc which identified that the study was underpowered.

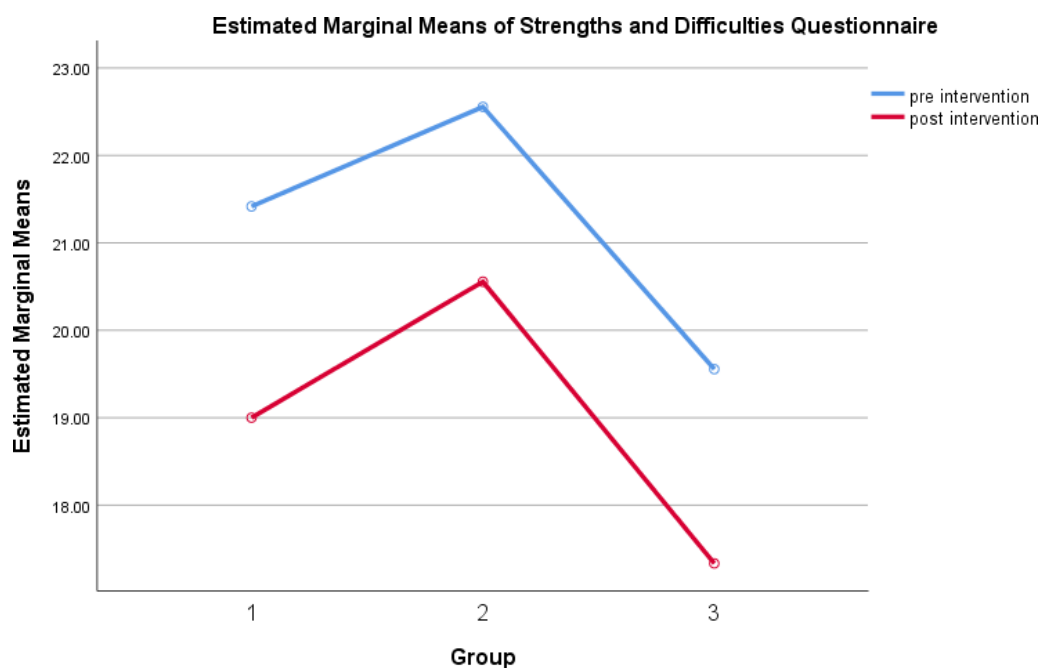
	N=	PRE MEAN(SD)	POST MEAN(SD)	p	EFFECT SIZE (COHEN'S D)
WEMWEBS	34	37.14 (7.8)	38.94 (10.1)	.279	0.19
SDQ	30	22.2 (5.2)	18.9 (4.7)	.016*	0.66
DERS	28	126.7 (26.5)	109.4 (30.7)	.017*	0.6
CAMM	33	17.69 (5.9)	19.03 (5.3)	.287	0.24
DBT-WCCL BLAME OTHERS	28	1.72 (0.71)	1.46 (0.72)	.106	0.36
DBT-WCCL GENERAL DYSFUNCTION	28	2.09 (0.46)	1.91 (0.47)	.12	0.38
DBT-WCCL SKILLS USE	28	1.57 (0.48)	1.69 (0.45)	.18	0.26

\*statistically significant at 95%

*Figure 3*

The results showed that there was no statistically significant change in overall general wellbeing using WEMWBS scale; on mindfulness using the CAMM measure and on DBT skills use and ways of coping using the DBT-WCCL. However, results from the SDQ and DERS indicate that the intervention did have a statistically significant impact with moderate effect sizes.

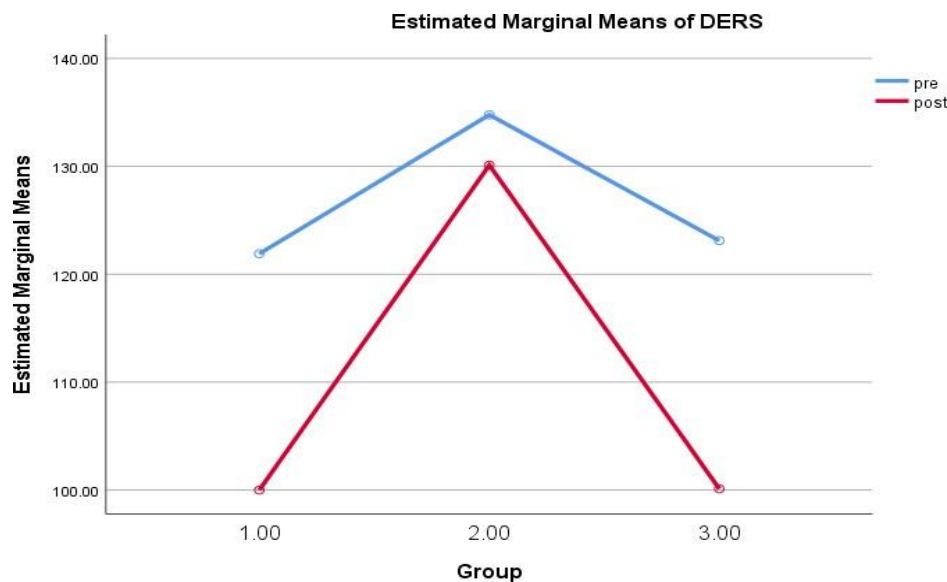
Further analysis was carried out on SDQ results using a mixed between-within models' analysis of variance (Pallant 2013). There was no significant interaction between group and outcome across all three groups, Wilks' Lambda=. 99,  $F(1,27)= .18$ ,  $p= .98$ . There was a minor main effect between pre and post measures with all three groups showing a reduction in SDQ scores over time, Wilks Lambda=.82,  $(F1,27)= 5.8$ ,  $p=.02$ , partial eta squared= .18 (fig2)



**Figure 4**

As the data was clustered into groups further analysis was carried out on DERS results using a mixed between-within models' analysis of variance (Pallant 2013). There was no

significant interaction between group and outcome across all three groups, Wilks' Lambda=.94,  $F(2,25)=.79$ ,  $p=.47$ . There was a moderate main effect between pre and post measures with all three groups showing a reduction in DERS scores over time, Wilks' Lambda=.25,  $(F(1,25)=5.8)$ ,  $p=.02$ , partial eta squared=.2. (fig3)



**Figure 5**

The relationship between changes in SDQ and changes in DERS was investigated using Pearson product-moment correlation co-efficient. Preliminary analysis was carried out to ensure no violations of the assumptions of normality, linearity and homoscedasticity. There was a strong positive correlation between the two measures,  $r=.57$ ,  $n=27$ ,  $p<.01$  with reductions in scores in the DERS associated with reductions in scores in the SDQ.

A one way between-groups analysis of variance was performed to investigate group differences in outcomes. Eight dependent variables were used; SDQ, CAMM, WEMWBS, WCCL (skills use, blame others and general dysfunction) and DERS. The independent variable was group. Preliminary assumption testing was conducted to check for normality, linearity, univariate and multivariate outliers, homogeneity of variance-co-variance matrices and multicollinearity, with no serious violations noted. There was no

statistically significant result between groups on the combined dependent variables  $f(14,34)=.638$ ,  $p=.814$ ; Wilks Lamda=.63; partial eta squared= .21.

## QUALITATIVE ANALYSIS

Thematic analysis was used to analyse the data and followed the process set out by Braun and Clarke (2013). All interviews were audio recorded and transcribed by the lead author. They were initially coded into broad themes and then interpreted. Guidelines set out by Leech and Onwuegbuzie (2011) and Elliott, Fischer and Rennie (1999) also influenced the analysis.

The qualitative analysis illustrated the participants interpretations of the impact of the group on their wellbeing, academic functioning and skills use. Feedback on how the group could be developed was also obtained.

Four superordinate themes and nine sub themes were identified :*Figure 6*

SUPERORDINATE THEMES	SUB THEMES
1. Impact of Group.	1. Functioning before group. 2. Functioning after group. 3. Benefits of being in a group.
2. Skills Development.	4. Skills use. 5. Where skills were used.
3 Impact on learning.	6. Academic performance. 7. Use of skills in academic settings.
4 Format.	8. Usefulness of group setting. 9. Areas for improvement.

*Figure 6*

## **IMPACT OF GROUP**

### Functioning before group

All participants showed a great deal of insight and understanding into their problematic behaviours which ranged from externalised displays of anger and relationship breakdown to internalised examples of significant anxiety and subsequent withdrawal from social settings. Behaviours were impacting on relationships with parents, friends, teachers and other pupils.

Participant A:

*Emm, my behaviour was really bad, and my emotions were out of control ...and then it went to cutting.*

Participant B:

*I wasn't doing my work ..... and just wasn't being a normal pupil.*

Participant F:

*I had a lot of emotional problems involving school, basically cos I get bullied I never used to be able to sleep that much and I would be awake tossing and turning..... having loads of thoughts about what might happen at school.*

Behaviours were present at school and home.

Participant H:

*It was mainly arguments, it was quite rough at home....there was almost violence.....*

Many of the participants expressed a real sense of anger about the behaviour of others and regret about their own inability to react in pro-social ways. All of the participants

expressed a sense of regret about their behaviour as well as frustration that they were unable to manage their behaviours in more helpful pro-social ways.

Participant J:

*It felt like I was in a storm and it was thrashing me around and I just couldn't get my place.*

### Functioning after the group

All participants reported positively on the impact of the group on their functioning and were able to identify several improvements in externalised and internalised behaviours. Examples were provided where they had recognised the impact of their own behaviour and how they had taken steps to modify it; often in the face of ongoing challenges.

Participant A:

*Say me and mum had an argument and we clashed and then say I think what could I do and then I say could I go a different day and she said yeah and it just takes you off a different path and its just better.*

Participant D:

*..... the bullying is still going on.....but I will just calm myself down and say don't argue. And I just keep saying it over and over in my head...*

Participants expressed relief about being able to manage situations more effectively and not respond to multiple stressors. They were unable to control the many, varied and at times distressing processes in a busy school, but they were able to manage their responses to external stimuli.



Participant F:

*It makes me feel happy about myself that I can actually do something it's almost like  
I've got this secret tool that I can use...it's like a superpower that I can use.*

Several of the participants spoke of the impact on their internal states and their capacity to become more integrated into other groups. This reinforced their sense of wellbeing.

Participant J:

*Probably without all the skills I learned in the DBT group I don't know if would have  
been able to carry on with the art group. I felt a lot better and my confidence went up  
and my self-esteem went up.*

There were also more subtle increases in functioning in the highly complex social situation of a school.

Participant H:

*And it's to know other people's emotions .....it's really helped me to get an insight into  
what each emotion looks like.*

The four young people who had disclosed that they self-harmed prior to the group explained that they had either stopped self-harming or the frequency of their self-harming had markedly reduced.

One participant felt that the group had only very limited impact on her functioning but was still able to articulate that things had not got worse.

Participant I:

*It [my ability to manage things] hasn't got better but it hasn't got worse like things  
usually do.*

### Benefits of being in a group

All spoke warmly about the group process and the chance to be in a small targeted group with a shared identity and belonging. Participants could try out skills in a smaller group which had implications for their functioning in other groups.

Participant I:

*as you.....it was almost like that was my safe space.*

*Knowing that you have somewhere to go where people are going through the same stuff*

Participant E:

*I made new friends. It's just helped me a lot*

Participant D:

*Being in the group situation has really helped me to start socialising. It's sort of given me that boost to go outside of the group and talk to people.*

This participant compared the group setting to individual therapy and how she found the group easier.

Participant C:

*It's not always just on you. It's nice to take the pressure away.*

### **SKILLS DEVELOPMENT**

#### Skills used and location of skills use

All participants were able to identify using one or more key DBT skills. Several of the participants identified complex social situations where they had used mindfulness techniques to manage distress and emotional arousal to facilitate learning.

Participant B:

*I use them [mindfulness techniques] when I am making music and I just sit in my chair and I focus on my body to stay calm and focus more. Like if I was in class and I wasn't paying attention I would do that, and I was able to do the work better.*

Participant I:

*I have been going to those places [previously avoided] and I feel like I am about to get panicky and then I pick up something really random and look at the detail on it and try to focus on that.*

Other participants were able to discuss using several techniques at one time when dealing with challenges of busy classes.

Participant H:

*I tend to use breathing techniques and things just to take my mind off of it so I'm not focussing on the teacher shouting...*

Participant J:

*Emm, when I start getting anxious I find the skill where you put your head in cold water just settled me down so much.....I don't always have an iced bucket with me so it's not so easy but I have a bottle of water and I freeze it and I can just splash it on during the day..... [I use it] most of the week as I sometimes get stressed and I use it to stop me having a full on anxiety attack.*

Others discussed using some of the more abstract DBT skills that require a greater level of cognitive awareness.

Participant C:

*Because you learn what the pros and cons are. We did loads of things and like  
dialectical thinking .....*

Several participants identified further cognitive skills such as the use of the concept of Wise Mind when problem solving.

Participant E:

*...if I fell out with one of my friends I would use wise mind and think about the situation  
before I take things further.*

Participant B:

*.....I just try and stay in that wise mind thing and not get wound up and try and see  
things from their side.*

This is an integral skill that requires a higher level of cognitive awareness and motivation to use. It would suggest that participants were both learning and using DBT specific skills to manage situations. Other participants did not name skills but described them.

Participant D:

*.....it was the self sooth things.....and the mindfulness exercises because I still use  
them.*

Participant B:

*Emm I don't know what it's called but I reckon it's just about how you talk to people  
and ask for things and stay calm and that.*

Participant C:

*I can't remember what it was called but you have to think and listen and say what you need to say to get heard without screaming or shouting.*

Participant H:

*The DBT really helped to divert around them [problems] and to come back to them later.*

All participants either named or described DBT-SA specific skills that they had used since their involvement with the group. They were able to recognise the usefulness and generalisability of these skills which in turn became a significant reinforcer of these behaviours.

## **IMPACT ON LEARNING**

### **Academic Performance**

DBT-SA skills impacted on learning with all but one of the participants identifying ways in which this occurred. Not only did this remove a barrier to learning but also reinforced further use of these skills.

Participant B:

*I used to get really stressed especially in maths because I am not very good at that but DBT had a good impact because I have not disrupted or messed about since I have been in the group.*

Participant D:

*Its good cos when I used to get upset I hardly do any work but I have done a lot more work than I used to.....I have been doing it so good I got this [produces a merit award].*

Others identified the usefulness of being in a group to help them prepare for the challenges of a learning environment by reducing emotional dysregulation to allow for further learning.

#### Use of skills in academic settings

Participant F:

*Yeah, it's helped me concentrate more cos I've spoken about everything that needed to be said and then it's like a weight off my shoulders.*

One participant reflected thoughtfully on how DBT-SA skills had not only aided his exam performance but also his self-efficacy.

Participant J:

*I did a resit for my English and before I just couldn't focus but this time I could sit there and if couldn't think of what to write I would move onto the next bit.*

### **FORMAT OF THE GROUP**

#### Format of the group and areas for improvement

There were mixed opinions about the group process secondary to the content. Some participants found the two-hour sessions useful whereas others would have preferred two one-hour sessions. Alternative venues such as outdoor classrooms were identified as an option by other participants.

Interestingly, none of the participants spoke about the programme being delivered in Welsh or English. It may be the case that as the interviews were carried out in English this was not addressed fully by the participants or the interviewer. It is therefore difficult

to establish the impact of the programme being delivered in the language that is predominantly used in each school.

## **DISCUSSION**

Within the DBT model, self-harm is seen as a manifestation of challenges in emotional regulation (Linehan, 1993) and avoidance of emotional states (Mikolajczak, Petrides, & Hurry, 2009). Although this study was not set up to specifically target self-harm, the increases in emotional regulation of participants and the reported cessation and reduction of self-harm by participants in the qualitative interviews, indicate that its impact on self-harm is a secondary benefit of this programme.

A statistically significant impact on general strengths and difficulties and emotional regulation in this group of young people is reported. However, the effect sizes for the SDQ and DERS were moderate and it did not have any impact on levels of mindfulness, general wellbeing and ways of coping. These effect sizes are consistent with other studies addressing anxiety and depression (Werner-Seidler et al., 2017). Participants were able to describe areas where their skills in emotional regulation were more effective as well as increasing their sense of self efficacy. However, Flynn, Joyce, Weihrauch & Corcoran (2018) established that DBT-SA, when delivered as a universal intervention, had a statistically significant effect on emotion symptoms and internalising problems with significant effect sizes (Cohen's  $d=0.65$  and  $0.83$  respectively).

CAMM examines a whole range of mindfulness skills, whereas participants mainly described shifting attentional bias to improve emotional regulation. It may be that young people needed further guidance and instruction in using more advanced mindfulness techniques that require greater meta-cognitive awareness and control. This contrasts with the findings from Chi, Bo, Liu, Zhang, & Chi, (2018) where effect sizes

were very positive when adolescents received the Mindfulness Based Stress Reduction programme (hedges  $g$  0.45-1.46) although this is a more extensive programme focused solely on the delivery of mindfulness-based skills.

According to the DBT-WCCL, there were no significant differences in the number of skills utilised which may be related to the high number of complex skills identified in this questionnaire (59). Results are consistent with the findings of Flynn et al (2018) in their study of the effectiveness of DBT when delivered to a whole class. It may be more appropriate to use a Goals Based Outcome (GBO) method for participants to focus on a small selection of the goals and skills they wish to increase. This could then be evaluated within a GBO to allow for a more personalised intervention (Law & Jacob, 2015).

Group facilitators were new to this intervention and the way in which it was delivered was novel. Due to time constraints, only the head of the counselling service had three-days training by the authors of the programme. Other facilitators had received one day of training and as this was a contrasting model to their usual therapeutic modality, further training in the delivery of this programme is warranted. The subjects involved are complex and the recommendation from standard DBT is that participants go through the group process twice to fully establish skills use and their generalisability. One of the groups was delivered in Welsh using English materials that were not translated. The groups were delivered by pastoral teachers and schools-based counselling staff. This has limited analysis of the efficacy of the programme when solely delivered by school staff or external staff. Other studies have highlighted the increased effectiveness of external staff (Werner-Seidler et al., 2017).



This intervention was a feasibility study and did not have a control group which poses significant challenges in evaluating the impact of the programme versus the effects of being in a well-supported group. However, the qualitative analysis highlighted a range of DBT skills that participants had used to manage distress. All participants were able to identify at least one DBT skill they had used which illustrated that participants were benefitting from the use of a specific DBT intervention and not just their inclusion in a group. An important factor in the sustainability of the group and the uptake by schools is the impact that it has on young people's learning. Although there was no independent verification, the positive impact on learning was highlighted by almost all students who were using DBT skills to manage complex classroom environments, relationships and learning demands. A significant strength of the study was the way in which young people were selected by school teachers and school-based counsellors. They presented with a variety of social and educational needs which is an appropriate reflection of young people within a mainstream school. The promising nature of this intervention is in line with other studies looking at the effectiveness of DBT in schools (Zapolski & Smith, 2017) and builds on previous evidence of the potential of DBT as a transdiagnostic intervention (Neacsiu, Eberle, Kramer, Wiesmann & Linehan, 2014).

## **LIMITATIONS**

There are several limitations of this study. As there was not a control group, this study is open to criticism that benefits gained were purely as a result of being in a group. The group itself was run over eleven weeks and as such it was a challenge to ensure that all key elements of the programme were delivered in a differentiated manner to all participants. Two skills were delivered each session which may have impacted on skills development. The participants in the qualitative analysis self-selected and were not chosen at random and may have been more likely to speak positively about the

programme. Several of the participants had been involved with Child and Adolescent Mental Health Services and counselling services in the past and a small number were still meeting school-based counsellors. It is therefore difficult to isolate which method of intervention was having the greatest impact on the participants. Due to the limited time allowed for the research project there were no follow up or long-term measures utilised. It is therefore unclear if the impact of this intervention will continue. The study was underpowered in terms of number of participants. All measures were self-report and this study would have benefitted from independent measures of progress.

## **CLINICAL SIGNIFICANCE**

This study has identified promising clinically significant results. In line with previous research carried out into DBT, DBT-SA has shown to be effective in increasing skills in emotional regulation. This is a key transdiagnostic skill that will both enhance wellbeing and lessen the risk of mental health problems developing in young people. From the qualitative analysis all participants identified skills they had used consistently to manage emotional dysregulation. This is important as it allows young people to regulation their emotional state and then utilise other DBT skills such as interpersonal effectiveness. From a clinical perspective, young people with more significant emotional regulation difficulties would gain most from this programme. Although, the level, type and frequency of self-harm was not included as an outcome variable young people who did describe self-harm all indicated that they no longer self-harmed. A potential use of this programme is to address the emotional regulation needs of young people when they first start to exhibit problematic self-harming behaviours. This would potentially avoid behaviours becoming entrenched and reinforced. A secondary impact of this programme was the impact on young people's capacity to access learning. Young people described utilising skills from DBT-SA that enabled them to cope with the myriad of challenges with school classrooms, exam pressures and informal times within the school day. The effectiveness of DBT-SA as a targeted intervention has been shown. This further strengthens the options of DBT-SA being used as both a targeted and universal intervention depending on the needs of the young people involved.

## **CONCLUSION**

In conclusion this feasibility study has illustrated the potential for a positive impact of the DBT Steps A programme when delivered by teachers and school-based counsellors on a targeted basis. The skills taught in DBT-SA are based on a pre-existing treatment modality and philosophy. This study has given further indications of the flexibility of a DBT approach in addressing the needs of a targeted group of young people and is in line with recommendations on tiered delivery of interventions (Fazel, Hoagwood, Stephen, & Ford, 2014). Other targeted programmes address a specific mental health need e.g. FRIENDS (Stallard et al., 2014). However, this iteration of DBT is aimed at groups of young people with complex needs to develop the intra and interpersonal skills for life. Further controlled studies and longer-term outcomes are required to fully assess the effectiveness of this intervention in the manner described above.

