# “You’ve got to have the right mind-set, if you really want to change you’ve got to work at it”: Exploring young people’s experiences of Dialectical Behaviour Therapy for Adolescents (DBT-A) in a community Child and Adolescent Mental Health Service.

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Thesis submitted in partial fulfilment of the requirements of Staffordshire University for the degree of Doctorate in Clinical Psychology

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**THESIS PORTFOLIO: CANDIDATE DECLARATION**

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| **Declaration and signature of candidate** |
| I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.  I confirm that the decision to submit this thesis is my own.  I confirm that except where explicitly stated, the work has not been submitted for another academic award.  I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.    Signed: Date: 23/08/2020 |

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# Thesis Abstract

Qualitative research exploring how people experience therapeutic approaches can help researchers to understand more about the processes involved in therapy. This can have implications for clinical practice and help to improve service provision. Recognising views from a wide range of people is important, as it provides a broader and more inclusive understanding. Three papers are presented exploring how both adults and young people experience Dialectical Behavioural Therapy (DBT).

A review of the literature is presented in paper 1. The existing literature exploring the experiences of DBT focused on adult populations. The evidence-base presents a largely positive narrative of DBT, suggesting that skills within this therapy resulted in an improved quality of life. The literature does not represent many views of those who may have disengaged from DBT, the challenges of the approach, or the views of young people.

In response to gaps in the existing literature, paper 2 presents the empirical research that was undertaken exploring young people’s experience of DBT for adolescents (DBT-A) in a child and adolescent mental health service. Eight young people took part in semi-structured interviews that were analysed using Thematic Analysis. Four themes were identified: ‘Taking responsibility’, ‘Change is complicated’, ‘Hard work pays off’, and ‘DBT is tough, but it’s worthwhile’. These themes are discussed in detail. Implications for service development and future research are discussed.

In paper 3, an executive summary of the empirical paper is presented. The summary is aimed at young people and those working within child and adolescent mental health services. It provides a brief background to DBT-A, an overview of the research, and suggestions for services.

# Paper 1: Literature Review

# How do service users experience elements of Dialectical Behaviour Therapy: A literature review.

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**This paper has been written to the standard required for submission to the publication ‘Clinical Psychology and Psychotherapy’ (excluding the word count). Author guidelines for submission can be found in Appendix A**

# Abstract

This review aimed to identify research exploring experiences of elements of Dialectical Behaviour Therapy (DBT) as a therapeutic approach. The review included experiences from a variety of populations and clinical settings, to obtain a broad range of views in hopes of further understanding the process and outcomes within DBT. A systematic search of six databases identified 13 eligible research papers for review; 12 qualitative and one mixed method study. Age limiters were not set, however all eligible papers focused on adult populations.

There was variation in the quality of the research with an overall lack of sample characteristics and researcher reflexivity noted throughout. The research was assessed and outcomes synthesised. The research consistently showed that DBT provided participants with an increased skill set, more effective emotional regulation, increased self-acceptance, and improvements in the quality of personal relationships. The research also indicated the importance of the therapist and the usefulness of peer support within the skills groups. The challenges of participating in DBT were not as frequently explored within the literature; though difficulties with the high levels of motivation required to participate in DBT, rigidity of the approach, and lack of alternative therapeutic options were raised.

This review shows that DBT has utility across a variety of populations and clinical settings. However, future research would benefit from greater focus on those who disengage from DBT, considering the utility of DBT for adolescent populations, and exploring individual elements of DBT in greater detail.