## REFERENCES

- Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019). Thematic analysis. *Handbook of Research Methods in Health Social Sciences*, 843-860.
- British Psychological Society. (2018). Code of Ethics (and Conduct). *The British Psychological Society*, (July).
- Calear, A. L., & Christensen, H. (2010). Systematic review of school-based prevention and early intervention programs for depression. *Journal of Adolescence*, 33(3), 429–438.
- Chi, X., Bo, A., Liu, T., Zhang, P., & Chi, I. (2018). Effects of mindfulness-based stress reduction on depression in adolescents and young adults: A systematic review and meta-analysis. *Frontiers in Psychology*, 9(JUN), 1–11.
- Clarke, A. M., Morreale, S., Field, C. A., Hussein, Y., & Barry, M. M. (2015). What works in enhancing social and emotional skills development during childhood and adolescence? A review of the evidence on the effectiveness of school-based and out-of-school programmes in the UK. *What Works in Enhancing Social and Emotional Skills Development during Childhood and Adolescence? A Review of the Evidence on the Effectiveness of School-Based and out-of-School Programmes in the UK*, (February), 1–237.
- Clarke, B. &. (2013). Using thematic analysis in psychology. *Journal of Chemical Information and Modeling*, 53(9), 1689–1699.
- Domitrovich, C. E., Durlak, J. A., Staley, K. C., & Weissberg, R. P. (2017). Social-Emotional competence: An essential factor for promoting positive adjustment and reducing risk in school children. *Child Development*, 88(2), 408–416.
- Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011).

The Impact of Enhancing Students' Social and Emotional Learning: A Meta-Analysis of School-Based Universal Interventions. *Child Development*, 82(1), 405–432.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British journal of clinical psychology*, 38(3), 215-229.

Fazel, M., Hoagwood, K., Stephan, S., & Ford, T. (2014). Mental health interventions in schools in high-income countries. *The Lancet Psychiatry*, 1(5), 377–387.

Flynn, D., Joyce, M., Weihrauch, M., & Corcoran, P. (2018). Innovations in Practice: Dialectical behaviour therapy–skills training for emotional problem solving for adolescents (DBT STEPS-A): evaluation of a pilot implementation in Irish post-primary schools. *Child and Adolescent Mental Health*, 23(4), 376-380.

Flynn, D., Joyce, M., Weihrauch, M., Corcoran, P., Gallagher, E., O'sullivan, C., & Hurley, P. (2018) *Dialectical Behaviour Therapy-Skills Training for Emotional Problem Solving for Adolescents (DBT STEPS-A): Pilot Implementation in an Irish Context*.

Ford, T., Parker, C., Salim, J., Goodman, R., Logan, S., & Henley, W. (2018). The relationship between exclusion from school and mental health: a secondary analysis of the British Child and Adolescent Mental Health Surveys 2004 and 2007. *Psychological medicine*, 48(4), 629-641.

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of psychopathology and behavioral assessment*, 26(1), 41-54.

- Greco, L. A., Baer, R. A., & Smith, G. T. (2011). Assessing mindfulness in children and adolescents: Development and validation of the child and adolescent mindfulness measure (CAMP). *Psychological assessment*, 23(3), 606.
- Goodman, R. (2001). Psychometric properties of the strengths and difficulties questionnaire. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40(11), 1337-1345
- Goodman, M. S., Madni, L. A., & Semple, R. J. (2017). Measuring Mindfulness in Youth: Review of Current Assessments, Challenges, and Future Directions. *Mindfulness*, 8(6), 1409–1420.
- Katz, C., Bolton, S. L., Katz, L. Y., Isaak, C., Tilston-Jones, T., & Sareen, J. (2013). A systematic review of school-based suicide prevention programs. *Depression and Anxiety*, 30(10), 1030–1045.
- Kersten, P., Czuba, K., McPherson, K., Dudley, M., Elder, H., Tauroa, R., & Vandal, A. (2016). A systematic review of evidence for the psychometric properties of the Strengths and Difficulties Questionnaire. *International Journal of Behavioral Development*, 40(1), 64–75.
- Law, D., & Jacob, J. (2015). *GOALS AND GOAL BASED OUTCOMES (GBOs) Some Useful Information Third Edition*. Retrieved from <https://www.corc.uk.net/media/1219/goalsandgbos-thirdedition.pdf>
- Linehan, M. (1993). *Skills training manual for treating borderline personality disorder* (Vol. 29). New York: Guilford Press.
- Leech, N. L., & Onwuegbuzie, A. J. (2011). Guidelines for Conducting and Reporting Mixed Research in the Field of Counseling and Beyond. *Journal of Counseling &*

*Development*, 88(1), 61–69.

MacPherson, H. A., Cheavens, J. S., & Fristad, M. A. (2013). Dialectical Behavior Therapy for Adolescents: Theory, Treatment Adaptations, and Empirical Outcomes. *Clinical Child and Family Psychology Review*, 16(1), 59–80.

Maheswaran, H., Weich, S., Powell, J., & Stewart-Brown, S. (2012). Evaluating the responsiveness of the Warwick Edinburgh Mental Well-Being Scale (WEMWBS): Group and individual level analysis. *Health and Quality of Life Outcomes*, 10(1), 1.

Mazza, J. J., Dexter-Mazza, E. T., Miller, A. L., Rathus, J. H., & Murphy, H. E. (2016). *DBT Skills in Schools: Skills Training for Emotional Problem Solving for Adolescents Dbt Steps-a*. Guilford Publications.

Medical Research Council "Do I need NHS REC Approval?" Retrieved from <http://www.hra-decisiontools.org.uk/ethics/>

Mental Health of Childen and Young People in England 2017 retrieved from <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017#key-facts>

Mehlum, L., Tørmoen, A. J., Ramberg, M., Haga, E., Diep, L. M., Laberg, S., Grøholt, B. (2014). Dialectical behavior therapy for adolescents with repeated suicidal and self-harming behavior: A randomized trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, 53(10), 1082–1091.

Mikolajczak, M., Petrides, K. V., & Hurry, J. (2009). Adolescents choosing self-harm as an emotion regulation strategy: The protective role of trait emotional intelligence. *British Journal of Clinical Psychology*, 48(2), 181-193.

- Miller, A. L., Rathus, J. H., & Linehan, M. M. (2015). DBT skills manual for adolescents. *New York: Guilford.*
- Morgan, C., Webb, R. T., Carr, M. J., Kontopantelis, E., Green, J., Chew-Graham, C. A., & Ashcroft, D. M. (2017). Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care. *bmj*, 359, j4351.
- Neacsiu, A. D., Rizvi, S. L., Vitaliano, P. P., Lynch, T. R., & Linehan, M. M. (2010). The dialectical behavior therapy ways of coping checklist: development and psychometric properties. *Journal of clinical psychology*, 66(6), 563-582.
- Neil, A. L., & Christensen, H. (2009). Efficacy and effectiveness of school-based prevention and early intervention programs for anxiety. *Clinical Psychology Review*, 29(3), 208–215.
- Nelson-Gray, R. O., Keane, S. P., Hurst, R. M., Mitchell, J. T., Warburton, J. B., Chok, J. T., & Cobb, A. R. (2006). A modified DBT skills training program for oppositional defiant adolescents: promising preliminary findings. *Behaviour Research and Therapy*, 44(12),
- Neumann, A., van Lier, P. A., Gratz, K. L., & Koot, H. M. (2010). Multidimensional assessment of emotion regulation difficulties in adolescents using the difficulties in emotion regulation scale. *Assessment*, 17(1), 138-149.
- Pallant, J. (2013). *SPSS survival manual*. McGraw-Hill Education (UK).
- Patalay, P., Fink, E., Fonagy, P., & Deighton, J. (2016). Unpacking the associations between heterogeneous externalising symptom development and academic attainment in middle childhood. *European child & adolescent psychiatry*, 25(5), 493-500.
- Patalay, P., Gondek, D., Moltrecht, B., Giese, L., Curtin, C., Stanković, M., & Savka, N.



- (2017). Mental health provision in schools: approaches and interventions in 10 European countries. *Global Mental Health*, 4.
- Paulus, F. W., Ohmann, S., & Popow, C. (2016). Practitioner Review: School-based interventions in child mental health. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 57(12), 1337–1359.
- Rathus, J. H., & Miller, A. L. (2003). Dialectical Behavior Therapy Adapted for Suicidal Adolescents. *Suicide and Life-Threatening Behavior*, 32(2), 146–157.
- Miller, A. L., Rathus, J. H., & Linehan, M. M. (2015). DBT skills manual for adolescents. *New York: Guilford*.
- Reddy, L. A., Newman, E., De Thomas, C. A., & Chun, V. (2009). Effectiveness of school-based prevention and intervention programs for children and adolescents with emotional disturbance: A meta-analysis. *Journal of School Psychology*, 47(2), 77–99.
- Ricard, R. J., Lerma, E., & Heard, C. C. C. (2013). Piloting a Dialectical Behavioral Therapy (DBT) Infused Skills Group in a Disciplinary Alternative Education Program (DAEP). *Journal for Specialists in Group Work*, 38(4), 285–306.
- Snell, T., Knapp, M., Healey, A., Guglani, S., Evans-Lacko, S., Fernandez, J. L., Ford, T. (2013). Economic impact of childhood psychiatric disorder on public sector services in Britain: Estimates from national survey data. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 54(9), 977–985.
- Stallard, P., & Buck, R. (2013). Preventing depression and promoting resilience: feasibility study of a school-based cognitive-behavioural intervention. *The British Journal of Psychiatry*, 202(s54), s18-s23.
- Stallard, P., Skryabina, E., Taylor, G., Phillips, R., Daniels, H., Anderson, R., & Simpson, N.

(2014). Classroom-based cognitive behaviour therapy (FRIENDS): A cluster randomised controlled trial to Prevent Anxiety in Children through Education in Schools (PACES). *The Lancet Psychiatry*, 1(3), 185–192.

Swales, M., Hibbs, R. A. B., Bryning, L., & Hastings, R. P. (2016). Health related quality of life for young people receiving dialectical behaviour therapy (DBT): a routine outcome-monitoring pilot. *SpringerPlus*, 5(1).

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): Development and UK validation. *Health and Quality of life Outcomes*, 5(1), 63.

Weare, K., & Nind, M. (2011). Mental health promotion and problem prevention in schools: what does the evidence say? *Health promotion international*, 26(suppl\_1), i29-i69.

Werner-Seidler, A., Perry, Y., Calear, A. L., Newby, J. M., & Christensen, H. (2017). School-based depression and anxiety prevention programs for young people: A systematic review and meta-analysis. *Clinical Psychology Review*, 51, 30–47.

Zapolski, T. C. B., & Smith, G. T. (2017). Pilot Study: Implementing a Brief DBT Skills Program in Schools to Reduce Health Risk Behaviors Among Early Adolescents. *Journal of School Nursing*, 33(3), 198–204.

## **Chapter 3 – Contributions to Theory and Clinical Practice**

### **Chapter 3 ABSTRACT– Contributions to Theory and Clinical Practice**

The current thesis has explored the feasibility of DBT- SA as a targeted intervention to a group of young people with moderate levels of psychological difficulties. This programme is aimed at the promotion of pro-social skills to prevent further mental health problems and high-risk behaviours. The systematic review looked at a specific risk factor for death by suicide i.e. the presence of suicide related imagery. Using an evidence-based model of suicide the findings of the research and review papers have been applied to this model as a means of understanding the impact of both sets of findings. This paper will discuss the implications of findings for future research, theory development, and clinical practice.

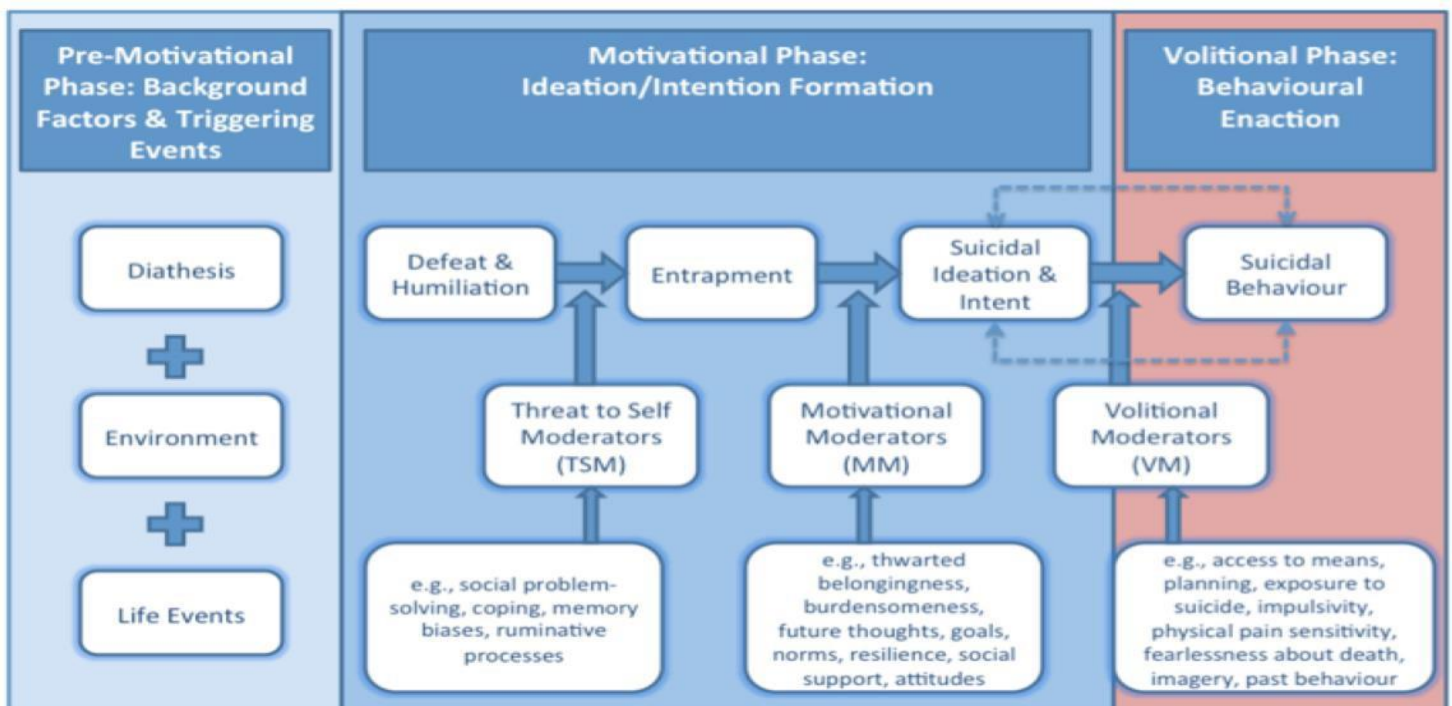
## **Introduction**

Suicide is a multi-faceted, idiosyncratic and highly complex behaviour that results from a myriad of systemic, individual, emotional and cognitive elements. This paper will investigate the implications for clinical practice, theory development and future research from the results of research into the DBT-SA programme and the findings of the systematic review into suicide imagery in this thesis. This will be done in the context of the Integrated Motivational-Volitional Model of Suicide Behaviour (IMV); (O'Connor 2011; O'Connor & Kirtley, 2018). The phases of the IMV model will be described and the strategies and skills learnt in DBT-SA will be reviewed. Consideration will be given as to how DBT-SA may provide useful tools for addressing those phases. The role and function of imagery and how it contributes to our understanding of the risks posed in each phase will be discussed. There is considerable crossover between DBT-SA and Imagery within the IMV model but for the sake of clarity for the reader, they will be reviewed separately.

Mehlum et al., (2014) established that adapted DBT for adolescents is an effective treatment for reducing suicidal ideation and behaviour and there is strong evidence of the effectiveness of standard DBT in reducing suicide risk (Linehan, 2006b). Although the DBT-SA programme was not specifically targeted at reducing suicide risk, there is some evidence that teaching skills, such as coping, problem solving, decision making, and cognitive skills may reduce risk and prevent the development of suicidal behaviour (Katz et al., 2013). This review paper will examine ways in which DBT-SA can be used to introduce skills to mitigate the risk of beginning a journey that may lead a person to die by suicide. The use of this intervention in this manner, is very much rooted in the field of early intervention and the development of skills to support positive mental health and effective behavioural strategies.

Imagery has recently been added to the 2018 iteration of the IMV model as a volitional factor due to its role in cognitive rehearsal for a life threatening behaviour (O'Connor & Kirtley, 2018). However, the systematic review carried out previously has indicated that imagery could be a factor in the pre-motivational, motivational and volitional phases and may represent a more complex function than suggested.

### **IMV Model**



*Figure 1; (O'Connor and Kirtley 2018)*

Recent research has increased the understanding of ideation to action models of suicide and has indicated that there are differences in the factors involved in the motivation to die by suicide compared to carrying out the act (Klonsky, Saffer, & Bryan, 2018). The IMV model builds on previous models that have attempted to further understand the transition from ideation to action.

The Interpersonal Theory of Suicide (ITS); (Joiner, 2005) is seen as the first iteration in this new generation of models. This model hypothesises that the combination of thwarted

belongingness and perceived burdensomeness leads to an increase in motivation to die by suicide. Thwarted belongingness comes about when a person's need to be connected or feel a sense of belonging is not met. Perceived burdensomeness is the state when a person believes they are a burden to others and that others would be better off if the person themselves was dead (Klonsky, Saffer, & Bryan, 2018a). This increased desire, when coupled with the acquired capability for suicide means that a person may move from thinking about suicide to carrying it out. Thwarted belongingness, perceived burdensomeness, entrapment and goal disengagement are identified as key factors in the development of suicidal ideation (Dhingra, Boduszek, & O'Connor, 2016). Entrapment is seen as the process where a person feels they have no chance of rescue or escape (O'Connor & Kirtley, 2018). Fearlessness about death, impulsivity and exposure to suicidal behaviour have also been identified as being present in people that take action to die by suicide (Dhingra, Boduszek, & O'Connor, 2015). The IMV is a tri-partite model that illustrates the bio-psychosocial context in which suicidal ideation and behaviour can manifest; the factors that increase motivation and the components that influence the move from ideation to action (*figure 1*).

### **DBT-Steps A, Imagery and the IMV model.**

According to the IMV model there are multiple areas that need to be addressed to prevent a person dying by suicide. These span the trajectory from background factors and triggering events to elements that increase motivation and processes that increase volition. To tackle death by suicide, all features in this trajectory may need to be dealt with as a person moves through this model. The scope of this review does not allow for a full examination of the many issues but will look at how DBT- SA skills can be utilised as an early intervention strategy and the role that imagery plays in each phase of the model.

## **IMV and DBT-SA**

### *Pre-motivational phase and DBT-SA*

The role of the diathesis-environment-life event triad is a key component in the development of risk factors for suicide. It is the relationship between these three elements that increase the risk of someone moving towards suicide ideation and volition in the IMV model. Young people at the age of the participants in the study may have a neuro-developmental vulnerability at a time when they are particularly influenced by their sense of self in relation to others (Hawton, Saunders, & O'Connor, 2012). The diathesis-environment model is an underpinning philosophy of the standard DBT model in adults, in that difficulties in emotional regulation stem from emotional vulnerabilities coming up against invalidating environments (Linehan, 1995). DBT-SA shares this same philosophy which influences the various therapeutic modalities in DBT i.e. personal therapy and group skills interventions. There is good evidence of the effectiveness of skills based groups to manage emotional dysregulation (Neacsiu, Eberle, Kramer, Wiesmann, & Linehan, 2014). Outcomes from the DBT-SA research in this thesis have illustrated the impact of the programme on emotional regulation as evidenced by the reduction in the DERS scores. Information gathered from the qualitative component of the research highlighted the complex and at times invalidating environment and relationships within schools for the young people involved. As a counterpoint, it highlighted the skills that DBT- SA provided to enhance their capacity to deal with these environments. Young people referred to having developed a “secret power” and special skills to deal with social and academic challenges. This group of young people are particularly vulnerable to pressures related to rejection by peers, substance use, gender and sexuality, transitions and individuation from parents (Mazza, Dexter-Mazza, Miller, Rathus & Murphy, 2016). However, the results from this feasibility study indicated that DBT- SA can increase skills



in emotional regulation and thus theoretically may prevent a young person commencing a clinical trajectory towards suicide.

#### *Motivational Phase and DBT- SA*

The IMV model has highlighted key factors that are seen as increasing motivation to die by suicide. Rumination and social problem solving are identified as risk factors in this process. The teaching of mindfulness skills is aimed at addressing brooding rumination whereby a young person may be spending excessive periods of time focusing on a negative interpretation of their future or harshly critical interpretation of their past. Although there was not a statistically significant result when mindfulness skills were assessed using a mindfulness measure, the use of basic mindfulness skills as a means of staying focused and being in the moment was discussed by participants during the qualitative interviews and examples of its effectiveness were frequently put forward. DBT-SA teaches *Interpersonal Effectiveness* skills that help participants be more effective in developing and improving relationships whilst maintaining self-respect as a goal is achieved. Balancing these three needs of self, relationships and goals is an integral component of this module and can increase a young person's capacity to be effective when faced with challenges in social situations. Coping is an additional factor within the IMV model and is seen as threat to self moderator and is related to social problem solving and feelings of entrapment (O'Connor & Kirtley, 2018). Increasing participants' capacity to cope with emotional situations is taught using the *Cope Ahead* skill. This involves role- play and in vivo practice to allow young people the opportunity to utilise a DBT skill and reduce the sense of being emotionally overwhelmed when dealing with complex social situations. A particularly moving example of this was given by a boy in the previous research when reflecting on his recent exam performance compared to his previous difficulties.

A key component in this area is the use of Radical Acceptance. This complex skill involves the acceptance of the present moment and one participant spoke about this skill when re-sitting school exams. People can feel trapped or entrapped when in a complex situation and their interpretation may be flawed. DBT- SA uses the skills of *Check the Facts* to match emotional response to the facts of a situation. Participants in the study described using elements of this skill to manage relationships. *Opposite action* is taught in DBT- SA as a means of changing an emotion by acting opposite to the emotion urge. Young people spoke about using this skill to attend extra-curricular groups that they had previously avoided.

#### *Secondary Motivational Factors and DBT- SA*

Thwarted belongingness and perceived burdensomeness are the main tenets of the Interpersonal Theory of Suicide and there is strong evidence for their role in motivation factors that lead to suicidal desire (Klonsky, Saffer, & Bryan, 2018b). Although it does not specifically address suicide risk, DBT-SA provides several lessons that aim to prevent this sense of thwarted belongingness and perceived burdensomeness. The lesson on *Check the Facts* specifically aims to increase skills in checking interpretations and revising initial interpretations to match the facts with a resulting change in emotion. Although the data analysis did not show an impact on overall skills use, participants in the qualitative analysis spoke frequently about how using skills had significantly improved their impression of themselves, their impact on their parents and their sense of belonging within the family. The qualitative research highlighted a secondary benefit of involvement in a group of this nature. Participants spoke very warmly about the sense of a shared identity and connectedness to other young people in the group and saw this as a significant positive impact compared to individual therapy or universal whole class interventions. Relationship effectiveness skills are also taught using the *Dear Man* device.

This allows young people to ensure their relationships are maintained whilst still being effective in gaining their objectives.

#### *Volitional Factors and DBT- SA*

Within this phase of the model there are specific factors that contribute to an increased risk of suicide. DBT- SA is not the indicated treatment in this phase of the model, although standard DBT does have a crisis management protocol in place. However, it is the development of skills from undergoing DBT-SA training that may prevent a young person having deficits that stop them taking protective action when in a suicidal crisis.

*Pros and cons* and *TIP* skills are key skills that young people can effectively deploy in this situation. *Pros and Cons* is aimed at increasing acceptance of reality and improving distress tolerance through evaluating the pros and cons of acting or not acting on urges. Young people in the qualitative analysis spoke about making the right choice about whether or not to use a previous problematic behaviour to manage a crisis. *TIP* skills are highly effective short-term interventions to manage acute distress. This involves learning strategies to lower high levels of emotional arousal and can help reduce impulsivity by activating the parasympathetic nervous system. Young people spoke about using cold water on their face and paced breathing exercises to reduce high levels of acute distress and ultimately decrease impulsivity.

#### **IMV and Imagery**

##### *Pre-motivational Phase and Imagery*

There is burgeoning evidence of the link between imagery and a wide variety of clinical disorders (Ji, Kavanagh, Holmes, MacLeod, & Di Simplicio, 2019). There is further evidence that for individuals with bi-polar disorder, images may play a causal role in their mood changes (O'Donnell, Di Simplicio, Brown, Holmes, & Burnett Heyes, 2018).

Within the field of cognition there is increasing re-interest in the states of hyperphantasia and aphantasia i.e. presence of vivid imagery or absence of imagery-based cognition. One potential hypothesis is that people who have vivid imagery may use mental imagery more frequently and it may be advisable for clinicians to establish the predominant cognitive style on an imagery continuum to further aid assessment and formulation (Extreme Imagination Conference, 2019). The predisposition to use imagery and the amplifying effect of imagery is very much related to the diathesis-environment- trigger events phase of the IMV model. Imagery can also be related to previous suicide attempts and is seen as increasing risk, particularly in people with borderline personality disorder (Schultebrasucks et al., 2019).

#### *Motivational Phase and Imagery*

Within the IMV model, ruminative processes are an important moderator in the defeat-entrapment relationship. Evidence put forward by (Selby, Anestis, & Joiner, 2007); (Chu et al., 2016) and (Chu, Rogers, Gai, & Joiner, 2018) has highlighted the role and function of violent daydreaming as a ruminative strategy that impacts on key risks for the movement through the IMV. It may be the case that a person's ruminative images are related to their interpretation of their circumstances and relationships and they may visualise factors repeatedly and in vivid detail. From a clinical perspective it is important that people are asked about the presentation, form, function and interpretation of imagery-based rumination to ensure that a full and thorough formulation can be created. A consistent theme throughout the research into imagery is that research participants have very rarely been asked about their suicide related images in clinical practice. However, when asked, images can often be very detailed, distressing and impactful. Chu et al., (2016) highlighted that imagery-based rumination and suicidal ideation may increase

memory encoding and retrieval difficulties with a corresponding drop in mood due to overgeneralised autobiographical memories.

### *Secondary Motivational Factors and Imagery*

Within the IMV model thwarted belongingness and perceived burdensomeness are identified as motivational moderators i.e. when someone feels they do not have any connection to others or perceive themselves as a burden to others, they may move towards the volitional phase. Chu et al., (2018) established there was a significant and positive relationship between violent daydreaming and thwarted belongingness, perceived burdensomeness and levels of suicidal ideation. These results could be interpreted as violent daydreaming instilling and reinforcing harsh and critical attitudes towards oneself and others; furthermore, increasing a sense of alienation from and to others which could increase the risk of death by suicide. Ruminative styles such as this are often not discussed in clinical practice. . It may be the case that people will only discuss the verbal cognitions they experience and unless specifically questioned, this area of risk may not be evaluated. Images that are seen as an escape from entrapment or related to defeat can increase suicidal ideation and subsequent risk (Ng et al., 2016).

### *Volitional Factors and Imagery*

In the IMV model, imagery is seen as increasing risk as it is hypothesised as a form of cognitive rehearsal. Although the systematic review carried out above has provided examples of other functions and meanings of images related to suicide, there is additional evidence for this rationale. The suggested process in this example is one where imagery is a rehearsal of the act of dying by suicide. In addition to this it is believed that more frequent and intense images can stimulate mechanisms of habituation to a behaviour, and reducing resistance to these behaviours (Holaday & Brausch, 2015). Flash forwards imagery increases the risk of a person in a crisis, to act on their urges to die by suicide.

This is hypothesised to increase the future cognitive availability of a particular act as a behavioural response. Comforting or positive images related to death following suicide may also reduce resistance to death by suicide (Crane et al., 2014). Images of suicide are seen as a mental rehearsal of a future action. For some who visualise the aftermath of suicide it can increase the likelihood of it being appraised as a positive option (Holaday & Brausch, 2015).

### **Research Implications**

Further research is required to fully understand the longitudinal impact of programmes such as DBT- SA as an intervention on suicide and suicidal ideation. However, by introducing these skills at both a universal and targeted level there is the potential of these programmes preventing a person moving through the different processes in the IMV model. The DBT-SA study was a feasibility study into its use as a targeted intervention and follows on from other research into the use of DBT as a universal intervention. This iteration of DBT-SA is an expensive intervention and further randomised controlled studies into the effectiveness of DBT-SA as a universal versus targeted intervention are required. Further research needs to look at what specific areas of DBT-SA are effective with young people with this sub tier 3 CAMHS cluster of difficulties. For example, is it more effective to focus on emotional regulation versus interpersonal effectiveness?

There needs to be further research into the addition of imagery into different parts of the IMV model and the ways in which imagery can increase risk in the different parts of this model. Eye movement dual tasks have been shown to be a promising intervention in the treatment of suicidal imagery (Van Bentum et al., 2017) as it is hypothesised that Eye Movement Desensitisation Reprocessing interventions can reduce the impact of suicide images in a person's prospective memory. However, the results from this intervention are yet to be published and it is not clear how effective this intervention will be.

## **Conclusion**

Skills based transdiagnostic programmes at the level of DBT-SA are not specific suicide management programmes. However, this review paper has examined the ways in which DBT-SA can be used to introduce skills where deficits or the absence of these skills can increase the risk of someone dying by suicide. Quantitative results have indicated the impact on emotional regulation. However, as importantly, the qualitative analysis has highlighted the very real way that DBT- SA has impacted positively on young people's lives.

In the absence of clear treatment protocols, there must be an increased understanding that imagery related to suicide is an idiosyncratic and nuanced process and clinicians need to be mindful of this when assessing, formulating, supporting, intervening and treating. DBT, as a school of interventions would benefit from adding skills to manage suicide imagery to its modalities. Ensuring that a specific understanding of the role, function and meaning of images at each stage of the IMV model will enhance risk management and treatment.

## **Reflections on the Process of Research**

Initial consideration of the systematic review and research paper in this thesis may seem to be coming from very different perspectives. However, they are two ends of a spectrum and continuum of care that both mirrors my career and ongoing professional passions. Although I have most recently worked in a Tier 3 specialist CAMHS team with high risk suicidal young people, my career in CAMHS started in 2000 when I started work in a community based, early intervention service in North Wales. This service was very much at the forefront of innovation and service delivery and many of the initiatives that are seen across Wales were brought to the area or were actively supported by this service e.g. PATHS (Greenberg, Kusche, Cook, & Quamma, 1995);

Incredible Years (Webster-Stratton, Jamila Reid, & Stoolmiller, 2008) and FRIENDS (Barrett, Farrell, Ollendick, & Dadds, 2010). Early intervention has remained a huge part of my career and was a significant driving force behind the exploration of DBT-SA as a transdiagnostic intervention that targeted young people who were at risk of developing mental health problems.

Researching this intervention was a fantastic experience and one that took me out of the field of practitioner to one of researcher. Transitioning between these roles was new to me and required a great deal of personal reflection to allow me to take an unbiased and objective perspective on a programme and intervention style that I had long identified with. On one very specific occasion I had to present my research proposal and co-deliver training to a group of practitioners who would be delivering the programme. On previous occasions I would have been the practitioner. I was now supporting others and recognised how anxiety provoking it was when relying on others to deliver the programme that was true to the manual in a timely manner. I was very aware of the urge to ensure that work was carried out in a way that would allow me to carry out this research. However, there were times when this potentially may not be the optimum method of intervention for the young people involved in the group. I had to take a very clear perspective that the intervention and the outcomes for the young people came first and my research came second. Performing the research role allowed me to take a step back and acknowledge that there were some positive outcomes from the programme but there were also significant areas for improvement in the intervention. Although this was an uncomfortable process, it was necessary and has allowed me to develop more effectively as a researcher.

Using a mixed methods approach was important for me as this holds both sides of the scientist-practitioner role that I attempt to embody. Understanding the experiences of the young people who had gone through this programme and how it affected the stories they



told about themselves was vital to the validity of the research but also to how I practice. Hearing the stories of the young people and the processes they had gone through to use DBT skills to live their lives in a different way was truly awe-inspiring and reminded me why early and targeted interventions are vital to a young person's development. I placed a significant emphasis on hearing and understanding the stories that young people told me. This has enhanced my research experience and the quality of the research as it has highlighted areas that were not identified through the quantitative element.

Whilst early intervention was a significant part of my early career in CAMHS, I have moved further towards working with more complex and high-risk young people, many of whom are suicidal. Carrying out a systematic review into suicide related imagery has allowed me to explore this issue even further. As I do not readily think in images I have been fascinated by people who do. I have spent a long time trying to find ways to gain a deeper understanding of what sense people make of images and the very significant impact they can have on people's lives. From my clinical practice and previous reading, I have been aware of the impact of imagery in relation to conditions such as OCD and the impact it has on the level of distress experienced by people. However, I have been unable to look at this in any great depth. Having the opportunity to examine imagery related to suicide and relating it to clinical assessments and interventions has been a huge privilege. Again, this reflects my passion to focus on clinical applications of research and how it can make me and other practitioners more effective in supporting high risk and complex young people and adults.

As I near the end of this long journey, I remain committed and passionate to early and targeted interventions that tackle mental health problems in their infancy as well as services for the children in "the missing middle" (Neagle et al., 2018). However, these services should be delivered in conjunction with specialist services to ensure that children,

young people and adults who are at the greatest risk of dying by suicide receive an optimum service. It is only by ensuring that we continue to provide this full spectrum of services that we will be able to meet the needs of all young people (T4CYP, 2016). However, ensuring that interventions meet the needs of all young people is not without its problems. A key challenge in this process is ensuring that the right young people get the right intervention at the right time. Universal interventions have many advantages in that they are non-stigmatising, can be delivered to large groups of people but do have lower effect sizes. Targeted groups can have larger effect sizes but there remains the challenge of ensuring the right young people are selected in a way that does not increase anxiety or reinforce problematic behaviours. However, there is always the possibility of young people being missed by any selection process. In retrospect, the selection process for this piece of research could have been enhanced by having clearer discussions with the local CAMHS team and identifying young people who had been referred but did not meet the threshold for this service. It may also be prudent to include young people who are starting to develop problematic emotional regulation behaviours e.g. self harm to increase their skills. Again, in retrospect, it is very clear that the involvement of the local CAMHS team would have been advantageous to the selection of young people, the delivery of the programme, the follow up of young people and increasing support and training for the school based counsellors. This has been a key learning point for me as a researcher and practitioner.

When this process has been challenging I have reminded myself that this research may have an impact on people's lives and how they are supported to recover. Keeping this to the forefront of my mind has enabled me to stay focused on the task when I have felt swamped by what felt like an impossible undertaking. Having the opportunity, time, support and ability to undertake a piece of original research has been a huge privilege and I will be forever in debt to the people throughout my career who have helped me get here.

## REFERENCES

- Barrett, P. M., Farrell, L. J., Ollendick, T. H., & Dadds, M. (2006). Long-term outcomes of an Australian universal prevention trial of anxiety and depression symptoms in children and youth: An evaluation of the Friends program. *Journal of Clinical Child and Adolescent Psychology, 35*(3), 403-411.
- Chu, C., Podlogar, M. C., Rogers, M. L., Buchman-Schmitt, J. M., Negley, J. H., & Joiner, T. E. (2016). Does Suicidal Ideation Influence Memory? A Study of the Role of Violent Daydreaming in the Relationship Between Suicidal Ideation and Everyday Memory. *Behavior Modification, 40*(5), 731–747.  
<https://doi.org/10.1177/0145445515625189>
- Chu, C., Rogers, M. L., Gai, A. R., & Joiner, T. E. (2018). Role of thwarted belongingness and perceived burdensomeness in the relationship between violent daydreaming and suicidal ideation in two adult samples. *Journal of Aggression, Conflict and Peace Research, 10*(1), 11–23. <https://doi.org/10.1108/JACPR-10-2016-0255>
- Crane, C., Barnhofer, T., Duggan, D. S., Eames, C., Hepburn, S., Shah, D., & Williams, J. M. G. (2014). Comfort from suicidal cognition in recurrently depressed patients. *Journal of Affective Disorders, 155*(1), 241–246.  
<https://doi.org/10.1016/j.jad.2013.11.006>
- Dhingra, K., Boduszek, D., & O'Connor, R. C. (2015). Differentiating suicide attempters from suicide ideators using the Integrated Motivational-Volitional model of suicidal behaviour. *Journal of Affective Disorders, 186*, 211–218.  
<https://doi.org/10.1016/j.jad.2015.07.007>
- Dhingra, K., Boduszek, D., & O'Connor, R. C. (2016). A structural test of the Integrated Motivational-Volitional model of suicidal behaviour. *Psychiatry Research,*

239, 169–178. <https://doi.org/10.1016/j.psychres.2016.03.023>

Greenberg, M. T., Kusche, C. A., Cook, E. T., & Quamma, J. P. (1995). Promoting emotional competence in school-aged children: The effects of the PATHS curriculum. *Development and Psychopathology*, 7(1), 117–136.  
<https://doi.org/10.1017/S0954579400006374>

Hawton, K., Saunders, K. E. A., & O'Connor, R. C. (2012). Self-harm and suicide in adolescents. *The Lancet*, 379(9834), 2373–2382. [https://doi.org/10.1016/S0140-6736\(12\)60322-5](https://doi.org/10.1016/S0140-6736(12)60322-5)

Holaday, T. C., & Brausch, A. M. (2015). Suicidal imagery, history of suicidality, and acquired capability in young adults. *Journal of Aggression, Conflict and Peace Research*, 7(3), 127–138. <https://doi.org/10.1108/jacpr-10-2014-0146>

Ji, J. L., Kavanagh, D. J., Holmes, E. A., MacLeod, C., & Di Simplicio, M. (2019). Mental imagery in psychiatry: conceptual & clinical implications. *CNS Spectrums*, 24(1), 114–126. <https://doi.org/10.1017/s1092852918001487>

Katz, C., Bolton, S. L., Katz, L. Y., Isaak, C., Tilston-Jones, T., & Sareen, J. (2013). A systematic review of school-based suicide prevention programs. *Depression and Anxiety*, 30(10), 1030–1045. <https://doi.org/10.1002/da.22114>

Klonsky, E. D., Saffer, B. Y., & Bryan, C. J. (2018a). Ideation-to-action theories of suicide: a conceptual and empirical update. *Current Opinion in Psychology*, 22, 38–43.  
<https://doi.org/10.1016/j.copsyc.2017.07.020>

Mehlum, L., Tørmoen, A. J., Ramberg, M., Haga, E., Diep, L. M., Laberg, S., ...

Grøholt, B. (2014). Dialectical behavior therapy for adolescents with repeated suicidal and self-harming behavior: A randomized trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, 53(10), 1082–1091.

<https://doi.org/10.1016/j.jaac.2014.07.003>

Neacsiu, A. D., Eberle, J. W., Kramer, R., Wiesmann, T., & Linehan, M. M. (2014). Dialectical behavior therapy skills for transdiagnostic emotion dysregulation: A pilot randomized controlled trial. *Behaviour Research and Therapy*, 59, 40–51.

<https://doi.org/10.1016/j.brat.2014.05.005>

Neagle, L., Brown, M., Griffiths, J., Millar, D., Reckless, M., David, H., ... Morgan, J. (2018). Mind over Matter: A report on the step change needed in emotional and mental health support for children and young people in Wales. *National Assembly for Wales*, (April). <https://doi.org/10.2307/29503852>

Ng, R. M. K., Di Simplicio, M., McManus, F., Kennerley, H., & Holmes, E. A. (2016). ‘Flash-forwards’ and suicidal ideation: A prospective investigation of mental imagery, entrapment and defeat in a cohort from the Hong Kong Mental Morbidity Survey. *Psychiatry Research*, 246(August), 453–460.

<https://doi.org/10.1016/j.psychres.2016.10.018>

O’Connor, R. C., & Kirtley, O. J. (2018). The integrated motivational-volitional model of suicidal behaviour. *Philosophical Transactions of the Royal Society B: Biological Sciences*, 373(1754), 295–298. <https://doi.org/10.1098/rstb.2017.0268>

O’Donnell, C., Di Simplicio, M., Brown, R., Holmes, E. A., & Burnett Heyes, S. (2018). The role of mental imagery in mood amplification: An investigation across subclinical features of bipolar disorders. *Cortex*, 105, 104–117.

<https://doi.org/10.1016/j.cortex.2017.08.010>

SchulteBraucks, K., Duesenberg, M., Simplicio, M. Di, Holmes, E. A., & Roepke, S. (2019). Suicidal Imagery in Borderline Personality Disorder and Major Depressive Disorder. *Journal of Personality Disorders*, 1–19.

[https://doi.org/10.1521/pedi\\_2019\\_33\\_406](https://doi.org/10.1521/pedi_2019_33_406)

Selby, E. A., Anestis, M. D., & Joiner, T. E. (2007). *Behavior Modification Emotion Dysregulation in Suicidality*. 867–879. <https://doi.org/10.1177/0145445507300874>

T4CYP, N. W. (2016). *Together for Children and Young People Nhs Wales Specialist Camhs Framework for Improvement*. Retrieved from

<http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=185&mid=326&fileid=652>

Van Bentum, J. S., Sijbrandij, M., Huibers, M. J. H., Huisman, A., Arntz, A., Holmes, E. A., & Kerkhof, A. J. F. M. (2017). Treatment of intrusive suicidal imagery using eye movements. *International Journal of Environmental Research and Public Health*, 14(7), 1–14. <https://doi.org/10.3390/ijerph14070714>

Webster-Stratton, C., Jamila Reid, M., & Stoolmiller, M. (2008). Preventing conduct problems and improving school readiness: Evaluation of the Incredible Years Teacher and Child Training Programs in high-risk schools. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 49(5), 471–488. <https://doi.org/10.1111/j.1469-7610.2007.01861.x>

## **Application for Ethical Approval**

**Project Title:** Evaluation of the DBT-Steps A (DBT-SA) programme when delivered by School based counsellors to a targeted population.

**Principal investigator:** Ramage, Graeme

**Other researchers:** Swales, Michaela

## Pre-screen Questions

### **Type of Project**

D.Clin.Psy

### **What is the broad area of research**

Clinical/Health

### **Funding body**

Internally Funded

### **Type of application (check all that apply)**

A new application that does not require sponsorship or scrutiny from an outside body?

### **Proposed methodology (check all that apply)**

Questionnaires and Interviews

### **Do you plan to include any of the following groups in your study?**

Children

Further details: This is a high school based, skills acquisition programme for young people who are over 14.