***Keywords:*** *Dialectical behaviour therapy; DBT; therapy; experience of therapy*

## **Key Practitioner Message**

* There is limited research regarding how people experience Dialectical Behavioural Therapy approaches
* Despite heterogeneity in the participant and intervention settings, the experience of DBT was mostly similar, with many participants reporting positive experiences and outcomes
* Research needs to expand to include more participant groups and those who disengage from DBT to develop a more thorough understanding of the processes and outcomes involved

# Introduction

Dialectical behaviour therapy (DBT) was developed by Marsha Linehan with the initial aim of supporting women with a diagnosis of ‘borderline personality disorder’ (BPD) who were engaging in life threatening behaviours, such as self-harm and suicide attempts (Linehan, 1993). BPD remains a controversial diagnosis and has been critiqued for ignoring the role of adverse life events often experienced by those receiving the diagnosis (Shaw & Proctor, 2005). Individuals receiving the diagnosis often experience; significant difficulties effectively regulating emotions (often leading to life-threatening behaviours), unhelpful thinking patterns, and difficulties maintaining positive relationships. Despite the contentious label, it is recognised that the difficulties associated with BPD require intervention (Stewart, Wilkson-Tough, & Chambers, 2019) and DBT aims to target such difficulties. DBT combines cognitive behavioural strategies with concepts of mindfulness from traditional Eastern teachings (Linehan, 1993). The aim of DBT is to provide acceptance and validation of a person’s current circumstances, and frame this as reasonable within the person’s life experiences whilst facilitating change by offering alternative ways of managing their distress (Trupin, Stewart, Beach, & Boesky, 2002).

The focus of DBT is: reducing life-threatening behaviours, behaviours that interfere with therapy, improving quality of life, and increasing emotional regulation skills (Swales, Heard, & Williams, 2000). A complete DBT intervention is delivered via a combination of skills groups and 1:1 therapy with the availability of telephone support, and a consultation group for therapists (Robins & Chapman, 2004). The individual sessions provide an opportunity to think about factors contributing to helpful and unhelpful behaviours, promote new skills, and review progress with therapy goals (Linehan, 1993). The group sessions focus on four skill areas: emotional regulation, recognising emotions and learning to manage them more effectively; distress tolerance, exploring ways to experience difficult emotions without acting upon them in an unhelpful way; mindfulness, building the ability to notice and accept feelings and to remain aware in the moment; interpersonal effectiveness, learning to assert oneself whilst remaining aware of the needs of others (Linehan, 1993).

## Effectiveness of DBT

Early research with women diagnosed with BPD showed DBT to be more effective than treatment as usual (TAU) in reducing the frequency and severity of self-injury, reducing days spent as an inpatient, and improving therapeutic engagement (Linehan et al., 1991), and the support for its effectiveness has continued to grow (e.g. Koons et al., 2001; Van Der Bosch et al., 2005). Randomised control trials (RCT) have also replicated positive outcomes, finding in a sample of 101 female participants that DBT was more successful in reducing suicide attempts, self-injury, and the need for inpatient mental health care when compared to ‘community interventions’ (Linehan et al., 2006). Furthermore, Linehan et al. (2006) demonstrated that these improvements were still present at one-year follow-up. More recently, Barnicot and Crawford (2018) found that in a sample of 90 adults diagnosed with BPD, those receiving DBT showed a more significant decline in self-harming behaviours, and an increased ability to regulate their emotions compared to those receiving mentalisation based therapy.

Whilst a meta-analysis assessing the efficacy of five RCTs did find that DBT was more effective than TAU in reducing self-harming behaviours, there were only marginally better outcomes in reducing attrition, and conversely there were no significant differences in the reported levels of low mood (Panos, Jackson, Hasan, & Panos, 2014). Moreover, two Cochrane reviews found mixed outcomes for the use of DBT when compared to other therapeutic approaches for adults diagnosed with BPD (Binks et al., 2006; Stoffers et al., 2012). Both reviews highlighted that participants in the DBT condition showed reductions in self-injury, suicidal ideation, and feelings of anger, however no significant differences were found for admissions to inpatient care or in intervention attrition rates. Further studies have failed to find a significant effect for DBT when compared to TAU (Carter, Willcox, Lewin, Conrad, & Bendit, 2010; McMain et al., 2009). The authors do recommend caution in interpreting these results due to the small sample sizes and lack of experimental rigour, making it difficult to statistically compare comparison groups; suggesting the need for more rigorous research into DBT interventions (Binks et al., 2006; Carter et al., 2010; Stoffers, et al., 2012).