### **Does your project require use of any of the following facilities and, if so, has the protocol been reviewed by the appropriate expert/safety panel? If yes please complete Part 2:B**

### **If your research requires any of the following facilities MRI, TMS/ tCS, Neurology Panel, has the protocol been reviewed by the appropriate expert/safety panel?**

Not applicable (the research does not require special safety panel approval)

### **Connection to Psychology, (i.e. why Psychology should sponsor the question)**

Investigator is a student in Psychology (including the North Wales Clinical Psychology Programme)

### **Does the research involve NHS patients? (NB: If you are conducting research that requires NHS ethics approval make sure to consult the Psychology Guidelines as you may not need to complete all sections of the Psychology online application)**

No

Further details: This proposal has been reviewed by Dr Mike Jackson, Dr Michaela Swales and Dr Chris Saville. All are employed by the North Wales Clinical Psychology Programme. It has been assessed against the document provided by the National Ethics Research Service "Does my project require review by a Research Ethics Committee". With reference to guidance note 7: The participants in this proposal are identified through their involvement with an Education Department school based counselling service which is based in a mainstream school. This service is funded and managed by the Education Department of xxxx Council. These are not young people who will be identified due to being involved in Social Care. • It does not involve withdrawing standard care • The research does not involve NHS patients or service users • It is not a social care research project funded by The DoH • There is not a legal requirement for this research • Another ethics committee i.e. School of Psychology would review this

### **Has this proposal been reviewed by another Bangor University Ethics committee?**

No

### **NHS checklist. Does your study involve any of the following?**



## Part 1: Ethical Considerations

***Will you describe the main experimental procedures to participants in advance, so that they are informed about what to expect?***

Yes

***Will you tell participants that their participation is voluntary?***

Yes

***Will you obtain written consent for participation?***

Yes

Further details: Young people will be involved if they are viewed as Gillick Competent and can consent to their own treatment. Young people will be given the option of informing their legal guardian. If young people are Gillick competent and choose to not inform their legal guardian, this is acceptable. This is a standard procedure within the School based Counselling service who will be delivering the programme.

***If the research is observational, will you ask participants for their consent to being observed?***

N/A

***Will you tell participants that they may withdraw from the research at any time and for any reason?***

Yes

***With questionnaires, will you give participants the option of omitting questions they do not want to answer?***

Yes

***Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?***

Yes

***Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)?***

Yes

***Will your project involve deliberately misleading participants in any way?***

No

***Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort? If \*Yes\* , give details and state what you will tell them to do should they experience any problems (e.g., who they can contact for help)***

No

Further details: This is not expected but if young people do experience any distress they can seek support from their personal counsellor. Young people will continue to meet with their individual counsellor throughout the duration of the intervention. The School based counselling Service is able to access support via their external advisory board. The local CAMHS team is represented on this board.

***Is there any realistic risk of any participants experiencing discomfort or risk to health, subsequent illness or injury that might require medical or psychological treatment as a result of the procedures?***

No

Further details: This is always a risk when working with young people. However, as has been written above, young people will continue to meet with their individual counsellor. These individual counsellors have access to the local CAMHS team via the team's external consultation body.

***Does your project involve work with animals? If \*Yes\* please complete Part 2: B***

No

***Does your project involve payment to participants that differs from the normal rates? Is there significant concern that the level of payment you offer for this study will unduly influence participants to agree to procedures they may otherwise find unacceptable? If \*Yes\* please complete Part 2: B and explain in point 5 of the full protocol***

No

***If your study involves children under 18 years of age have you made adequate provision for child protection issues in your protocol?***

Yes

Further details: The intervention is being delivered by the xxxx School Counselling Service. They follow the Child Protection Procedures and Protocols of xxxxxxxx Local Authority.

***If your study involves people with learning difficulties have you made adequate provision to manage distress?***

No

***If your study involves participants covered by the Mental Capacity Act (i.e. adults over 16 years of age who lack the mental capacity to make specific decisions for themselves) do you have appropriate consent procedures in place? NB Some research involving participants who lack capacity will require review by an NHS REC. If you are unsure about whether this applies to your study, please contact the Ethics Administrator in the first instance***

No

***If your study involves patients have you made adequate provision to manage distress?***

N/A

***Does your study involve people in custody?***

No

***If your study involves participants recruited from one of the Neurology Patient Panels or the Psychiatry Patient Panel then has the protocol been reviewed by the appropriate expert/safety panel?***

N/A

***If your study includes physically vulnerable adults have you ensured that there will be a person trained in CPR and seizure management at hand at all times during testing?***

N/A

***Is there significant potential risk to investigator(s) of allegations being made against the investigator(s). (e.g., through work with vulnerable populations or context of research)? No***

Further details: This risk is not significant but any allegations of this nature would be investigated and managed through xxxxxxxx Council who employ the school based counsellors

***Is there significant potential risk to the institution in any way? (e.g., controversy or potential for misuse of research findings.)***

No

## **Part 3: Risk Assessment**

### ***Is there significant potential risk to participants of adverse effects?***

No

Further details: This group is an acquisition of skills group and is not a treatment group. It is focused on the development of distress tolerance, emotional regulation, interpersonal effectiveness and mindfulness. There are strict guidance within DBT about the explicit discussion of self harm. Participants are advised against this at every session. Any potential distress will be managed in session by one of the facilitators or will be managed in individual counselling sessions by the young person's individual counsellor.

### ***Is there significant potential risk to participants of distress?***

No

Further details: This group is an acquisition of skills group and is not a treatment group. It is focused on the development of distress tolerance, emotional regulation, interpersonal effectiveness and mindfulness. There are strict guidance within DBT about the explicit discussion of self harm. Participants are advised against this at every session. Any potential distress will be managed in session by one of the facilitators or will be managed in individual counselling sessions by the young person's individual counsellor.

### ***Is there significant potential risk to participants for persisting or subsequent illness or injury that might require medical or psychological treatment?***

No

Further details: There is always a risk when working with young people. However, this a group based skills acquisition programme and not a treatment group. As such, it is not envisaged that there is significant risk to young people.

### ***Is there significant potential risk to investigator(s) of violence or other harm to the investigator(s) (e.g., through work with particular populations or through context of research)?***

No

### ***Is there significant potential risk to other members of staff or students at the institution? (e.g., reception or other staff required to deal with violent or vulnerable populations.)***

No

### ***Does the research involve the investigator(s) working under any of the following conditions: alone; away from the School; after-hours; or on weekends?***

No

### ***Does the experimental procedure involve touching participants?***

No

### ***Does the research involve disabled participants or children visiting the School?***

No

## Declaration

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

Yes

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

Yes

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

Ye

## Part 2: B

### ***Brief background to the study***

Further details: DBT-SA has recently been developed (Mazza, Dexter-Mazza, Miller, Rathus and Murphy 2016). It is based on the principles of Dialectical Behavioural Therapy (DBT) (Linehan 1993, 2015a) and is a further development of this method of intervention. It shares the same emphasis on skills development as standard DBT with modules aimed at increasing emotional regulation, mindfulness, distress tolerance and interpersonal effectiveness. It is intended as an additional component within a school curriculum to promote social and emotional learning. Within this present proposal it is intended that the programme will be delivered to a targeted group of young people who are already receiving services from the School Counselling Service, within xxxx. The 30 session, skills based programme will be delivered over 15 weeks. It is hypothesised that there is a common underlying dysfunction in emotional regulation in the development of mental health problems. Because of these common precipitants in the development of mental health problems, and the innate flexibility of the core DBT philosophy, it is expected that DBT can be further adapted. This adaptation will yield significant benefits when it is utilised as a preventative intervention in young people, within a school environment. It is expected that this intervention will increase well-being in the targeted group by; increasing mindfulness, strengthening emotional regulation, enhancing interpersonal effectiveness, and improving distress tolerance. Development in these areas will improve mental health and lessen the risks of developing problematic behaviours to manage stress and distress. It is then expected that this group will be less likely to require more intensive and expensive services in the future. This proposal builds on ongoing research as it is a further adaptation of the DBT-SA programme. At present, there is ongoing research into the efficacy of DBT-SA when delivered by class teachers as a universal intervention. This study is designed that the DBT-SA programme will be delivered by school based counsellors to a targeted group of young people who are at increased risk of developing mental health problems

### ***The hypotheses***

Further details: • DBT-Steps A is an effective intervention in reducing emotional dysregulation and increasing distress tolerance and interpersonal skills in a targeted group of young people when delivered by a group of school based counsellors.

### ***Participants: recruitment methods, age, gender, exclusion/inclusion criteria***

Further details: It is intended that DBT Steps-A will be delivered to a targeted group of young people who are already involved with the school counselling service. This is a preventative programme and is NOT a treatment group. The young people would be invited to attend the programme within school time at their registered school. It would be targeted at young people who are below a Tier 3 CAMHS threshold but who would benefit from additional support. The programme would be delivered by school based counsellors. The young people are already involved with the school based counselling service and would continue to meet with their individual counsellor but less frequently. The aim of this is to ensure young people are generalising the teaching into their day to day lives. It also ensures continuity at the end of the programme. The young people will all be over 14, a mix of genders and be assessed as Gillick competent if they are consenting to their involvement without their parent's consent. These are young people who may be at risk of developing a mental health problem. They do not have an identified mental health problem and do not have a specific diagnosis. This intervention is aimed at skills acquisition and the development of strategies to prevent the onset of mental health problems.

### ***Research design***

Further details: • Firstly, a series of pre and post measures with young people. This will involve all young people in all groups if they have consented to this process. • Secondly, qualitative analysis of a sub group of young people to establish their experience of the group. This will take the form of a phenomenological qualitative analysis. It is expected that this will involve 6-8 young people who will be randomly selected to take part. They can choose to not participate or withdraw if required.

***Procedures employed***

Further details: DBT-SA has recently been developed (Mazza, Dexter-Mazza, Miller, Rathus and Murphy 2016). It is based on the principles of Dialectical Behavioural Therapy (DBT) (Linehan 1993, 2015a) and is a further development of this method of intervention. It shares the same emphasis on skills development as standard DBT with modules aimed at increasing emotional regulation, mindfulness, distress tolerance and interpersonal effectiveness. It is intended as an additional component within a school curriculum to promote social and emotional learning. There are several methods of delivery of the DBT-SA programme from universal to targeted. Within this present proposal it is intended that the programme will be delivered to a targeted group of young people who are already receiving services from the School Counselling Service, within xxxxxx. The 30 session, skills based programme will be delivered over 15 weeks. The programme will be delivered through the mediums of groupwork, discussion and worksheets.

***Measures employed***

Further details: DBT Ways of Coping Checklist (Neacsiu, Rizvi, Vitaliano, Lynch, Linehan 2010) a measure designed to assess the use of skills taught in DBT. • Difficulties in Emotion Regulation Scale (Gratz Roemer, 2004). 36-item, self-report questionnaire of emotional dysregulation that assesses the following areas; 1. Nonacceptance of emotional responses 2. Difficulties engaging in goal directed behaviour 3. Impulse control difficulties 4. Lack of emotional awareness 5. Limited access to emotion regulation strategies 6. Lack of emotional clarity. • Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997). The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire about 3-16 year olds. It looks at emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour. It also utilises an impact scale. • Child and Adolescent Mindfulness Measure (CAMM) (Baer, Greco Smith 2011). The CAMM is a 10 item questionnaire designed to assess mindfulness skills in youth over the age of 9 years; it assesses lack of awareness of ongoing activity and judgmental or avoidant responses to thoughts and feelings. • Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) (Tennant, Hiller, Fishwick, Platt, Joseph, Weich Stewart-Brown 2007) . The Warwick-Edinburgh Mental Well-being scale was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing.

***Qualifications of the investigators to use the measures (Where working with children or vulnerable adults, please include information on investigators' CRB disclosures here.)***

Further details: Graeme Ramage is a Trainee Clinical Psychologist who has worked as Specialist CAMHS Practitioner for the the last 17 years. He holds two undergraduate degrees and a Post Graduate Diploma in Cognitive Behavioural Therapy from University of Chester. He also holds a specialist Post Graduate Certificate in Child Protection from Dundee University. He is a CRB checked.

***Venue for investigation***

Further details: Three mainstream schools in xxxx.

***Estimated start date and duration of the study (N.B. If you know that the research is likely to continue for more than three years, please indicate this here).***

Further details: December 2017 - July 2017.

***Data analysis***

Further details: There are two sets of data. The first will comprise of pre and post intervention anonymized questionnaires. These will be stored securely and analysed using SPSS. Qualitative data will be stored on a secure Bangor University server and accessed by the lead researcher. This will be done within the university confines. This data will be analysed using an interpretative phenomenological analysis to fully understand the lived experiences of the young people's involvement in the group.

***Potential offence/distress to participants***

Further details: This is always a risk when working with young people. However, the group will be facilitated by two adults at all times. The young people will continue to meet with their individual counsellors for ongoing support. The content of the group is focused on skills acquisition and the philosophy of DBT ensures that any explicit discussion of self-harm is avoided.

***Procedures to ensure confidentiality and data protection***

Further details: Young people will be encouraged to inform parents of their involvement in this programme. However, a potential ethical difficulty will occur if a young person is involved with the School Counselling Service without their parent's knowledge. A young person can consent to their own treatment if they can prove they have the capacity to fully understand the implications of an intervention. All questionnaires will be allocated a code to ensure confidentiality. The school-based counsellors will comply with their code of confidentiality. The qualitative data analysis write-up will be fully anonymized and any identifying information will be removed.

***\*How consent is to be obtained (see BPS Guidelines and ensure consent forms are expressed bilingually where appropriate. The University has its own Welsh translations facilities on extension 2036)***

Further details: Consent will be obtained from the young person themselves if they are deemed to be Gillick Competent. Young people will be encouraged to seek additional consent from parents. However, if a participant is not deemed to be Gillick competent and does not wish for their parents to be informed then they will not be able to take part in this programme. This is a difficulty that the School-based counselling service faces and if this was the case they would not be involved in the school-based counselling service and would not be put forward for this programme.

***Information for participants (provide actual consent forms and information sheets) including if appropriate, the summary of the study that will appear on SONA to inform participants about the study. N.B. This should be a brief factual description of the study and what participants will be required to do.***

Further details: See supporting documents

***Approval of relevant professionals (e.g., GPs, Consultants, Teachers, parents etc.)***

Further details: The School-based counselling staff have been working in close contact with the schools concerned and the programme will be going ahead. It is planned that the lead researcher, Graeme Ramage, will meet with the school leadership to seek permission for this research to go ahead. This is not expected to cause any difficulties as the schools are already in agreement to the programme going ahead. However, if the school leadership team do not grant agreement for the research to go ahead this will not take place in that particular school.

***Payment to: participants, investigators, departments/institutions***

Further details: There will be no payment to the participants or schools concerned.

***Equipment required and its availability***

Further details: None required

***If students will be engaged in a project involving children, vulnerable adults, one of the neurology patient panels or the psychiatric patient panel, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)***

Further details: The staff delivering the programme are all employed as school-based counsellors by xxxx Schools Counselling Service. The lead researcher, Graeme Ramage, has a 28-year-long career in Health and Social Care. He is a qualified nurse, social worker, and has worked in specialist CAMHS for the last 17 years.

***If students will be engaged in a project involving use of MRI or TMS, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)***



Further details: N/A

***What arrangements are you making to give feedback to participants? The responsibility is yours to provide it, not participants' to request it.***

Further details: Participants will be given the option of attending group feedback session where the results of this research will be fed back. They will be given the option of receiving a written feedback sheet if they do not wish to attend a group feedback.

***Finally, check your proposal conforms to BPS Guidelines on Ethical Standards in research and sign the declaration. If you have any doubts about this, please outline them.***

## Part 4: Research Insurance

***Is the research to be conducted in the UK?***

Yes

***Is the research based solely upon the following methodologies? Psychological activity, Questionnaires, Measurements of physiological processes, Venepuncture, Collections of body secretions by non-invasive methods, The administration by mouth of foods or nutrients or variation of diet other than the administration of drugs or other food supplements***


Yes

Further details: Pre and post intervention standardised questionnaires and qualitative interviews.

***Research that is based solely upon certain typical methods or paradigms is less problematic from an insurance and risk perspective. Is your research based solely upon one or more of these methodologies? Standard behavioural methods such as questionnaires or interviews, computer-based reaction time measures, standardised tests, eye-tracking, picture-pointing, etc; Measurements of physiological processes such as EEG, MEG, MRI, EMG, heart-rate, GSR (not TMS or tCS as they involve more than simple 'measurement' ); Collections of body secretions by non-invasive methods, venepuncture (taking of a blood sample), or asking participants to consume foods and/or nutrients (not including the use of drugs or other food supplements or caffeine).***

Yes

Further details: Pre and post intervention standardised questionnaires and qualitative interviews.


ethics@bangor.ac.uk

Graeme Ramage

10/07/2018

Ethical approval granted for 2017-16146-A14315 Amendment to to Evaluation of the DBT-Steps A (DBT-SA) programme when delivered by School based counsellors to a t...

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Dear Graeme,

2017-16146-A14315 Amendment to to Evaluation of the DBT-Steps A (DBT-SA) programme when delivered by School based counsellors to a targeted population.

Your research proposal number 2017-16146-A14315 has been reviewed by the Psychology Ethics and Research Committee and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and supporting documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

## What is STEPS-A?

STEPS-A is a programme delivered in school settings to teach young people skills to improve their coping strategies. Specifically, it aims to help your son/daughter to develop skills to manage their emotions in healthy ways and build their resilience. STEPS-A was developed and tested by school psychologists in the U.S.A.

## What do the skills help with?

Skills that are taught in the programme relate to four main topics:

- ◆ Regulation of emotions
- ◆ First aid stress management
- ◆ Interpersonal skills
- ◆ Mindfulness.

These skills help to prevent unhelpful coping mechanisms (e.g. deliberate self-harm, substance abuse etc) and can be used by young people in the following contexts:

- ◆ Academic pressure
- ◆ Alcohol and drug use
- ◆ Relationships (peers, family & romantic)
- ◆ Deliberate self-harming behaviour
- ◆ Suicidal behaviour
- ◆ Bullying
- ◆ Antisocial behaviour

## How is it relevant to your son/daughter?

Research and health professionals have identified the increasing need for more effective emotion regulation and problem-solving skills in British adolescents. School stress has been identified as a major trigger for adolescents to engage in unhelpful and sometimes harmful coping mechanisms.

## Why your son/daughter?

Your son or daughter is involved with the school School based counselling service .

- ◆ This group will support the work of the school based counsellors
- ◆ This will increase the capacity of young people to cope with the demands of school
- ◆ This will help young people be fully engaged with the school curriculum and community

## Why is STEPS-A being implemented in your School?

Mainstream schools provide the most appropriate setting to promote mental health and teach skills to a universal adolescent population. Furthermore, it has been suggested that adolescents are more likely to engage in harmful coping mechanisms when they know someone who already engages in these behaviours. Therefore, schools play an important role in teaching skills to prevent the development of those ineffective behaviours and strengthen student resilience.

This unique opportunity has been provided to your school based on their interest in health promotion. The programme will be evaluated to explore if you, your son/daughter and your school found the programme beneficial, before potentially making it available nationally.

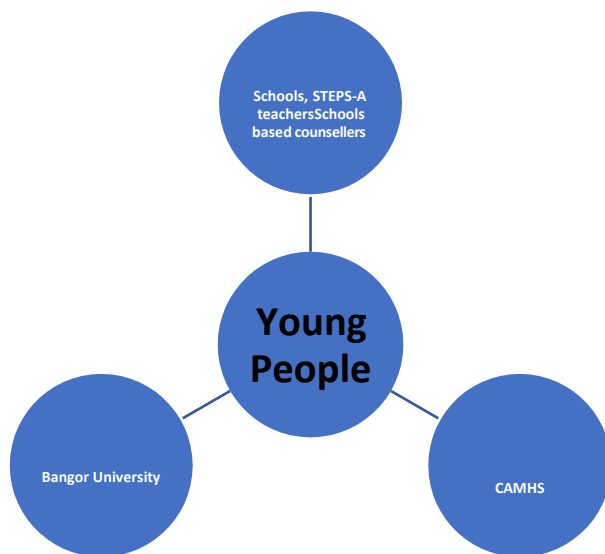
For more information regarding the evaluation of the programme, please refer to the enclosed research information leaflet.

### How will STEPS-A be taught in the school?

The programme material is taught by school based Counsellors from xxxx School Counselling Service

The counsellors have been trained in the delivery of the STEPS-A programme and are part of a STEPS-A network team that supports and consults regularly.

Members of this team include other educational and health professionals who are already involved in school such as those from CAMHS. Therefore, the team can provide extra support to a student if necessary. Bangor University will also be involved with the school during this time.



As part of the weekly classes, your child will be asked to do some homework and practice the skills, so that they will be able to use these skills in their daily lives

### How will you be involved

We have to balance off the need for confidentiality for young people and ensuring parents are involved. We would encourage you to discuss any concerns with the school-based counselling service

**If you have any questions or concerns please contact your son's/daughter's school based counsellor or the head of the school based counselling service:**

XXXX

Clinical Lead

Ffon / Tel:  
01824708064

e-bost/e-mail:  
[dan.trevor@xxxx.gov.uk](mailto:dan.trevor@xxxx.gov.uk)

**In the case of any complaints concerning the conduct of research, these should be addressed to School Manager, Hefin Lewis, School of Psychology, Brigantia Building, Bangor University, Gwynedd, LL57 2AS.**

## Skills Training for Emotional Problem Solving for Adolescents (STEPS-A)




**Information for Parents/Guardians**

## What is STEPS-A?

STEPS-A is a programme for secondary school pupils that aims to teach you life skills for improving your coping strategies. Specifically, it aims to equip you with skills for managing your emotions in healthy ways and to increase your resilience for when you have to cope with stressful situations. STEPS-A was developed by school psychologists in the U.S.A.

## What skills will be taught?

The STEPS-A curriculum is divided into four main Modules called Mindfulness, Distress Tolerance, Emotion Regulation and Interpersonal Effectiveness. This is a picture of the specific skills taught in each module.

Distress Tolerance	Emotion Regulation	Interpersonal Effectiveness
<ul style="list-style-type: none"><li>• Making distress bearable</li><li>• Pros&amp;Cons</li><li>• Radical Acceptance</li><li>• Self-soothe</li><li>• Block impulsivity</li></ul>	<ul style="list-style-type: none"><li>• Identify Emotions and functions</li><li>• Describe Emotions</li><li>• Increasing and decreasing emotions</li></ul>	<ul style="list-style-type: none"><li>• Effectively asking or saying no</li><li>• Maintaining relationships and self - respect</li><li>• Evaluating Options</li></ul>
		
Increasing self-awareness, becoming less judgemental, gaining control of attention.		