## DBT beyond BPD

Whilst the initial intention of DBT was to support those diagnosed with BPD (Linehan, 1993), a growing body of research advocates for its use with a wider range of people experiencing difficulties with emotional regulation, in a variety of clinical settings. Lungu and Linehan (2016) highlighted that DBT can be effectively adapted across clinical populations for those experiencing difficulties managing overwhelming emotions and engaging in harmful behaviours, such as substance misuse. DBT has been shown to be effective for a range of presentations such as improving eating difficulties (Bankoff, Karpel, Forbes, & Pantalone, 2012; Kröger et al., 2010), reducing substance misuse (Dimeff, Rizvi, Brown, & Linehan, 2000), and improving mood regulation for those with a diagnosis of bipolar disorder (Van Dijk, Jeffery, & Katz, 2013). DBT was initially intended as a community-based intervention (Linehan, 1993); however, there are also promising outcomes to support the use of DBT within inpatient care settings (e.g. Bohus et al., 2004).

A recent systematic review has demonstrated some possible benefits of DBT and DBT skills groups in improving self-reported anxiety and depression, and reducing risk (e.g. frequency of ‘aggressive’ behaviours towards others, risk assessment scores) for those diagnosed with a learning disability (LD) across both community and inpatient settings (McNair, Woodrow, & Hare, 2017). The review recognises the increasing DBT evidence base for this population, however due to a lack of transparency around the interventions and lack of comparison groups within the research, the authors emphasise caution in generalising the outcomes (McNair et al., 2017). The efficacy of DBT has also been shown for adolescent populations (Hollenbaugh & Lenz, 2018), showing positive outcomes by reducing incidents of self-harming behaviours for those experiencing suicidal ideation (Rathaus & Miller, 2002), those living within the care system (James, Winmill, Anderson, & Alfoadari, 2011), and within inpatient mental health settings (McDonnell et al., 2010).

There is a large quantitative evidence base for DBT spanning settings and populations. Despite the advised caution when interpreting outcomes (e.g. Stoffers et al., 2012; McNair et al., 2017), DBT is currently a recommended intervention in the United Kingdom (UK) for those with a diagnosis of BPD (The National Institute for Health and Care Excellence Guidelines [NICE], 2009), and as highlighted in the aforementioned literature, is a developing approach across a range of clinical populations (e.g. Baillie & Slater, 2014).

## Qualitative Research

Despite the vast quantitative evidence base, there is limited qualitative research, with only limited studies offering a service user perspective on their experience of engaging with a DBT informed intervention (McSherry, O’Connor, Hevey, & Gibbons, 2012). Qualitative research can be beneficial in identifying what matters to service users, how an intervention is experienced, highlighting obstacles, what is beneficial and why, as well as complementing quantitative research (Pope, Royen, & Baker, 2002). The UK National Health Service (NHS) advocates for the use of more qualitative research as it aids a more detailed understanding of participant views, as well as potentially being an empowering experience (NHS England, 2017).

## Rationale for Review

Quantitative research into the effectiveness of DBT has demonstrated benefits within various clinical populations. Qualitative research has the potential to add to the evidence base by allowing people to give insight into their individual experiences, something that is harder to ascertain from routine outcomes measures (Elliot, 2008). Qualitative studies provide an in-depth view of a smaller sample size, which does limit transferability of the results beyond the context of the research, so considering the outcomes from multiple qualitative studies could help to ascertain the frequency of experiences across a wider evidence base (Campbell et al., 2003). This review, therefore aims to collate and synthesise qualitative outcomes from a range of populations who have experienced a DBT informed intervention, to provide greater understanding of the process and outcomes of this therapeutic approach.

# Method

## Search Strategy

A preliminary search of Cochrane Library, the International Prospective Register of Systematic Reviews (PROSPERO), and Google Scholar was conducted to establish if a previous systematic review had been conducted in this area, and yielded no results. Following this, an electronic literature search was conducted via EBSCOHost between 8th and 15th March 2019. Citation searching of the reference lists of all included articles was employed, with further hand searches via Google Scholar. A grey literature search was also included. The following databases were used for the search:

* PsycINFO
* PsycARTICLES
* MEDLINE (Medical Literature Analysis and Retrieval System Online)
* CINAHL (Cumulative Index to Nursing and Allied Health Literature)
* SPORTDiscus

The following search terms were applied and article titles and abstracts searches were undertaken:

* DBT or “dialectical behaviour therapy” or “dialectical behaviour” or “dialectical behavioral therapy” or “dialectical behavioral”

AND

* experience or “experience of” or perspective or “perspective of” or views or “views of”

AND

* qualitative or qualitative research or qualitative study.

The search terms were identified based on terminology predominantly used within the literature. No limiters were applied.

## Publication Bias

In order to try to reduce publication bias and include as much relevant literature as possible, further grey literature searches were completed via the British Library EThOS, Open Grey, and Ebsco Open Dissertations. A total of six doctoral level dissertation papers were considered for inclusion in the review. It was not possible to obtain two of these from any source, despite attempts to contact the authors (Gayner, 1999; Araminta, 2000), and thus these were excluded from the review. Of the four remaining dissertations, one paper was excluded after a full read through. The paper aimed to explore what recovery meant to those diagnosed with BPD and how the DBT approach helped or hindered their perceived recovery from BPD. This was considered not to meet the inclusion criteria, as the primary focus was on recovery from BPD, rather than how DBT was experienced (Tsakopoilou, 2009). The three remaining dissertation papers were included in the review.

## Eligibility Criteria

Inclusion criteria

* Research focusing on service users’ experiences of DBT
* Participants have engaged or are currently engaging in a DBT intervention, an adapted DBT intervention, or a DBT skills group in a health care setting
* English language only; there was no funding available for translation services
* No specific age limiters were set during the scoping searches
* Participants were not required to meet specific diagnostic criteria, but be experiencing difficulties deemed appropriate for a DBT intervention

Exclusion criteria

* No substantial qualitative data included
* Studies including only the viewpoint of staff, carers, or family; however studies that include a variety of perspectives (including service users) and the outcomes are distinguished within the results were considered
* Studies exploring DBT combined with other therapeutic interventions, as this did not allow understanding of the process and outcomes of DBT in isolation

Please see *figure 1* for a diagram of the search process and stages of inclusion and exclusion.