## What do the skills help with?

All teenagers struggle with life stress. For example:

- ◆ Coping with academic demands
- ◆ Peer pressure around drug and alcohol use
- ◆ Managing relationships/ friendships/ bullying
- ◆ Dealing with suicidal thinking and behaviours.

The STEPS-A programme taught in schools specifically targets these stressful issues for teenagers. By participating in STEPS-A, you will learn new helpful coping strategies to deal with these stressors.

## How will these skills be taught?

The school based counsellors in your school have been trained to deliver this programme to help you get the most out of school. You will be asked to practice the skills outside of the classroom. You will also be asked to record which skills you tried to use and whether or not you found using the skills helpful.

## Why you and your school?

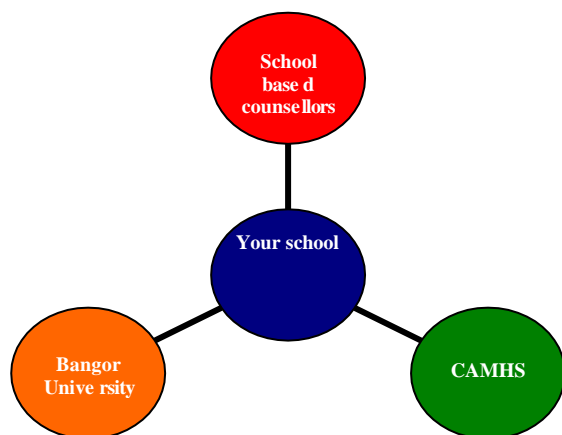
Your school is offering STEPS-A this year as part of a collaboration between your school and your school counsellors.

Your school came forward in wanting to be selected to be part of the STEPS-A initiative based on their past efforts to support their students, especially with regards to positive mental health.

You and your school are pioneers in this first roll out of STEPS-A in the UK. Your feedback, through completion of questionnaires, will help to shape the implementation of STEPS-A across secondary schools in the UK and as part of the curriculum in the future.

## Who is involved in the STEPS-A initiative?

Promoting positive mental health in schools is the most effective if several agencies work together to create a support network. Below is a picture of the key stakeholders in the STEPS-A project. Your STEPS-A counsellor is part of a STEPS-A network. He/she is supported and works closely with other professionals, also trained in the STEPS-A approach. This means that if you and other pupils taking part in the STEPS-A classes need further support, your STEPS-A counsellor is able to link with other members of the STEPS-A team (e.g. Clinical Psychologists at CAMHS). Members of staff from Bangor University will also be involved in the research element of this initiative as this is the first of it's kind to be done in the UK and will form part of a research project for one of the STEPS-A team members.



## Will I have to talk about things I don't want to talk about?

No, you don't have to talk about things you don't want to talk about. It is important to keep in mind that STEPS-A classes are similar to your other classes where you learn new things. Therefore, attending a STEPS-A class does not mean you will be forced to talk about personal difficulties. It does provide an opportunity for you and your friends to learn new skills. It encourages you to try those new skills in non-stressful situations, like the STEPS-A classroom, so that you feel more comfortable using them in situations where you experience high amounts of stress.

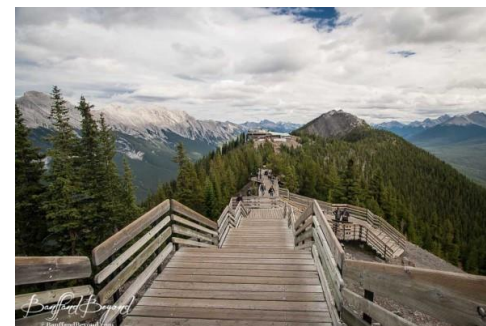
## Will your parents/ guardians be involved in any way?

We would like to get permission from your parents but if you are able to show that you understand what the programme is about then you don't need to tell your parents.

We would really like you to speak to your parents about this programme but we understand if you don't want to.

**If you have any questions or concerns, please contact your school based counsellor.**

## Skills Training for Emotional Problem Solving for Adolescents (STEPS-A)



### Information for Teens

## Beth yw STEPS-A?

Mae rhaglen STEPS-A yn cael ei chyflwyno yn yr ysgol i ddysgu sgiliau i bobl ifanc a wnaiff eu helpu nhw ymdopi. Yn benodol, mae'n ceisio helpu eich mab merch ddatblygu sgiliau i reoli eu hemosiynau mewn ffyrdd iach a'u gwneud nhw'n fwy gwydn. Datblygwyd a phrofwyd STEPS-A gan seicolegwyr ysgol yn Unol Daleithiau America.

## Beth mae'r sgiliau yn eu helpu?

Mae sgiliau a ddysgir yn y rhaglen yn ymwneud â phedwar o brif destunau:

- ◆ Rheoli emosiynau
- ◆ Cymorth cyntaf rheoli straen
- ◆ Sgiliau rhyngpersonol
- ◆ Ymwybyddiaeth ofalgar.

Mae'r sgiliau yma'n helpu o ran peidio â throï at ddulliau annifyr o ymdopi (e.e. hunan-niweidio, bwriadol cam-ddefnyddio sylweddau ac ati) a gall y pobl ifanc eu defnyddio yn y cyd-destunau canlynol:

- ◆ Pwysau academiaidd
- ◆ Alcohol a chyffuriau
- ◆ Perthnasoedd (cyfoedion, teulu a chariadon)
- ◆ Ymddygiad hunan-niweidiol bwriadol
- ◆ Ymddygiad sy'n gysylltiedig â hunan-laddiad

## Sut mae'n berthnasol i'ch mab/merch?

Mae ymchwil a gweithwyr ieuchyd proffesiynol wedi nodi'r angen cynyddol am well sgiliau i reoli emosiynau a datrys problemau ymhlith glasoed Prydain. Gwelwn fod straen yr ysgol yn aml yn peri i bobl ifanc yn eu harddegau droi at ddulliau ymdopi sy'n ddi-fudd ac weithiau'n niweidiol.

## Pam eich mab/merch?

Mae eich mab neu ferch yn ymwneud â gwasanaeth cwnsela'r ysgol.

- ◆ Bydd y grŵp hwn yn cefnogi gwaith cwnselwyr yr ysgol
- ◆ Mi wnaiff hyn helpu pobl ifanc ymdopi â phwysau'r ysgol
- ◆ Mi wnaiff helpu pobl ifanc ymwneud â chwricwlwm yr ysgol a'r gymuned

## Pam mae rhaglen STEPS-A yn cael ei gweithredu yn eich ysgol?

Ysgolion y brif ffrwd yw'r llefydd gorau i hyrwyddo ieuchyd meddwl a dysgu sgiliau i'r glasoed i gyd. Hefyd, gwelwn fod pobl ifanc yn fwy tebygol o droi at ddulliau ymdopi niweidiol os ydynt yn adnabod rhywun arall sy'n gwneud hynny. Felly, mae'n bwysig bod yr ysgolion yn dysgu sgiliau i atal hynny rhag digwydd a gwneud y myfyrwyr yn fwy gwydn.

Mae'ch ysgol yn cael cynnig y cyfle gwyh yma oherwydd ei diddordeb mewn hybu ieuchyd

Caiff y rhaglen ei gwerthuso a'i harchwilio i weld a fu'n fanteisiol i'ch mab/merch a'r ysgol cyn ei chyflwyno, o bosib, yn genedlaethol.

Cewch ragor o wybodaeth ynghylch gwerthuso'r rhaglen ar daflen wybodaeth yr ymchwil.

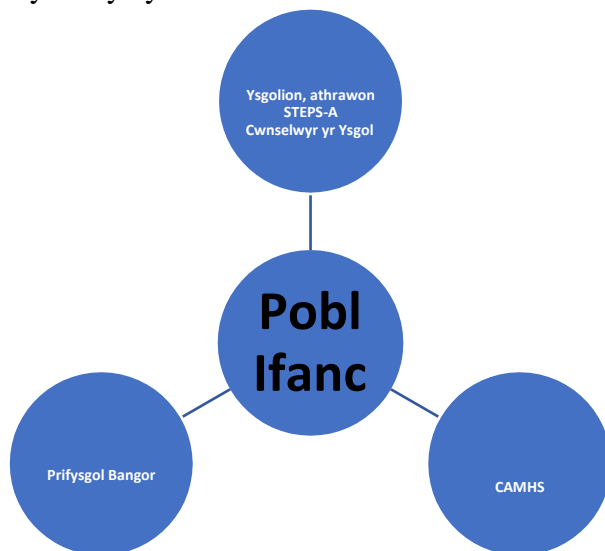


## Sut caiff STEPS-A ei ddysgu yr ysgol?

Caiff deunyddiau'r rhaglen eu dysgu gan Gwnselwyr Gwasanaeth Cwnsela Ysgolion Sir Ddinbych

Mae'r cwnselwyr wedi cael eu hyfforddi i gyflwyno Rhaglen STEPS-A ac yn rhan o dîm rhwydwaith STEPS-A sy'n cefnogi ac yn ymgynghori'n rheolaidd.

Mae aelodau'r tîm yn cynnwys gweithwyr proffesiynol eraill o faes addysg ac iechyd sydd eisoes yn ymwneud â'r ysgolion megis CAMHS. Felly, gall y tîm roi cefnogaeth ychwanegol i fyfyrwr os bydd angen. Bydd Prifysgol Bangor hefyd yn ymwneud â'r ysgol yn ystod y cyfnod hwn.



Fel rhan o'r dosbarthiadau wythnosol, gofynnwn i'ch plentyn wneud rhywfaint o waith cartref ac ymarfer y sgiliau, fel y bydd yn gallu defnyddio'r sgiliau mewn bywyd bob dydd

## Beth fydd eich rhan chi?

Rhaid i ni ystyried angen y bobl ifanc am gyfrinachedd a sicrhau rhan y rhieni. Byddem yn eich annog i drafod unrhyw bryderon gyda gwasanaeth cwnsela'r ysgol

**Os oes gennych unrhyw gwestiynau neu bryderon, cysylltwch â chwnselydd ysgol eich mab/merch neu bennaeth gwasanaeth cwnsela'r ysgol:**

Dan Trevor

Arweinydd Clinigol

Ffon / Tel: 01824708064

e-b ost / e-mail: [dan.trevor@xxxx.gov.uk](mailto:dan.trevor@xxxx.gov.uk)

**Anfonwch unrhyw gwynion ynglŷn â'r ffordd y cynhelir yr ymchwil at Reolwr yr Ysgol, Mr Hefin Lewis, Yr Ysgol Seicoleg, Adeilad Brigantia Prifysgol Bangor, Gwynedd, LL57 2AS.**

## Rhaglen STEPS-A (Hyfforddiant Sgiliau ar gyfer Datrys Problemau Emosiynol y Glasoed)



**Gwybodaeth i  
Rieni/Gwarcheidwaid**

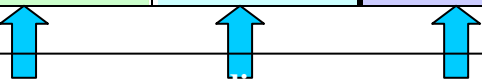
## Beth yw STEPS-A?

Rhaglen ar gyfer disgyblion ysgolion uwchradd yw STEPS-A sy'n ceisio dysgu sgiliau bywyd i chi fedru ymdopi'n well. Yn benodol, mae'n ceisio rhoi sgiliau i chi ar gyfer rheoli eich emosiynau mewn ffyrdd iach a'ch gwneud chi'n fwy gwydn ar gyfer yr adegau hynny y byddwch o dan straen. Datblygwyd STEPS-A gan seicolegwyr ysgol yn Unol Daleithiau America.

## Pa sgiliau fydd yn cael eu dysgu?

Mae pedwar o brif fodiwlau i gwricwlwm STEPS-A sef Ymwybyddiaeth Ofalgar, Goddef Gofid, Rheoli Emosiynau ac Effeithiolrwydd Rhyngpersonol. Dyma ddarlun o'r sgiliau penodol a ddysgir ym mhob modiwl.

Goddef Trallod	Rheoli Emosiynau	Effeithiolrwydd Rhyngpersonol
<ul style="list-style-type: none"> <li>Gallu dioddef gofid</li> <li>Manteision ac anfanteision</li> <li>Derbyn Radical</li> <li>Hunan-leddfu</li> <li>Peidio â bod yn fyrbrwyll</li> </ul>	<ul style="list-style-type: none"> <li>Adnabod Emosiynau a swydd ogaethau</li> <li>Disgrifio Emosiynau</li> <li>Cynyddu a lleihau emosiynau</li> </ul>	<ul style="list-style-type: none"> <li>Gofyn neu ddweud na yn effeithiol</li> <li>Cynnal perthnasoedd a hunan-barch</li> <li>Cloriannu dewisiadau</li> </ul>



Codi hunan-ymwybyddiaeth, bod yn llai beirniadol, ennill rheolaeth dros eich sylw.

## Beth mae'r sgiliau yn eu helpu?

Mae pawb yn ei ardegau'n cael trafferth gyda straen bywyd. Er enghraifft:

- ◆ Ymdopi â'r pwysau academiaidd
- ◆ Pwysau gan gyfoedion i ddefnyddio cyffuriau ac alcohol
- ◆ Rheoli perthnasoedd / cyfeillgarwch / bwlio
- ◆ Delio â meddyliau ac ymddygiad sy'n ymwneud â hunan-laddiad.

Mae'r Rhaglen STEPS-A a ddysgir yn yr ysgol yn mynd ati'n benodol i dargedu'r materion anodd yma sy'n poeni pobl ifanc yn eu harddegau. Trwy gymryd rhan yn STEPS-A, mi wnewch chi ddysgu ffyrdd newydd o ymdopi â'r pethau sy'n achosi'r straen.

## Sut caiff y sgiliau hyn eu dysgu?

Mae cwnselwyr yr ysgol wedi cael eu hyfforddi i gyflwyno'r rhaglen hon i'ch helpu chi wneud yn fawr o'r ysgol Gofynnwn i chi ymarfer y sgiliau y tu allan i'r ystafell ddosbarth. Gofynnwn i chi hefyd gofnodi pa sgiliau wnaethoch chi geisio'u defnyddio ac a fu'r sgiliau'n ddefnyddiol i chi.

## Pam chi a'ch ysgol chi?

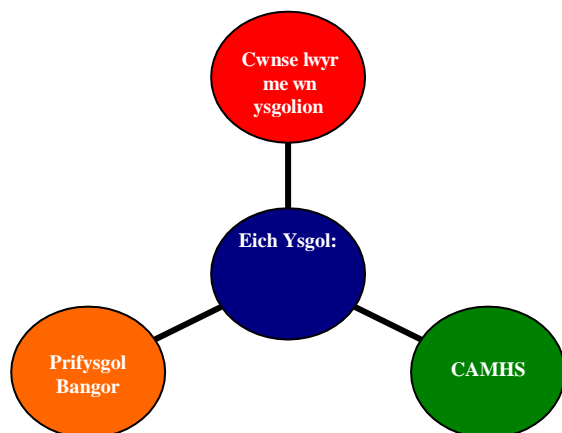
Mae eich ysgol chi'n cynnig STEPS-A eleni ar y cyd â'ch ysgol chi a chwnselwyr yr ysgol.

Cynigiodd eich ysgol gymryd rhan ym menter STEPS-A yn seiliedig ar eu hymdrechion yn y gorffennol yn cefnogi eu myfyrwyr, yn enwedig o ran iechyd meddwl da.

Rydych chi a'ch ysgol yn arloeswyr yn cyflwyno STEPS-A am y tro cyntaf yn y Deyrnas Unedig. Trwy gwblhau'r holiaduron byddwch yn helpu llunio STEPS-A a'i weithredu yn ysgolion uwchradd y wlad ac fel rhan o'r cwricwlwm at y dyfodol.

## Pwy sy'n gysylltiedig â'r fenter STEPS-A?

Mae hybu iechyd meddwl cadarnhaol yn yr ysgol yn llawer mwy effeithiol os oes nifer o asiantaethau'n gweithio gyda'i gilydd i greu rhwydwaith cefnogi. Isod mae darlun o randdeiliaid allweddol y Project STEPS-A. Mae'ch cwnselydd STEPS-A yn rhan o Rwydwaith STEPS-A. Cefnogir ef/hi gan weithwyr proffesiynol eraill sydd wedi eu hyfforddi mewn STEPS-A ac mae'n gweithio'n agos â nhw. Felly, os oes angen mwy o gymorth arnoch chi a'r disgyblion eraill sy'n dilyn dosbarthiadau STEPS-A, eraill o'r tîm STEPS-A (e.e. Seicolegwyr Clinigol CAMHS). Bydd aelodau o staff Prifysgol Bangor Hefyd yn ymwneud ag ymchwil y cynllun. Dyma'r cyntaf o'i fath yn y Deyrnas Unedig. Bydd yn rhan o broiect ymchwil un o aelodau'r tîm STEPS-A.



## A fydd raid i mi siarad am bethau nad wyf eisiau eu trafod?

Na fydd, ni fydd dim rhaid i chi siarad am bethau dach chi ddim eisiau eu trafod. Mae'n bwysig cofio bod dosbarthiadau STEPS-A yn debyg i ddosbarthiadau eraill lle'r ydych chi'n dysgu pethau newydd. Felly, chewch chi ddim eich gorfodi i siarad am broblemau personol mewn dosbarth STEPS-A. Mae'n gyfle i chi a'ch ffrindiau ddysgu sgiliau STEPS-A. Mae'n eich annog chi i roi cynnig ar y sgiliau hynny heb ddim pwysau na straen, mewn dosbarth STEPS-A, er mwyn i chi deimlo'n fwy cyfforddus yn eu defnyddio mewn sefyllfaoedd lle'r ydych dan straen mawr.

## A fydd eich rhieni/gwarcheidwaid yn gysylltiedig mewn unrhyw ffordd?

Hoffem gael caniatâd eich rhieni, ond os gallwch ddangos eich bod yn deall beth yw'r rhaglen ni fydd dim rhaid i chi ddweud wrth eich rhieni.

Hoffem yn fawr i chi siarad â'ch rhieni am y rhaglen ond rydym yn deall yn iawn os nad ydych chi eisiau gwneud hynny.

Os oes gennych unrhyw gwestiynau neu bryderon, cysylltwch â chwnselydd yr ysgol.

## Rhaglen STEPS-A (Hyfforddiant Sgiliau Datrys Problemau Emosiynal i'r Glasoed) STEPS-A



Gwybodaeth i'r Arddegau



## **DBT Steps A INFORMATION SHEET FOR PARENTS/CARERS**

### **What is it?**

We recognise that parents are the most important and skilled people in supporting their sons and daughters.

However, we also recognise that schools and support services can be helpful in this process. Social and emotional learning programmes are vital to support young people to develop the skills that are required to negotiate a complex school environment but also to deal with a myriad of social and emotional challenges out with school. These skills have been described as “the process through which children and adults effectively apply the knowledge, attitudes and skills necessary to understand and manage emotions”

DBT Steps A is a programme that has been created to help young people develop skills to deal with the many challenges they face in their day to day lives.

Research has identified that young people can get the most out of their school and personal experiences if they learn the skills to; Recognise and manage emotions; set and achieve positive goals, appreciate the perspective of others; make responsible decisions and handle interpersonal situations effectively

It has also been identified that can be useful for young people to learn skills in; self-awareness; self-management; social awareness; relationship skills and responsible decision making

These are skills that are useful for all young people.

DBT Steps A is a programme that can help young people develop these skills by focussing on four key areas. These are:

- Emotional Regulation
- Distress Tolerance
- Interpersonal Relationships
- Mindfulness

### **How is the Programme delivered?**

The programme has recently been delivered in schools in Ireland and North-West Wales to all young people in Year 9 in certain schools. School Based Counsellors in Denbighshire Schools are delivering this programme to young people they are involved with. The aim is to see if this programme is effective when it is delivered to small groups of young people. Young people will meet in small groups of 12-15 young people for a session a week for 16 weeks.

### **What is the research all about and who is involved?**

The research involves your son/daughter filling in questionnaires at the beginning and the end of the groupwork programme. One of the researchers will meet with some of the young people at the end of the programme to find out what they thought about the programme.

The programme is being delivered by trained School Based Counsellors who are employed by xxxx Council and are accredited by the British Association of Counselling and Psychotherapy.

The programme is being researched by Graeme Ramage and Dr Michaela Swales. Graeme is studying for a Doctorate in Clinical Psychology at Bangor University. He has an extensive history of working in Health and Social Care and has worked in Child and Adolescent Mental Services for 17 years in both Scotland and Wales. Dr Swales is an internationally recognised expert in DBT and has worked with children and young people for over twenty years.

### **Why is my son/daughter involved?**

Your son/daughter is involved with the school based counselling service. This programme will support the work of the individual counsellors to help young people get the most out of school and life outside school. Young people will still be meeting with their school based counsellor during the programme.

Your son or daughter will not be forced to attend this groupwork programme and they can continue to meet with their counsellor if they choose to leave the groupwork.

Your son/daughter can also be involved in the groupwork programme and not be involved in the research. Some young people may be involved in the research at the start but you and they can choose to leave the research and still be involved in the programme.

### **What about confidentiality?**

The group discussions are confidential, and all the research materials are anonymised with a code. These documents will be safely stored and destroyed at the end of the research.

### **What if I need further information or want to make a complaint?**

If you have any questions you can contact **Graeme Ramage** on [psp93c@bangor.ac.uk](mailto:psp93c@bangor.ac.uk) or xxxx on 01 01824708064 or xxxx@xxxx.gov.uk

**In the case of any complaints concerning the conduct of research, these should be addressed to School Manager, Hefin Lewis, School of Psychology, Brigantia Building, Bangor University, Gwynedd, LL57 2AS.**

## **DBT Steps A TAFLEN WYBODAETH I RIENI/GOFALWYR**

### **Beth ydyw?**

Rydym yn cydnabod mai'r rhieni yw'r bobl bwysicaf a mwyaf abl i gefnogi eu meibion a'u merched.