## Previous Literature

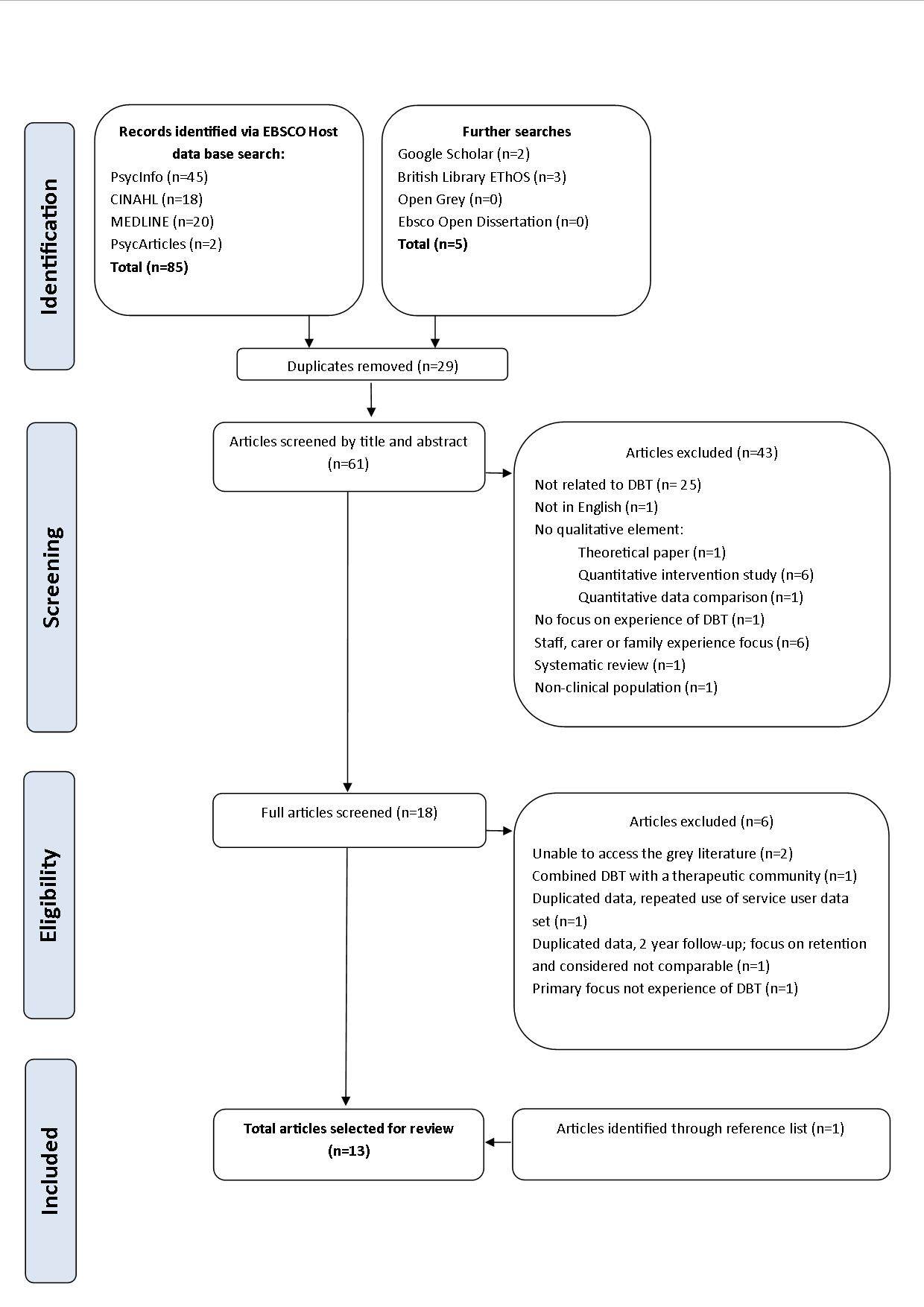
During the initial scoping searches of Cochrane, PROSPERO and Google Scholar, no systematic reviews analysing participant’s experiences of DBT were identified. Furthermore, no systematic reviews were highlighted in the initial literature searches. However, due to an administrative error, and re-run of the original database search on the 24th May 2019, a systematic review of the experiences of DBT from the perspective of adults diagnosed with BPD was identified (Little, Tickle, & Roshan das Nair, 2017). This review identified seven papers published up to 8th July 2016 and focused solely on adults with a diagnosis of BPD.

As the current review has broadened the search to include all clinical populations, it was felt that this review would provide a more comprehensive perspective on experiences of DBT. Moreover, due to the limited qualitative research in the area, it was felt that the review would still hold clinical significance in providing further insight into how diverse populations experience DBT. The systematic review (Little et al., 2017) was not included in this sample and all eligible literature had been identified for the current review.

Quality Appraisal

The ‘Critical Appraisal Skills Programme’ (CASP, 2018) checklist for qualitative research was used to evaluate each study. This was chosen due to recommendations from NICE guidance (NICE, 2018). Whilst Crossland, Hewitt and Walden (2017) used a mixed method design, due to the limited and only descriptive nature of the quantitative data, it was felt that the qualitative CASP would also be pertinent for this study. Each question was given a score between 0 and 2; if a response was ‘no’ or ‘can’t tell’, scores of 0 were awarded, if the answers that were scored as ‘yes’, they were awarded 1 point if there was limited information and 2 points if there was sufficient information. Each study was given a score out of 20, scores for the reviewed studies ranged between 11 and 19. For more detailed scoring see Appendix C.

*Figure 1.* Summary of the literature search screening and selection process following PRISMA guidelines (Moher et al., 2009).



# Results

Thirteen studies met the inclusion criteria and were included in this review. All studies focused on participants’ experience of undertaking a DBT informed intervention, with one study also looking at the barriers to engaging with DBT (Barnicot, Couldrey, Sandhu, & Priebe, 2015). See *Table 1* for summary of included studies.

## Study Setting and Sample Characteristics

The majority of the studies (n=10) were conducted in the UK, with the remaining studies being conducted in Sweden (Perseius, Öjehagen, Ekdahl, Åsberg, & Samuelsson, 2003), the USA (Cunningham, Wolbert, & Lillie, 2004), and Ireland (McSherry et al., 2012). Eight studies were in adult mental health services, four in specialist LD services, and one in a community forensic service. All non-UK studies were based within community adult mental health settings. Of the UK based studies, three were conducted in NHS adult mental health community teams (Barnicot et al., 2015; Hodgetts, Wright, & Gough, 2007; Smith, 2013), two in an LD community team (Crossland et al., 2017; Slater, 2017), one in a community forensic setting (Russell & Siesmaa, 2016), one an NHS LD inpatient unit (Thomson & Johnson, 2016), two in adult mental health private hospitals (Childs-Fegredo & Fellin, 2018; Despreles, 2010), and one in a private LD hospital (Roscoe, Petalas, Hasting, & Thomas, 2015).

Eight of the studies reviewed complete DBT interventions, consisting of individual therapy, skills group sessions, telephone coaching, and a team consult (Barnicot et al., 2015; Cunningham et al., 2004; Despreles, 2010; Hodgetts et al., 2007; Perseius et al., 2003; Roscoe et al., 2015; Russell & Siesmaa, 2016; Smith, 2013). Two further studies stated that participants engaged in both the individual therapy and skills group, but it was unclear if telephone coaching or team consult were available (Slater, 2017; Thomson & Johnson, 2016). The remaining studies utilised an adapted DBT programme (McSherry et al., 2012; consisting of 27 weekly group skills, followed by individual support, telephone coaching, and team consult), or skills groups only (Childs-Fegredo & Fellin, 2018; Crossland et al., 2017).

All participants had engaged with the intervention for between three months to three years. When participating in the research, most participants were still engaging with the intervention, with the exceptions of Thomson and Johnson (2016) and Crossland et al. (2017). This may have restricted some participant’s ability to comment on the process and outcomes of DBT in its entirety. Furthermore, participant’s responses may have been biased; they may have reported a more favourable opinion as they were currently receiving support or may have withheld any negative feedback for fear of consequences, for example their therapist finding out and this negatively impacting their relationship.

The age of the sample ranged from 19 to 61 years old, though four studies did not report the age of participants (Barnicot et al., 2015; Childs-Fegredo & Fellin, 2018; Slater, 2017; Thomson & Johnson, 2016). In seven studies, primary diagnosis was predominantly reported as BPD. Six of the studies included populations without a BPD diagnosis (Barnicot et al., 2015; Childs-Fegredo & Fellin, 2018; Crossland et al., 2017; Roscoe et al., 2015; Russell & Siesmaa, 2016; Slater, 2017), and four studies included those with an LD diagnosis (Crossland et al., 2017; Roscoe et al., 2015; Slater, 2017; Thomson & Johnson, 2016). Whilst all studies reported some participant information, this varied across the literature. Limited information regarding participant context reduces the transferability of the findings.

## Methodology and Recruitment

The studies utilised three different forms of qualitative data analysis; qualitative content analysis (Perseius et al., 2003), thematic analysis (Barnicot et al., 2015; Crossland et al., 2017; Cunningham et al., 2004; McSherry et al., 2012; Russell & Siesmaa, 2016), and interpretative phenomenological analysis (IPA) (Childs-Fegredo & Fellin, 2018; Despreles, 2010; Hodgetts et al., 2007; Roscoe et al., 2015; Slater, 2017; Smith, 2013; Thomson & Johnson, 2016).