Fodd bynnag, rydym hefyd yn cydnabod y gall ysgolion a gwasanaethau cymorth fod yn ddefnyddiol yn y broses hon. Mae rhaglenni dysgu cymdeithasol ac emosiynol yn hanfodol i helpu pobl ifanc ddatblygu'r sgiliau sydd eu hangen arnynt i lywio eu ffordd drwy amgylchedd cymhleth yr ysgol a hefyd i ddelio â lluo o heriau cymdeithasol ac emosiynol y tu allan i'r ysgol. Disgrifiwyd y sgiliau hyn fel "proses sy'n helpu plant ac oedolion ddefnyddio'r wybodaeth, yr agweddau a'r sgiliau sy'n angenrheidiol i ddeall a rheoli emosiynau'n effeithiol"

Mae DBT Steps A yn rhaglen a grëwyd i helpu pobl ifanc ddatblygu sgiliau i ddelio â'r heriau niferus y maent yn eu hwynebu yn eu bywydau beunyddiol.

Mae ymchwil yn dangos y gall pobl ifanc wneud yn fawr o'u profiadau yn yr ysgol a'u profiadau personol o ddysgu sgiliau; Adnabod a rheoli emosiynau; gosod a chyflawni nodau cadarnhaol, gwerthfawrogi safbwyntiau pobl eraill; gwneud penderfyniadau cyfrifol ac ymwneud â sefyllfaoedd rhyngpersonol yn effeithiol

Nodwyd hefyd y gall fod yn ddefnyddiol i bobl ifanc ddysgu sgiliau; hunanymwybyddiaeth; hunanreolaeth; ymwybyddiaeth gymdeithasol; sgiliau perthynas a gwneud penderfyniadau cyfrifol

Mae'r rhain yn sgiliau sy'n ddefnyddiol i bob person ifanc.

Mae DBT Steps A yn rhaglen a all helpu pobl ifanc ddatblygu'r sgiliau hyn trwy ganolbwyntio ar bedwar maes allweddol. Y rhain yw:

- Rheoli Emosiynau
- Goddef Trallod
- Cysylltiadau Rhyngpersonol
- Ymwybyddiaeth Ofalgar

### **Sut y cyflwynir y Rhaglen?**

Yn ddiweddar, cyflwynwyd y rhaglen mewn ysgolion yn Iwerddon a Gogledd Orllewin Cymru i bob person ifanc ym 14-15 oed mewn rhai ysgolion. Mae Cwnselaerydd yn Ysgolion Sir Ddinbych yn cyflwyno'r rhaglen hon i'r bobl ifanc y maent yn ymwneud â nhw. Y nod yw gweld a yw'r rhaglen hon yn effeithiol pan gaiff ei chyflwyno i grwpiau bach o bobl ifanc. Bydd y bobl ifanc yn cyfarfod mewn grwpiau bach o 12-15 o bobl ifanc am sesiwn yr wythnos am 16 wythnos.

### **Beth yw pwrpas yr ymchwil a phwy sy'n cymryd rhan?**

Ar gyfer yr ymchwil bydd eich mab/merch yn llenwi holiaduron ar ddechrau a diwedd y rhaglen gwaith grŵp. Bydd un o'r ymchwilwyr yn cwrdd â rhai o'r bobl ifanc ar ddiwedd y rhaglen i glywed eu barn am y rhaglen.

Caiff y rhaglen ei chyflwyno gan Gwnselwyr hyfforddedig yn yr Ysgolion sy'n cael eu cyflogi gan Gyngor Sir Ddinbych. Maen nhw wedi eu hachredu gan Gymdeithas Cwnsela a Seicotherapi Prydain.

Mae'r rhaglen yn cael ei hymchwilio gan Graeme Ramage a Dr Michaela Swales. Mae Graeme yn astudio ar gyfer Doethuriaeth mewn Seicoleg Glinigol ym Mhrifysgol Bangor. Mae ganddo brofiad helaeth ym maes Iechyd a Gofal Cymdeithasol ac mae wedi gweithio mewn Gwasanaethau Meddwl Plant a Phobl Ifanc am 17 mlynedd yn yr Alban ac yng Nghymru. Mae Dr Swales yn arbenigwr o fri rhyngwladol mewn DBT ac mae wedi gweithio gyda phlant a phobl ifanc ers dros ugain mlynedd.

### **Pam mae fy mab merch yn gysylltiedig?**

Mae eich mab/merch yn ymwneud â gwasanaeth cwnsela'r ysgol. Bydd y rhaglen hon yn cefnogi gwaith y cwnselwyr unigol i helpu pobl ifanc wneud yn fawr o'r ysgol a'u bywydau y tu allan i'r ysgol. Bydd y bobl ifanc yn dal i gyfarfod â'u cwnselwyr ysgol yn ystod y rhaglen.

Chaiff eich mab / eich merch ddim eu gorfodi i gymryd rhan yn y rhaglen gwaith grŵp yma a gallant barhau i gwrdd â'r cwnselydd os byddant yn dewis gadael y gwaith grŵp.

Gall eich mab/eich merch hefyd fod yn rhan o'r rhaglen gwaith grŵp heb fod yn rhan o'r ymchwil. Efallai y bydd rhai pobl ifanc yn cymryd rhan yn yr ymchwil ar y dechrau, ond cânt ddewis gadael yr ymchwil a bod yn rhan o'r rhaglen o hyd.

### **Beth am gyfrinachedd?**

Mae'r trafodaethau grŵp yn gyfrinachol, ac mae'r holl ddeunyddiau ymchwil yn ddiennw gyda chod. Caiff y dogfennau hyn eu storio a'u dinistrio'n ddiogel ar ddiwedd yr ymchwil.

### **Beth os oes angen rhagor o wybodaeth arnaf neu os wyf am wneud cwyn?**

Os oes gennych unrhyw gwestiynau, cysylltwch â Graeme Ramage, [psp93c@bangor.ac.uk](mailto:psp93c@bangor.ac.uk) neu xxxx, 01 01824708064 neu [xxxx@xxxx.gov.uk](mailto:xxxx@xxxx.gov.uk)

**Anfonwch unrhyw gwynion ynglŷn â'r ffordd y cynhaliwyd yr ymchwil at reolwr yr ysgol, Mr Hefin Lewis, Rheolwr yr Ysgol Seicoleg, Adeilad Brigantia Prifysgol Bangor, Gwynedd, LL57 2AS.**



## **DBT Steps A TAFLEN WYBODAETH I BOBL IFANC**

### **Beth ydyw?**

Mae rhaglenni dysgu cymdeithasol ac emosiynol yn hanfodol i helpu pobl ifanc ddatblygu'r sgiliau sydd eu hangen arnynt i lywio eu ffordd drwy amgylchedd cymhleth yr ysgol a hefyd i ddelio â lluo o heriau cymdeithasol ac emosiynol y tu allan i'r ysgol. Disgrifiwyd y sgiliau hyn fel "proses sy'n helpu plant ac oedolion ddefnyddio'r wybodaeth, yr agweddau a'r sgiliau sy'n angenrheidiol i ddeall a rheoli emosiynau'n effeithiol"

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Mae ymchwil yn dangos y gall pobl ifanc wneud yn fawr o'u profiadau yn yr ysgol a'u profiadau personol o ddysgu sgiliau; Adnabod a rheoli emosiynau; gosod a chyflawni nodau cadarnhaol, gwerthfawrogi safbwyntiau pobl eraill; gwneud penderfyniadau cyfrifol ac ymwneud â sefyllfaoedd rhyngbersonol yn effeithiol

Nodwyd hefyd y gall fod yn ddefnyddiol i bobl ifanc ddysgu sgiliau; hunanymwybyddiaeth; hunanreolaeth; ymwybyddiaeth gymdeithasol; sgiliau perthynas a gwneud penderfyniadau cyfrifol

Mae'r rhain yn sgiliau sy'n ddefnyddiol i bob person ifanc.

Mae DBT Steps A yn rhaglen a all helpu pobl ifanc ddatblygu'r sgiliau hyn trwy ganolbwyntio ar bedwar maes allweddol. Y rhain yw:

- Rheoli Emosiynau
- Goddef Trallod
- Cysylltiadau Rhyngbersonol
- Ymwybyddiaeth Ofalgar

### **Sut y cyflwynir y Rhaglen?**

Yn ddiweddar, cyflwynwyd y rhaglen mewn ysgolion yn Iwerddon a Gogledd Orllewin Cymru i bob person ifanc ym Mlwyddyn 9 mewn rhai ysgolion. Mae Cwnselwyr yn Ysgolion Sir Ddinbych yn cyflwyno'r rhaglen hon i'r bobl ifanc y maent yn ymwneud â nhw. Y nod yw gweld a yw'r rhaglen hon yn effeithiol pan gaiff ei chyflwyno i grwpiau bach o bobl ifanc. Bydd y bobl ifanc yn cyfarfod mewn grwpiau bach o 12-15 o bobl ifanc am sesiwn yr wythnos am 16 wythnos.

### **Beth yw pwrpas yr ymchwil a phwy sy'n cymryd rhan?**

Ar gyfer yr ymchwil byddwch yn llenwi holiaduron ar ddechrau a diwedd y rhaglen gwaith grŵp. Bydd un o'r ymchwilwyr yn cwrdd â rhai o'r bobl ifanc ar ddiwedd y rhaglen i glywed eu barn am y rhaglen.

Caiff y rhaglen ei chyflwyno gan Gwnselwyr hyfforddedig yn yr Ysgolion sy'n cael eu cyflogi gan Gyngor Sir Ddinbych. Maen nhw wedi eu hachredu gan Gymdeithas Cwnsela a Seicotherapi Prydain.



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### **Pam ydw i'n cymryd rhan?**

Rydych chi'n ymwneud â'r gwasanaeth cwnsela mewn ysgolion. Bydd y rhaglen hon yn cefnogi gwaith y cwnselaerwyr unigol i helpu pobl ifanc wneud yn fawr o'r ysgol a'u bywydau y tu allan i'r ysgol. Byddwch yn dal i gyfarfod â'u cwnselaerwyr ysgol yn ystod y rhaglen.

Chewch chi ddim eich gorfodi i gymryd rhan yn y rhaglen gwaith grŵp yma a gallwch barhau i gwrdd â'ch cwnselaerwyr os byddwch yn dewis gadael y gwaith grŵp.

Gallwch hefyd fod yn rhan o'r rhaglen gwaith grŵp heb fod yn rhan o'r ymchwil. Efallai y bydd rhai pobl ifanc yn cymryd rhan yn yr ymchwil ar y dechrau, ond cewch ddewis gadael yr ymchwil a bod yn rhan o'r rhaglen o hyd.

### **Beth am gyfrinachedd?**

Mae'r trafodaethau grŵp yn gyfrinachol, ac mae'r holl ddeunyddiau ymchwil yn ddienw gyda chod. Caiff y dogfennau hyn eu storio a'u dinistrio'n ddiogel ar ddiwedd yr ymchwil.

### **Beth os oes angen rhagor o wybodaeth arnaf neu os wyf am wneud cwyn?**

Os oes gennych unrhyw gwestiynau, cysylltwch â Graeme Ramage, [psp93c@bangor.ac.uk](mailto:psp93c@bangor.ac.uk) neu xxxx, 01 01824708064 neu [xxxx@xxxx.gov.uk](mailto:xxxx@xxxx.gov.uk)

**Anfonwch unrhyw gwynion ynglŷn â'r ffordd y cynhaliwyd yr ymchwil at reolwr yr ysgol, Mr Hefin Lewis, Rheolwr yr Ysgol Seicoleg, Adeilad Brigantia Prifysgol Bangor, Gwynedd, LL57 2AS.**

**Study title: Evaluation of the DBT-Steps A (DBT-SA) programme when delivered by School based counsellors to a targeted population.**



**Child Consent Form Group Process**

This consent form should be read in conjunction with the information related to this study.

***DBT Steps A INFORMATION SHEET FOR CHILDREN***

REC Ref: 2017-16146

Participant ID number .....

**Please initial each box and sign at the end of this consent form to confirm you understand and agree with each item.**

- |  | Please<br>initial   |
|--|---|
| 1) I confirm that I have read and understood the attached participant information sheet have had the opportunity to ask the researcher questions, and have had these answered to my satisfaction.                                | <input type="checkbox"/>  |
| 2) I understand that my participation in this study is voluntary and I am free to withdraw at any point without giving a reason and without experiencing any disadvantages as a result of withdrawing.                           | <input type="checkbox"/>  |
| 3) I agree for the use of anonymised quotes to be used in reports and/or publications. I understand that no personal information will be used and nothing reported will be able to be linked back to me.                         | <input type="checkbox"/>  |
| 4) I agree that anonymised data collected (questionnaire) may be used by the research team for future research related to this project.  | <input type="checkbox"/>  |
| 5) I agree to be contacted about future research related to this study (optional).   | <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;">Please circle<br/>YES / NO</div> <input type="checkbox"/> </div> |
| 6) I have been informed of the support available to me should I get distressed whilst I am a participant in this study.  | <input type="checkbox"/>  |
| 7) I agree that the data I provide for this study (questionnaire) may be shared as anonymous data with other trusted collaborators. No information that could identify me will be made available to other researchers (optional) | <input type="checkbox"/>  |

Please circle  
YES / NO

8) I understand that if I share any information with the research team that indicates any risk of harm to myself or other people, they will need to share this with the relevant service. The researcher will discuss this with me first though.

☐

9) I agree to take part in the study named above.

☐

Name of participant

Date

Signature

.....

.....

.....

I confirm that this young person above has shown themselves to be Gillick Competent and I have fulfilled the requirements of the BACP guidance on working with young people contained within "Legal Issues and Resources for Counselling Children and Young People in England, Northern Ireland and Wales in School Contexts" *British Association of Counselling and Psychotherapy* 2016

Name of researcher

Date

Signature

.....

.....

.....

If you have any questions you can contact Graeme Ramage, Lead Researcher on [psp93c@bangor.ac.uk](mailto:psp93c@bangor.ac.uk) or xxxx on 01 01824708064 or [xxxx@xxxx.gov.uk](mailto:xxxx@xxxx.gov.uk)

### How do I express concern or make a complaint?

In the case of any complaints concerning the conduct of research, these should be addressed to School Manager, Hefin Francis, School of Psychology, Brigantia Building, Bangor University, Gwynedd, LL57 2AS.

**Study title: Evaluation of the DBT-Steps A (DBT-SA) programme when delivered by School based counsellors to a targeted population.**



**Child Consent Form Qualitative Interview**

This consent form should be read in conjunction with the information related to this study.

***DBT Steps A INFORMATION SHEET FOR CHILDREN***

REC Ref: 2017-16146

Participant ID number .....

**Please initial each box and sign at the end of this consent form to confirm you understand and agree with each item.**

- 1) I confirm that I have read and understood the attached participant information sheet have had the opportunity to ask the researcher questions, and have had these answered to my satisfaction.
- 2) I understand that my participation in this study is voluntary and I am free to withdraw at any point without giving a reason and without experiencing any disadvantages as a result of withdrawing.
- 3) I understand that I have been selected for further interviews once the group has finished. These individual interviews will take about 45 minutes. They will be conducted by Graeme Ramage (Lead Investigator) I am aware that I do not have to take part in these interviews if I don't want to.
- 4) I give my permission for my interview to be audio-recorded for the purpose of data analysis and reporting. Once they have been transcribed and anonymised, the recording will be destroyed.
- 5) I agree for the use of anonymised quotes to be used in reports and/or publications. I understand that no personal information will be used and nothing reported will be able to be linked back to me.
- 6) I agree that anonymised data collected (questionnaire and interview) may be used by the research team for future research related to this project.

Please  
initial

- 7) I agree to be contacted about future research related to this study (optional). Please circle YES / NO ☐
- 8) I have been informed of the support available to me should I get distressed whilst I am a participant in this study. ☐
- 9) I agree that the data I provide for this study (questionnaire and interview) may be shared as anonymous data with other trusted collaborators. No information that could identify me will be made available to other researchers (optional) Please circle YES / NO ☐
- 10) I understand that if I share any information with the research team that indicates any risk of harm to myself or other people, they will need to share this with the relevant service. The researcher will discuss this with me first though. ☐
- 11) I agree to take part in the study named above. ☐

Name of participant Date Signature  
 .....  
 .....  
 .....

I confirm that this young person above has shown themselves to be Gillick Competent and I have fulfilled the requirements of the BACP guidance on working with young people contained within "Legal Issues and Resources for Counselling Children and Young People in England, Northern Ireland and Wales in School Contexts" *British Association of Counselling and Psychotherapy* 2016

Name of researcher Date Signature  
 .....  
 .....  
 .....

If you have any questions you can contact Graeme Ramage on psp93c@bangor.ac.uk or xxxx on 01 01824708064 or [xxxx@xxxx.gov.uk](mailto:xxxx@xxxx.gov.uk)

### How do I express concern or make a complaint?

In the case of any complaints concerning the conduct of research, these should be addressed to School Manager, Hefin Francis, School of Psychology, Brigantia Building, Bangor University, Gwynedd, LL57 2AS.

**Study title: Evaluation of the DBT-Steps A (DBT-SA) programme when delivered by School based counsellors to a targeted population.**



**Parent/Carer Consent Form Group Process**

This consent form should be read in conjunction with the information related to this study.

***DBT Steps A INFORMATION SHEET FOR PARENTS/CARERS***

REC Ref: 2017-16146

**Please initial each box and sign at the end of this consent form to confirm you understand and agree with each item.**

- |   | Please<br>initial   |
|---|---|
| 1) I confirm that I have read and understood the attached participant information sheet have had the opportunity to ask the researcher questions, and have had these answered to my satisfaction.   | <input type="checkbox"/>  |
| 2) I understand that my son/daughter's participation in this study is voluntary and they free to withdraw at any point without giving a reason and without prejudice  | <input type="checkbox"/>  |
| 3) I agree for the use of anonymised quotes to be used in reports and/or publications. I understand that no personal information will be used and nothing reported will be able to be linked back to my son/daughter.                             | <input type="checkbox"/>  |
| 4) I agree that anonymised data that is collected (questionnaire) may be used by the research team for future research related to this project.   | <input type="checkbox"/>  |
| 5) I agree to be contacted about future research related to this study (optional).  | <div style="display: flex; align-items: center; justify-content: flex-end;"><div style="margin-right: 10px;">Please circle<br/>YES / NO</div><input type="checkbox"/></div> |
| 6) I have been informed of the support available to my son/daughter should they get distressed whilst they are a participant in this study.   | <input type="checkbox"/>  |
| 7) I agree that the data my son/daughter provides for this study (questionnaire) may be shared as anonymous data with other trusted collaborators. No information that could identify them will be made available to other researchers (optional) | <div style="display: flex; align-items: center; justify-content: flex-end;"><div style="margin-right: 10px;">Please circle<br/>YES / NO</div><input type="checkbox"/></div> |

8) I understand that if my son/daughter share any information with the research team that indicates any risk of harm to themselves or other people, they will need to share this with the relevant service. The researcher will discuss this with them first though.

☐

9) I agree that my son/daughter can take part in the study named above.

☐

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Name of participant

Date

Signature

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Name of Parent/Carer

Date

Signature

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Name of researcher

Date

Signature

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If you have any questions you can contact Graeme Ramage, Lead Researcher on  
psp93c@bangor.ac.uk or xxxx on 01 01824708064 or  
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**Study title: Evaluation of the DBT-Steps A (DBT-SA) programme when delivered by School based counsellors to a targeted population.**



**Parent/Carer Consent Form Qualitative Interview**

This consent form should be read in conjunction with the information related to this study.

***DBT Steps A INFORMATION SHEET FOR PARENTS/CARERS***

REC Ref: 2017-16146

**Please initial each box and sign at the end of this consent form to confirm you understand and agree with each item.**

- |  | Please<br>initial        |
|--|--------------------------|
| 1) I confirm that I have read and understood the attached participant information sheet have had the opportunity to ask the researcher questions, and have had these answered to my satisfaction.  | <input type="checkbox"/> |
| 2) I understand that my son/daughter's participation in this study is voluntary and they free to withdraw at any point without giving a reason and without experiencing any disadvantages because of withdrawing.  | <input type="checkbox"/> |
| 3) I understand that my child has been selected for further interviews once the group has finished. These individual interviews will take about 45 minutes. They will be conducted by Graeme Ramage (Lead Investigator) They can refuse to take part in this process. If they do start this process they can chose to leave it any time. | <input type="checkbox"/> |
| 4) I give my permission for their interview to be audio-recorded for the purpose of data analysis and reporting. Once recordings have been transcribed and anonymised, the recording will be destroyed.  | <input type="checkbox"/> |
| 5) I agree for the use of anonymised quotes to be used in reports and/or publications. I understand that no personal information will be used and nothing reported will be able to be linked back to my son/daughter.  | <input type="checkbox"/> |
| 6) I agree that anonymised data that is collected (questionnaire and interview) may be used by the research team for future research related to this project.  | <input type="checkbox"/> |
| 7) I agree to be contacted about future research related to this study (optional).   | <input type="checkbox"/> |

Please circle  
YES / NO



8) I have been informed of the support available to my son/daughter should they get distressed whilst they are a participant in this study.

☐

9) I agree that the data my son/daughter provides for this study (anonymised interview transcription) may be shared as anonymous data with other trusted collaborators. No information that could identify them will be made available to other researchers (optional)

Please circle  
YES / NO

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Name of participant

Date

Signature

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Name of Parent/Carer

Date

Signature

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Name of researcher

Date

Signature

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**Teitl yr astudiaeth: Gwerthuso'r rhaglen DBT-Steps A (DBT-SA) pan gaiff ei gyflwyno gan gwnselwyr mewn ysgol i boblogaeth benodol.**

**Ffurflen Gydsynio i Blant: Proses Grŵp**

**Dylid darllen y ffurflen gydsynio hon ar y cyd â'r wybodaeth sy'n gysylltiedig â'r astudiaeth.**

***DBT Steps A TAFLEN WYBODAETH I BLANT***

**REC Cyf:** 2017-16146

**Rhowch flaenlythrennau eich enw ym mhob blwch a llofnodwch ar ddiwedd y ffurflen gydsynio hon i gadarnhau eich bod yn deall ac yn cytuno â phob eitem.**

Rhowch flaenlythrennau eich enw

- 1) Cadarnhaf fy mod wedi darllen a deall y daflen wybodaeth i gyfranogwyr ac rwyf wedi cael cyfle i ofyn cwestiynau a chael atebion iddynt sydd wedi fy modloni.

- 2) Deallaf fod fy nghyfranogiad yn yr astudiaeth hon yn wirfoddol ac rwy'n rhydd i dynnu'n ôl ar unrhyw adeg heb roi rheswm a heb brofi unrhyw anfanteision o ganlyniad i dynnu'n ôl.

- 3) Cytunaf i ddyfyniadau di-enw gael eu defnyddio mewn adroddiadau a/neu gyhoeddiadau. Deallaf na chaiff unrhyw wybodaeth bersonol ei defnyddio ac na fydd modd cysylltu unrhyw beth a adroddir arno â mi.

- 4) Cytunaf y gall y tîm ymchwil ddefnyddio'r data a gasglwyd (holiadur) mewn ymchwil bellach sy'n gysylltiedig â'r project hwn, heb fy enwi.

- 5) Cytunaf i chi gysylltu â mi ynglŷn ag ymchwil bellach sy'n gysylltiedig â'r astudiaeth hon yn y dyfodol (dewisol).

6) Rwyf wedi cael gwybod am y gefnogaeth sydd ar gael i mi petawn yn mynd yn ofidus wrth gymryd rhan yn yr astudiaeth hon.

☐

7) Cytunaf y gellir rhannu'r data a roddwyd gennyf yn yr astudiaeth hon (cyfweliad) fel data di-enw gyda chydweithwyr eraill. Ni fydd unrhyw wybodaeth y gellir ei defnyddio i'm hadnabod ar gael i ymchwilwyr eraill (dewisol)

☐

Rhowch gylch

YDW/NAC YDW

8) Deallaf os byddaf yn rhannu gwybodaeth gyda'r tîm ymchwil sy'n awgrymu unrhyw risg posib o niwed i mi fy hun neu eraill, bydd rhaid iddynt rannu'r wybodaeth honno gyda'r gwasanaeth perthnasol. Ond bydd yr ymchwilydd yn trafod hyn gyda mi gyntaf.

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9) Cytunaf i gymryd rhan yn yr astudiaeth uchod.

☐

Enw'r cyfranogwr Dyddiad Llofnod

.....

Cadarnhaf fod y person ifanc uchod wedi dangos eu bod yn gymwys i gydsynio drostynt eu hunain yn unol â safonau Gillick ac rwyf wedi cyflawni gofynion canllawiau BACP ar weithio gyda phobl ifanc sydd wedi eu cynnwys yn "Legal Issues and Resources for Counselling Children and Young People in England, Northern Ireland and Wales in School Contexts" *British Association of Counselling and Psychotherapy* 2016

Enw'r ymchwilydd Dyddiad Llofnod

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Os oes gennych unrhyw gwestiynau, gallwch gysylltu â Graeme Ramage,  
psp93c@bangor.ac.uk neu xxxx, 01 01824708064 neu  
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**Teitl yr astudiaeth: Gwerthuso'r rhaglen DBT-Steps A (DBT-SA) pan gaiff ei gyflwyno gan gwnselwyr mewn ysgol i boblogaeth benodol.**

## **Ffurflen Gydsynio i Blant**

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***DBT Steps A TAFLEN WYBODAETH I BLANT***

**REC Cyf: xx/xx/xxxx**

**Rhif adnabod y cyfranogwr.....**

**Rhowch flaenlythrennau eich enw ym mhob blwch a llofnodwch ar ddiwedd y ffurflen gydsynio hon i gadarnhau eich bod yn deall ac yn cytuno â phob eitem.**

Rhowch flaenlythrennau eich enw

- 1) Cadarnhaf fy mod wedi darllen a deall y daflen wybodaeth i gyfranogwyr ac rwyf wedi cael cyfle i ofyn cwestiynau a chael atebion iddynt sydd wedi fy modloni.
- 2) Deallaf fod fy nghyfranogiad yn yr astudiaeth hon yn wirfoddol ac rwy'n rhydd i dynnu'n ôl ar unrhyw adeg heb roi rheswm a heb brofi unrhyw anfanteision o ganlyniad i dynnu'n ôl.
- 3) Deallaf y gallwn gael fy newis am gyfweiliadau pellach unwaith y bydd y grŵp wedi dod i ben. Rwy'n rhoi fy nghaniatâd i'm cyfweiliad gael ei recordio ar dâp sain at ddiben dadansoddi data ac ysgrifennu adroddiadau. Caiff y tapiau sain eu dinistrio unwaith y byddant wedi cael eu trawsgrifio a'u gwneud yn ddi-enw.
- 4) Cytunaf i ddyfyniadau di-enw gael eu defnyddio mewn adroddiadau a/neu gyhoeddiadau. Deallaf na chaiff unrhyw wybodaeth bersonol ei defnyddio ac na fydd modd cysylltu unrhyw beth a adroddir arno â mi.
- 5) Cytunaf y gall y tîm ymchwil ddefnyddio'r data a gasglwyd (holiadur a chyfweiliad) mewn ymchwil bellach sy'n gysylltiedig â'r project hwn, heb fy enwi.

6) Cytunaf i chi gysylltu â mi ynglŷn ag ymchwil bellach sy'n gysylltiedig â'r astudiaeth hon yn y dyfodol (dewisol).

☐

7) Rwyf wedi cael gwybod am y gefnogaeth sydd ar gael i mi petawn yn mynd yn ofidus wrth gymryd rhan yn yr astudiaeth hon.

☐

8) Cytunaf y gellir rhannu'r data a roddwyd gennyf yn yr astudiaeth hon (holiadur a chyfweliad) fel data di-enw gyda chydweithwyr eraill. Ni fydd unrhyw wybodaeth y gellir ei defnyddio i'm hadnabod ar gael i ymchwilwyr eraill (dewisol)

☐

9) Deallaf os byddaf yn rhannu gwybodaeth gyda'r tîm ymchwil sy'n awgrymu unrhyw risg posib o niwed i mi fy hun neu eraill, bydd rhaid iddynt rannu'r wybodaeth honno gyda'r gwasanaeth perthnasol. Ond bydd yr ymchwilydd yn trafod hyn gyda mi gyntaf.

☐

10) Cytunaf i gymryd rhan yn yr astudiaeth uchod.

☐

Enw'r cyfranogwr Dyddiad Llofnod

.....

Cadarnhaf fod y person ifanc uchod wedi dangos eu bod yn gymwys i gydsynio drostynt eu hunain yn unol â safonau Gillick ac rwyf wedi cyflawni gofynion canllawiau BACP ar weithio gyda phobl ifanc sydd wedi eu cynnwys yn "Legal Issues and Resources for Counselling Children and Young People in England, Northern Ireland and Wales in School Contexts" *British Association of Counselling and Psychotherapy* 2016

Enw'r ymchwilydd Dyddiad Llofnod

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Os oes gennych unrhyw gwestiynau, gallwch gysylltu â Graeme Ramage,  
psp93c@bangor.ac.uk neu xxxx, 01 01824708064 neu  
xxxx@xxxx.gov.uk

**Sut ydw i'n mynegi pryder neu'n gwneud cwyn?**

Dylid anfon unrhyw gwynion yn ymwneud â'r ffordd y cynhaliwyd yr ymchwil at reolwr yr  
ysgol, Mr Hefin Francis, Rheolwr yr Ysgol Seicoleg, Adeilad Brigantia Prifysgol Bangor,  
Gwynedd, LL57 2DG.

**Teitl yr astudiaeth: Gwerthuso'r rhaglen DBT-Steps A (DBT-SA) pan gaiff ei gyflwyno gan gwnselwyr mewn ysgol i boblogaeth benodol.**



**Ffurflen Gydsynio i Rieni/Gofalwyr: Proses Grŵp**

**Dylid darllen y ffurflen gydsynio hon ar y cyd â'r wybodaeth sy'n gysylltiedig â'r astudiaeth.**

***DBT Steps A TAFLEN WYBODAETH I RIENI/GOFALWYR***

**REC Cyf:** 2017-16146

**Rhowch flaenlythrennau eich enw ym mhob blwch a llofnodwch ar ddiwedd y ffurflen gydsynio hon i gadarnhau eich bod yn deall ac yn cytuno â phob eitem.**

Rhowch flaenlythrennau eich enw

- 1) Cadarnhaf fy mod wedi darllen a deall y daflen wybodaeth i gyfranogwyr ac rwyf wedi cael cyfle i ofyn cwestiynau a chael atebion iddynt sydd wedi fy modloni. ☐
- 2) Rwy'n deall bod fy mab/merch yn cymryd rhan yn y project yn wirfoddol ac y gall dynnu'n ôl ar unrhyw adeg, heb roi rheswm a heb unrhyw ragfarn. ☐
- 3) Cytunaf i ddyfyniadau di-enw gael eu defnyddio mewn adroddiadau a/neu gyhoeddiadau.  
Deallaf na chaiff unrhyw wybodaeth bersonol ei defnyddio ac na fydd modd cysylltu unrhyw beth a adroddir arno â'm mab/merch. ☐
- 4) Cytunaf y gall y tîm ymchwil ddefnyddio'r data a gasglwyd (holiadur) mewn ymchwil bellach sy'n gysylltiedig â'r project hwn, yn ddi-enw. ☐
- 5) Cytunaf i chi gysylltu â mi ynglŷn ag ymchwil bellach sy'n gysylltiedig â'r astudiaeth hon yn y dyfodol (dewisol). ☐
- 6) Rwyf wedi cael gwybod am y gefnogaeth sydd ar gael i'm mab/merch petaent yn mynd yn ofidus wrth gymryd rhan yn yr astudiaeth hon. ☐

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8) Deallaf os bydd fy mab/merch yn rhannu gwybodaeth gyda'r tîm ymchwil sy'n awgrymu unrhyw risg posib o niwed i mi fy hun neu eraill, bydd rhaid iddynt rannu'r wybodaeth honno gyda'r gwasanaeth perthnasol. Ond bydd yr ymchwilydd yn trafod hyn gyda hwy gyntaf.

☐

9) Cytunaf i'm mab/merch gymryd rhan yn yr astudiaeth uchod.

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Enw'r cyfranogwr Dyddiad Llofnod

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Enw'r rhiant/gofalwr Dyddiad Llofnod

.....

Enw'r ymchwilydd Dyddiad Llofnod

.....

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**Ffurflen Gydsynio i Rieni/Gofalwyr: Cyfweliad Ansoddol**

**Dylid darllen y ffurflen gydsynio hon ar y cyd â'r wybodaeth sy'n gysylltiedig â'r astudiaeth.**

***DBT Steps A TAFLEN WYBODAETH I RIENI/GOFALWYR***

**REC Cyf: 2017-16146**

**Rhowch flaenlythrennau eich enw ym mhob blwch a llofnodwch ar ddiwedd y ffurflen gydsynio hon i gadarnhau eich bod yn deall ac yn cytuno â phob eitem.**

Rhowch flaenlythrennau eich enw

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- 2) Rwy'n deall bod fy mab/merch yn cymryd rhan yn y project yn wirfoddol ac y gall dynnu'n ôl ar unrhyw adeg, heb roi rheswm a heb ddioddef unrhyw anfanteision o ganlyniad i dynnu'n ôl. ☐
- 3) Deallaf fod fy mhientyn wedi cael ei ddewis am gyfweiliadau pellach unwaith y bydd y grŵp wedi dod i ben. Bydd y cyfweiliadau unigol hyn yn para tua thri chwarter awr. Fe'u cynhelir gan Graeme Ramage (prif ymchwilydd) ac nid oes iddynt gymryd rhan yn y broses hon os nad ydynt eisiau gwneud hynny. Os byddant yn dechrau'r broses hon, gallant ddewis dynnu'n ôl ohoni ar unrhyw adeg. ☐
- 4) Rwy'n rhoi fy nghaniatâd i'w cyfweiliad gael ei recordio ar dâp sain at ddiben dadansoddi data ac ysgrifennu adroddiadau.  
Caiff y tap sain ei ddinistrio unwaith y byddant wedi cael eu trawsgrifio a'u gwneud yn ddi-enw. ☐
- 5) Cytunaf i ddyfyniadau di-enw gael eu defnyddio mewn adroddiadau a/neu gyhoeddiadau. Deallaf na chaiff unrhyw wybodaeth bersonol ei defnyddio ac na fydd modd cysylltu unrhyw beth a adroddir arno â'm mab/merch. ☐
- 6) Cytunaf y gall y tîm ymchwil ddefnyddio'r data a gasglwyd (holiadur a chyfweiliad) mewn ymchwil bellach sy'n gysylltiedig â'r project hwn, yn ddi-enw. ☐

- 7) Cytunaf i chi gysylltu â mi ynglŷn ag ymchwil bellach sy'n gysylltiedig â'r astudiaeth hon yn y dyfodol (dewisol). ☐
- 8) Rwyf wedi cael gwybod am y gefnogaeth sydd ar gael i'm mab/merch petaent yn mynd yn ofidus wrth gymryd rhan yn yr astudiaeth hon. ☐
- 9) Cytunaf y gellir rhannu'r data a roddwyd gan fy mab/merch yn yr astudiaeth hon (trawsgrifiad cyfweiliad di-enw) fel data di-enw gyda chydweithwyr eraill. Ni fydd unrhyw wybodaeth y gellir ei defnyddio i'w hadnabod ar gael i ymchwilwyr eraill (dewisol) ☐
- 10) Deallaf os bydd fy mab/merch yn rhannu gwybodaeth gyda'r tîm ymchwil sy'n awgrymu unrhyw risg posib o niwed i mi fy hun neu eraill, bydd rhaid iddynt rannu'r wybodaeth honno gyda'r gwasanaeth perthnasol. Ond bydd yr ymchwilydd yn trafod hyn gyda hwy gyntaf. ☐
- 11) Cytunaf i'm mab/merch gymryd rhan yn yr astudiaeth uchod.

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Enw'r cyfranogwr Dyddiad Llofnod

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Enw'r rhiant/gofalwr Dyddiad Llofnod

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Enw'r ymchwilydd Dyddiad Llofnod

.....

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 psp93c@bangor.ac.uk neu xxxx, 01 01824708064 neu  
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### Interview Schedule

The qualitative part of the research will be undertaken using an Interpretative Phenomenological Analysis.

There are two main aims of this part of the research:

1. To meet with the young people involved and establish what impact they think the programme has had on them. There may be areas where the programme has affected them that are picked up in the quantitative analysis.
2. This is the first time this programme has been delivered in this format. It is hoped that the young people involved will be able to give feedback to allow for modifications and developments in the future.

The schedule will be a semi structured process and participants will be selected at random from the groups.

The interviews will be recorded for further analysis. It will be explained explicitly at the start and end of this process that:

- All data will be anonymised and confidential
- This is entirely optional, and participants can withdraw at any time
- All data will be stored securely and destroyed at the end of the research
- Participants can choose to withdraw their data before analysis and data will be destroyed
- All discussions are confidential except where there are concerns about the young person's or another person's welfare

#### Question 1

What did you find most helpful about the group?

#### Question 2

What do you think we need to improve on?

#### Questions 3

Tell me a bit more about what you have learned?

#### Question 4

What have you have learned in the group that you have you been using outside the group?

Question 5

How has the group helped you in class, at home and with friends?

Question 6

Have you been feeling more relaxed since attending the group?

Question 7

How do you think the group has affected how you interact with other young people?

Question 8

How do you think the group has impacted on your ability to stay calm?

Question 9

How else has the group impacted on you in your day to day life?

Question 10

Were there things you were doing being involved in the group that you didn't think you should be doing

Question 11

Have these things changed?

Question 12

What are you doing differently?

Question 13

Were there things you didn't understand in the group?

Question 14

How has your life changed since you have been on the group?

Right

Wont come out. Wont eat

And you are meeting with someone from CAMHS at the moment?

Yeah, they are putting me back onto therapy.

Right, so when was the last time met with someone from CAMHS

For therapy, it was Tuesday.

So yesterday?

Good. So can I ask you something else So what is it about other people's emotions?

Re I used to misunderstand other people's emotions and I sort of go about it the wrong way. Like they may be feeling sad but I'll think they are feeling fine. I'll start talking to them but I'll set myself back.

And what would happen then with your relationships with those young people.

Normally, end up falling out or just not talking for months and that was the start of not socialising at all. I haven't been out with my mates outside of school for over a year

And you said something about insight. What do you mean by that?

Insight?

Insight into other people?

sketch Trying to understand how other people are feeling and thinking. Its really, really difficult. But this eleven-week group has really helped. I don't fully understand but I get the basics of just the more obvious emotions which I didn't really understand before. It's really helped me to understand my own emotions. Cos it got to one point where they just signed me off from therapy because I didn't relay know what to talk about. Cos I didn't really understand my emotions. I didn't really understand how I felt.

So how has the group helped you with that?

sketch Its just distress tolerance and things, we haven't really looked at like really in depth at emotions but through other parts of it we have done emotions. And I have just sort of realised that's how I felt. Couldn't explain it in words.

So it sounds like what you are saying is that the group has given you the words so you can share those processes with other people.

What impact has that had on your life?

post Its changed my life completely. I can actually talk about how I feel now. It feels, before it felt like, it almost felt like I was non-verbal. When I was feeling down and now I can actually talk about it and I know the words to described how I feel

And what impact has that had on your mood?

post Its been a lot better actually. I used to get really really angry with myself when I couldn't find the words to describe my emotions. Buts it really had a positive impact and I've just been able to sit



How would you have felt if this had been done as a whole class?

I don't think I would have been as comfortable because I can't normally cope with group situations

So the small group suited you well

At the start I was very nervous, I was quite close to backing out. But then I just thought I would give it a go and I pushed myself to give it a go

Well done

*int* And it just sort of really gave me that confidence just to be able to talk in small groups

Okay, was there anything else that we could have done differently to have helped you in those early days?

*pluss* I think the classroom, being in a room in school was a downside.

Right

Cos when you are in a classroom in school there is always that atmosphere its like its in the walls. And you've got to speak in a certain way and you've got to sit in a certain way, you've got to act in a certain way

So what do you think, if you were designing the programme again, what do you think could have been different?

*Wing* Probably either an outside shelter or just being in nature, just being in natural surroundings.

That's a very good idea I really like that idea

Emm, and the other you said was about other's people's emotions. How do you think DBT has helped you with that?

*skills* As well as understanding my own emotions, through the same process Ive started to pick up oh if I feel like this and that's how I look when I feel like this that might be how they feel when they look like that. Its just sort of shown me just sort of matching up the look to the emotion. Its really helped.

So what impact has that had on your relationships with other people?

I've been able to talk to people and not end not socialising. Ive been able to on very small scale..

Wee steps

*ll* Yeah but Ive been able to start talking to people outside school

*ll* Brilliant

And slowly progressing taking it day by day working my way up to eventually going out with my mates for a few hours.

Is that a goal you have?

Yeah

*ll* Is that something you would want to do to enjoy living your life?

01

What was it about the  
Probably was...

pe 1

Right and how does that manifest itself with you

With me I start getting really sweaty and start to shake and I will start not being able to breathe and I will start crying

Okay. And was that something that was interfering in your individual life?

Yea, it was really bad but it has got a lot better after starting this. It used to be pretty much every day and I would have to leave lessons.

post

Really, so what's different now?

Now I am quite rarely having one. Usually about once a month.

Right so give me an idea what would happen in the past. What happened?

pe 1

Em. Even talking to new people I wouldn't be able to do it, I would close in and I would go blank and I would try to get out of that situation as soon as possible and there were situations I start panicking and I would start losing it and start shaking really bad and just have to run out of class.

pe 1

And that's when it become overwhelming and you just need to get away?

Yeah and how often was that happening. Usually every day

Right, and what impact was that having on your learning?

impact on learning

I just couldn't, I just wasn't able to focus. My anxiety would get really bad and I would need to leave the class. I was starting to fail things and my levels were starting to drop but I couldn't do anything about it.

And was just at school or was it at home and in the community.

I'm a lot better now but I wouldn't be able to go outside because I don't like leaving the house at all.

Have you seen anyone else or have you seen a counsellor or the CAMHS team?

other services

I used to go to CAMHS but I didn't like it as it felt like it was extremely repetitive. It was really formal, and we would go over the same things all the time. I understand that I need to understand things, but it just felt like I was in a classroom again. It was difficult.

pe 1

Can I ask you a bit of a difficult question? On a scale of 1-10 how difficult were you finding things before you started DBT

An eight.

And how about once you were involved in DBT?

I would say I was able to control it a lot better but I was still having a lot of self doubts.

What about now you have finished with DBT?

post

I barely have any anxiety and I am a lot more confident and my friends have been noticing that I am more confident.

Why do you think that is?

post

After learning the skills and after going to the DBT I was able to start a group in art and I was able to open up and show how I truly am.



Tip

Like when I was feeling stressed I could like dunk my head in the sink.

Excellent. How often have you used that?

Quite a lot actually and I stepped it up a notch one day and had a very cold shower.

How did you find it?

It's good because you focus more on the cold rather than what's going on in school and stuff.

This is a really odd question but what skill is that?

I don't know

Its okay. I was just wondering.

Tipok 8

On a scale of 1-10 with 10 being the highest, how useful have you found that?

Really

My mum walked in on me doing it once

Did she know what you were doing?

No! She was like xxxxxx why do you have your head in a bowl?

And what did you told her?

It was something we learned in my group because she knows what the group is about and she was okay with it.

And has that stopped doing other things that you may have done in the past?

pool

Not sure, I have been going out of my comfort zone recently but when it gets overwhelming I will do one of my DBT things and it like it helps me and I can go through more stuff.

So is having these skills is it making life better, is it making you have a life worth living?

Yeah, its helped me a lot because last year wasn't the best and |I just feltlike I need something.

Anything else that was good about DBT?

group relation

It brought everybody together in a way. Because you see the people walking around=d school but you would never go up to them and talk them but lately it's been like we have become closer as a group and we have talked a lot to each other and I have become quite close to them and we have like little inside jokes.

Is there anything we could have done differently?

form

I didn't like how it was in a classroom just because everyone can walk past you and people can see you are in there.

Right, where do you think it should have been?

Not sure but maybe outside of school like down by the river or in the park.

Right. That's really useful. Anything else? What about home practice? How did you find that?



### Samples of transcript within the “Functioning before the group” Sub theme

#### Participant A

- Emm, my behaviour was really bad and my emotions were out of control and I was doing stupid stuff.
- That’s fine yeah. Ehh. It started off with punching walls
- Then it went to punching myself and then it went to cutting and just progressed.
- Since year 8.
- They were okay. I didn’t really have a strong relationship with mum when everything was going on but its helped.
- Yeah, I used to. I’ve suffered from bullying so if anyone said anything then I’d like oi!

#### Participant B

- I wasn’t doing my work. I was shouting and standing up and messing about with my mates and getting on teaches nerves, getting sent out and just wasn’t being a normal pupil.
- I think it’s because of stuff at home and I was more stressed about it rather than my school work.
- I was very stressed especially in maths because I am not very good at that and because I get criticised and then I overthink that I cant do this and then I start messing about and get disruptive.
- I was proper miserable before I started the group.

#### Participant C

- Because me and my mum we kept on arguing all the time. You’ve got arguing and then you’ve got arguing 24/7. It was all the time
- Like because I was starting to get sick of it and like I was getting more angry
- Like we kept on arguing just about anything, it could literally be anything on the face of the earth.
- Yeah and like I would lose my temper with the teacher if they were asking me what’s wrong because I didn’t like talking about it. I always kept my emotions to myself

#### Participant D

- I would have just cried and went up to my and room and then I wouldn’t tell anyone for a while until my dad found out cos he saw me crying one night cos he saw me go up to my room and I wasn’t very happy.

#### E Participant

- Eh difficult. Really difficult because I had a difficult time with my dad and I took it out on myself
- I self harmed
- Because, before the group I used get like if I fell out with a friend I used to I didn’t take it far but my emotions used to take it far and I used to be like I used to flip out about and I used to be really upset about it and I didn’t know what to do but when I think about now and I fall out with my friends I know what to do cos I know how to react in that whats the best thing to do for me and my friends. Yeah I think things through before I do it. Like before, before DBT I didn’t used to think , I used to just do whatever. But now I take things slow and I think about it before I say anything

### **Participant F**

- It was because I had a lot of emotional problems involving school basically cos I get bullied and that
- Basically people would be horrible and then I would just burst out into tears and have a go at them and get all stressed
- Yeah because I used to get so stressed from school so em I never used to be able to sleep that much and I would be awake tossing and turning
- Loads of thoughts about what might happen at school the next day and if everyone is horrible to me. Lots of what ifs
- I'd most likely get stressed and start screaming my head off and then I would have got bullied me even more and it would have got worse and worse

### **Participant G**

- Emm I have been diagnosed with severe anxiety by the CAMHS people

### **Participant H**

- I've always sort of been the quiet one who tries to stay at the back of the class and not communicate.
- And I think I've always struggled with my emotions and things
- It was mainly arguments, it was quite rough at home at one point we went through quite a bad stage of arguments, there was violence,
- Anyone. I just couldn't socialise at all. I just sort of locked myself away.
- I used to misunderstand other people's emotions and I sort of go about it the wrong way. Like they may be feeling sad but I'll think they are feeling fine. I'll start talking to them but I'll set myself back.
- Normally, end up falling out or just not talking for months and that was the start of not socialising at all.
- Em the reason my mum thought I should come to it was because I am a very emotional person and I am not good with expressing how I am feeling and I keep it to myself rather than upset anyone else.

### **Participant I**

- Em I have really bad social anxiety
- With me I start getting really sweaty and start to shake and I will start not being able to breathe and I will start crying
- Yea, it was really bad but it has got a lot better after starting this. It used to be pretty much every day and I would have to leave lessons.

## **Samples of transcript within the “Skills” Sub theme**

### **Participant A**

- If someone starts on me now I will say something but I will let it go.
- Cos I just like before I get angry I will think about what I am doing now and I will calm myself down.
- Say mean mum had an argument she didn't want me to go but I wanted to go, on a certain day and we were head to head and we clashed and then say I think what could I do and then I say could I go a different day and she said yeah and it just takes you off a different path and it's just better
- Yeah to like find the middle

### **Participant B**

- I know how to control my anger and I know how to concentrate as well now
- I am doing this breathing thing that we learnt and this thing I think its called wise mind or something like that that helps me
- Yeah because I used to get really wound up but now I take my time and calm down down and get into that wise mind thing. It helps me go through the problems and not get wound up
- I just try and stay in that wise mind thing and not get wound up and try and see things from their side. We just talk about it more like proper people do
- Emm I don't know what it's called but I reckon it's just about how you talk to people and ask for things and stay calm and that.
- Yeah they were good. I use them when I am making music and I just sit in my chair and I focus on my body to stay calm and focus more. Like if I was in class and I wasn't paying attention I would do that and it helped me to focus and I was able to do the work better

### **Participant C**

- Its just like learning to control emotions and how to deal with people and how to see how other people react with your behaviour
- Because you learn what the pros and cons are, that was one of the skills. We did loads of things and dialectical thinking
- Its just the same as thinking about different opinions that people have and how they would be feeling. We had a chat about wise mind, emotional mind and something else.
- I cant remember what it was called but if you keep all your emotions in you will just have a massive build up and you can react in a bad. You have to think and listen and say what you need to say to get heard without screaming or shouting.
- Yeah just like say what you need to say but find better ways to say it but find better ways to say it.
- Yeah , I was just thinking is it going to do me any good? Like is it going to do my family any good and it doesn't.

- Yeah, my mum knew the first time and we had a massive fall out and I was really down that week but now I just think that this isn't doing to help the situation. It's not going to help me or help her.

#### **Participant D**

- We learnt about all the different minds so it was like emotion mind and all that sort of stuff
- Well for me personally it was the self sooth things because it was how I could stop myself from getting upset but then also the mindfulness exercises because I still use them because I don't like to think about so I think about going to the beach
- So I have got a box at home that I made and It's got all my stress squishy things in. It's got some slime in it and a book and pencils and pens
- Yeah, I told my mum and dad about it[mindfulness exercises] and I showed them the book and then they've been doing it with me as well
- Emm, definitely, ways to sooth yourself if you are feeling upset, and like the mindfulness helps a lot

#### **Participant E**

- Right {laughs}, it's so confusing. So wise mind is like I think it might be a different on but I'm not too sure but one of them I dunno if its wise mind before you think about the situation before you do something about it
- Cos like If I was in a situation where I fell out with one of my friends I would use wind mind because I would think about it before I say something Id be wise about it and think and think about the situation before I take things further. If that makes sense
- Yeah I think things through before I do it. Like before, before DBT I didn't used to think , I used to just do whatever. But now I take things slow and I think about it before I say anything
- Relaxing, knowing what to do, knowing to not flip out all the time
- Emm we came up with this thing, you sit in a room and its kinda like a worry half an hour and thinking things through. You sit in a room for thirty minutes on your own and you think about everything and you talk to yourself about it. After that thirty minutes is up you can't think about it. That's it. It stays in that room. And that's what he did with us. You sit in a room and you think about everything that's going on. After that half an hour you are not allowed to think about it.
- Yeah cos I used to worry all the time and I use that half an hour and its really good. I'm a terrible sleeper but after that half an hour in my room I could sleep and nothing was on my mind cos I had left in that half an hour and then I said to myself that I will come back to it tomorrow. Its kinda like a book and you write it all down and you put that book away and you are not allowed to see it until tomorrow.

#### **Participant F**

- I would just burst out into tears and have a go at them and get all stressed and then since I've been in that group I've been able to control all that and just been able to calm down and find ways to calm down.
- Emm in school its been stressful but I've been able to like step back and be a bit more calmer.

- It's helped me do a bit of mindfulness. I just shut my eyes and do a bit of mindfulness and its helping me cope.
- When I start getting stressed, I feel like my control is like slipping I'll reel it back in and start doing a little bit of mindfulness.

#### **Participant F**

- Eh probably the mindfulness That's helped me quite a lot in school.
- Quite a lot throughout the day.
- Yeah it would be once or twice a lesson.
- It makes me feel happy about myself that I can actually do something in class that can make me relax and ignore all them horrible people.
- It sounds like you are saying that not only does it help you manage but it makes you feel stronger that you can manage.
- I feel more confident as well. It's almost like I've got this secret tool that I can use. Its like a superpower that I can use.
- Now, I've hardly been getting those thoughts but now at bedtime I hardly have any thoughts after I do the mindfulness.
- I think its because how I have been able to control my emotional state and all of that and how I've been able to think about what I am doing before I do things.
- So like, for example if people have been horrible to me and I get stressed inside but then I think that's not the right thing to do, lets do a bit of mindfulness.
- Now, the bullying is still going on but I have been trying to stay away from them but I will just calm myself down and say don't argue. And I just keep saying it over and over in my head

#### **Participant G**

- I think so but I am not sure but ever since I have been in DBT I have been doing more stuff to distract myself and it brings my mood back up.
- Yeah and I would think the message I have learned from that is not to let my bad thoughts get the better of me.

#### **Participant H**

- Its sort of essentially a tool box of skills that are a lot about coping strategies, physical strategies to do with dunking your head in water.
- Its just distress tolerance and things, we haven't really looked at like really in depth at emotions but through other parts of it we have done emotions. And I have just sort of realised that's how I felt. Couldn't explain it in words.
- Just sort of breathing, techniques, and things really helped when teachers were shouting in the room and even if they are not shouting at me.
- Its when they start raising their voices and things I tend to use breathing techniques and things just to take my mind off of it so I'm not focussing on the teacher shouting. I'm focussing on my breathing
- I used to get very agitated. Just before going in and breathing techniques that I sue when I'm angry just sort of helped me relax more and tensing up the muscles and then relaxing them, tensing up and relaxing really helped.
- The DBT really helped me just to sort of work around the problems that I'm experiencing. Just to divert around them and to come back to them at a later time.

### **Participant I**

- I have been expressing myself a lot more and I have been telling people how I am feeling
- I think it's about learning how to cope with things as well. We've been learning how to concentrate on a certain thing if you get nervous or something and that's really helped because I can't go into crowds of people because I feel panicky and so I have certain places that I go and certain places I can't go into but lately I have been going to those places and when I have I have been in them and I feel like I am about to get panicky and then I pick up something really random and look at the detail on it and try to focus on that instead of everything else around me
- Like when I was feeling stressed I could like dunk my head in the sink.
- Quite a lot actually and I stepped it up a notch one day and had a very cold shower.

### **Participant J**

- It's good because you focus more on the cold rather than what's going on in school and stuff.
- They teach you different skills like mindfulness to help you control all these different aspects and just to help you generally and keep your emotions in check so you don't get overwhelmed or too angry
- Probably mindfulness and emotional regulation.
- I think I used to be so quiet I used to get extremely angry really quickly but using the mindfulness I was able to calm myself down quicker and look at the situation and decide what to do in a more rational mind
- I guess I can describe it like being on calm water in boat. A lot more settled.
- It felt like I was in a storm and it was thrashing me around and I just couldn't get my pace and I was slipping everywhere.
- Emm, when I start getting anxious I find the skill where you put your head in cold water it just settled me down so much and my heart rate would just drop.
- Well because I don't always I have an iced bucket with me it's not so easy but I have a bottle of water and I freeze it and I can just splash it on during the day. Most of the week as I sometimes get stressed and I use it to stop me having a full on anxiety attack.
- Yeah, well it's because of the DBT skills that I feel better and I am able to focus on everything

### **Participant K**

- It's shown me coping mechanisms to divert the anger and frustration and being upset. It's diverted into being able to talk about it and not be shouting. As well as understanding my own emotions, through the same process I've started to pick up oh if I feel like this and that's how I look when I feel like this that might be how they feel when they look like that. Its just sort of shown me just sort of matching up the look to the emotion. Its really helped.

## Samples of transcript within the “Functioning after the group” Sub theme

### A

- Things at home are like better.
- Cos it just taught ways to like, see if me and mum were like stuck head to head it Id think about the group had said and open a new path.
- Say mean mum had an argument she didn't want me to go but I wanted to go, on a certain ay and we were head to head and we clashed and then say I think what could I do and then I say could I go a different day and she said yeah and it just takes you off a different path and its just
- My behaviour has changed a lot.
- I don't fight in school any more. I don't have as many arguments. I cant be bothered with them. And my relationship with mum is better.
- If someone starts on me now I will say something but I will let it go. Cos I just like before I get angry I will think about what I am doing now and I will calm myself down.
- Well they are better cos I haven't done anything that I regret so I haven't actually fallen out with someone so if they have a problem with me they have a problem with me. I don't have a problem with them so it easier to build the bond.
- [in response to asking when they last self-harmed] No no its okay its fine. Just before the group.

### B

- I know how to control my anger and I know how to concentrate as well now
- Em I think its had a good impact because I have not disrupted or messed about since I have been in the group
- No not really but it was something about the way you asked for stuff in a calm and civil way. Because if someone is giving me attitude and is off with me and I start doing the same thing with them then it makes the situation worse.
- I think I have got better plans for the future and I want to do music production because I use music to calm me down and I get right into it and try and stop thinking about things that have happened that day in school

### C

- I've changed my attitude and my attitude towards school because I hated school and I never wanted to go but now I am enjoying it more because I don't get wound up and kick off but now I like being here

### D

- Yeah, its helped me concentrate more cos I've spoken about everything that needed to be said and then its like a weight off my shoulders and I don't have to keep thinking about cos it was distracting me and I was thinking about all these things

### E

- Cos like If I was in a situation where I fell out with one of my friends I would use wise mind because I would think about it before I say something Id be wise about it and think and think about the situation before I take things further. If that makes sense
- Yeah I haven't fallen out with them, I didn't used to fall out with my friends a lot but it was the time before DBT and I was going through a rough week or something and then we started learning about wise mind and it really helped me and that's how we became friends again. Cos I told her about wise and she was like yeah
- I'm a terrible sleeper but after that half an hour in my room I could sleep and nothing was on my mind cos I had left in that half an hour and then I said to myself that I will come back to it tomorrow. Its kinda like a book and you write it all down and you put that book away and you are not allowed to see it until tomorrow.
- Well one of my teachers after a DBT lesson, I went into her lesson and she said you look really happy today so he had noticed that I was a lot more happier than the day before when I didn't have DBT, I noticed one of them said that you look really happy today. And a couple of days after you look a bit sad today, whats wrong and then I had DBT and they said I looked happy again. They know when I am happy and I am not

F

- Yeah, they are saying that I am doing good. With my homework I have been doing good as well. I used to never get it but now used to doing it. I have been doing it more good and because I have been doing it so good I got this (produces a merit award)
- It's changed quite a lot. I never used to want to go to school and now I am like I may as well go into I've been able to concentrate on my work and people try to distract me by talking to me by talking to me and I will be like hold on I'm just finishing this.
- It makes me feel happy about myself that I can actually do something in class that can make me relax and ignore all them horrible people.
- I feel more confident as well. It's almost like I've got this secret tool that I can use. Its like a superpower that I can use.
- Yeah I doing better at school. I've got to do GCSE's and they will be hard but I've got to get through it.

G

- Emm. I'm not entirely sure to be honest. I kinda struggle sometimes.

H

- Its been a lot better actually. I used to get really really angry with myself when I couldn't find the words to describe my emotions. Buts it really had a positive impact and I've just been able to sit there with my mum and actually talk about it whereas before my mum was getting annoyed with me because I didn't understand my emotions.
- As well as understanding my own emotions, through the same process Ive started to pick up oh if I feel like this and that's how I look when I feel like this that might be how they feel when they look like that. Its just sort of shown me just sort of matching up the look to the emotion. Its really helped.
- But being in the group situation has really helped me to start socialising. Its sort of given me that boost to go outside of the group and talk to people.
- It has had a positive effect. When we started the DBT group and once we had done a bit I was able to, well I used to just get up and walk out, I used to just tuck my chair in and say



see you later and walk out but now I'm tending to try and stay in class a bit more because I'm using the techniques I'm not getting as agitated and it's a lot easier for me to be comfortable to stay in a class when I'm not agitated. But a few teachers have had a massive effect on how my learning has progressed.

- I'd say of anything it's helped with coping strategies in exams because I used to relay struggle sitting in exams and it's really helped me.
- Because I did a resit for my English and before I just sat there for about three quarters of an hour just couldn't think about what to write, I just couldn't focus but this time I could sit there and if I couldn't think of what to write I would move onto the next bit. The DBT really helped me just to sort of work around the problems that I'm experiencing. Just to divert around them and to come back to them at a later time.

I

- Not sure, I have been going out of my comfort zone recently but when it gets overwhelming I will do one of my DBT things and it like it helps me and I can go through more stuff.

J

- Probably without all the skills I learned in the DBT group I don't know if I would have been able to carry on with the art group because I used to feel so awkward but after three weeks in, I felt a lot better and my confidence went up and my self-esteem went up.
- Well classes are still boring, but I am able to focus a lot more and have more fun with being with my friends and ignoring the people who just want to bring me down

K

- It's been easier to manage how I am feeling.

## QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES



### COMPONENT RATINGS

#### A) SELECTION BIAS

**(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?**

- 1 Very likely
- 2 Somewhat likely
- 3 Not likely
- 4 Can't tell

**(Q2) What percentage of selected individuals agreed to participate?**

- 1 80 - 100% agreement
- 2 60 - 79% agreement
- 3 less than 60% agreement
- 4 Not applicable
- 5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

#### B) STUDY DESIGN

**Indicate the study design**

- 1 Randomized controlled trial
- 2 Controlled clinical trial
- 3 Cohort analytic (two group pre + post)
- 4 Case-control
- 5 Cohort (one group pre + post (before and after))
- 6 Interrupted time series
- 7 Other specify \_\_\_\_\_
- 8 Can't tell

**Was the study described as randomized? If NO, go to Component C.**

No Yes

**If Yes, was the method of randomization described? (See dictionary)**

No Yes

**If Yes, was the method appropriate? (See dictionary)**

No Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

## C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?

- 1 Yes
- 2 No
- 3 Can't tell

The following are examples of confounders:

- 1 Race
- 2 Sex
- 3 Marital status/family
- 4 Age
- 5 SES (income or class)
- 6 Education
- 7 Health status
- 8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?

- 1 80 – 100% (most)
- 2 60 – 79% (some)
- 3 Less than 60% (few or none)
- 4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

## D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?

- 1 Yes
- 2 No
- 3 Can't tell

(Q2) Were the study participants aware of the research question?

- 1 Yes
- 2 No
- 3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

## E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?

- 1 Yes
- 2 No
- 3 Can't tell

(Q2) Were data collection tools shown to be reliable?

- 1 Yes
- 2 No
- 3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

## F) WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?

- 1 Yes
- 2 No
- 3 Can't tell
- 4 Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

- 1 80 -100%
- 2 60 - 79%
- 3 less than 60%
- 4 Can't tell
- 5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

## G) INTERVENTION INTEGRITY

(Q1) What percentage of participants received the allocated intervention or exposure of interest?

- 1 80 -100%
- 2 60 - 79%
- 3 less than 60%
- 4 Can't tell

(Q2) Was the consistency of the intervention measured?

- 1 Yes
- 2 No
- 3 Can't tell

(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?

- 4 Yes
- 5 No
- 6 Can't tell

## H) ANALYSES

(Q1) Indicate the unit of allocation (circle one)

community   organization/institution   practice/office   individual

(Q2) Indicate the unit of analysis (circle one)

community   organization/institution   practice/office   individual

(Q3) Are the statistical methods appropriate for the study design?

- 1 Yes
- 2 No
- 3 Can't tell

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?

- 1 Yes
- 2 No
- 3 Can't tell

GLOBAL RATING

COMPONENT RATINGS

Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

<b>A</b>	<b>SELECTION BIAS</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>B</b>	<b>STUDY DESIGN</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>C</b>	<b>CONFOUNDERS</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>D</b>	<b>BLINDING</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>E</b>	<b>DATA COLLECTION METHOD</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>F</b>	<b>WITHDRAWALS AND DROPOUTS</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
				Not Applicable

GLOBAL RATING FOR THIS PAPER (circle one):

- 1

STRONG

(no WEAK ratings)
- 2

MODERATE

(one WEAK rating)
- 3

WEAK

(two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No      Yes

If yes, indicate the reason for the discrepancy

- 1

Oversight
- 2

Differences in interpretation of criteria
- 3

Differences in interpretation of study

Final decision of both reviewers (circle one):

- 1

STRONG
- 2

MODERATE
- 3

WEAK