Of the IPA studies, the sample sizes ranged from three to 10. There are no guidelines stating the number of participants that are appropriate for IPA, as the focus is to gather a rich understanding of an individual’s experience (Pietkiewicz & Smith, 2012). However, given the homogeneity of the majority of the participant samples, and broad nature of the research aims within the literature, some of the studies may have benefitted from more participants in order to increase the opportunity to identify and explore differences within the data (e.g. Slater, 2017). In the thematic analysis studies samples ranged between four and 40 (all were between four-14 aside from Barnicot et al., 2015). With the exception of Crossland et al. (2017), all studies used suggested sample sizes for thematic research (Braun & Clarke, 2013). Crossland et al. (2017) employed a mixed methods approach but due to the small sample size (4 participants), there was only descriptive use of the quantitative data and limited transferability of the qualitative data.

All studies used purposive sampling, allowing for a homogenous sample appropriate for qualitative research. It was unclear in four studies how participants were selected (Cunningham et al., 2004; Despreles, 2010; Hodgetts et al., 2007; Russell & Siesmaa, 2016), making it difficult to judge potential selection bias and therefore reducing both the credibility and transparency of the research. Two studies stated that participants were chosen by the researcher or field supervisor (Roscoe et al., 2015; Slater, 2017), whilst this is transparent, the inclusion/exclusion criteria was not clear and therefore it is possible that those with more favourable views may have been selected, leaving other groups underrepresented and limiting the sensitivity of the data.

Five of the studies invited all participants who met a simple criterion (e.g. engaged with DBT for 6 months or more), limiting the potential for researcher selection bias (Childs-Fegredo & Fellin, 2018; McSherry et al., 2012; Perseius et al., 2003; Smith, 2013; Thomson & Johnson, 2016). Three of the studies, however, (McSherry et al., 2012; Perseius et al., 2003; Thomson & Johnson, 2016) did not provide detail regarding how the participants were approached, reducing the transparency and trustworthiness of the research. In addition, only two of the studies used individuals external to the care team to recruit to the research (Childs-Fegredo & Fellin, 2018; Smith, 2013), increasing trustworthiness and reducing researcher influence.

One study recruited participants based on the saturation of the data (Barnicot et al., 2015). Participants who had dropped out or had completed the DBT intervention were consecutively asked to participate until researchers felt that the data had become saturated. Although saturation of the data is not a requirement for thematic analysis, it does add a level of methodological rigour by improving the transferability of the outcomes (Fusch & Ness, 2015). Furthermore, it increases the trustworthiness and transparency of the research, as it reduces selection bias as it was offered to all those completing or prematurely ending therapy.

## Data Collection and Analysis

Eleven studies utilised semi-structured interviews, one used a mixture of semi-structured interviews and focus groups (McSherry et al., 2012), and one employed focus groups only (Slater, 2017). In addition to the semi-structured interview, the mixed method design used standardised measures of psychological well-being, distress, and overall functioning (Crossland et al., 2017). Whilst each study employed appropriate methodology for qualitative research, McSherry et al. (2012) did not adequately justify the use of focus groups in addition to the semi-structured interviews, or how participants were assigned to each method, reducing the transparency of the research.

All studies explicitly stated the approach to data analysis, however there was variation in the detail provided. Three of the thematic studies did not provide adequate detail to allow the reader to replicate the analysis process (Crossland et al., 2017; McSherry et al., 2012; Russell & Siesmaa, 2016). Whilst thematic analysis does allow for flexibility in how themes are derived from the data (Braun & Clarke, 2006), the limited information reduces the transparency and confirmability of the analysis and prevents the reader from assessing researcher reflexivity.

Eight studies reported using a method of triangulation, though the quality was varied. Only one study utilised data triangulation (Crossland et al., 2017), which does provide an increased level of rigour to the outcomes, but it remains limited by the small sample size. The remaining studies used a method of analyst triangulation. Four studies utilised multiple analysts to code and verify outcomes increasing trustworthiness (Barnicot et al., 2015; Childs-Fegredo & Fellin, 2018; Perseius et al., 2003; Thomson & Johnson, 2016). Barnicot et al. (2015) also employed an external researcher to review the analysis, increasing rigour by moderating potential researcher bias. Two further studies used a second researcher to check the themes derived from the data (Depresles, 2010; Smith, 2013), and one study used a single external researcher to complete the full analysis (McSherry et al., 2012). Both methodologies help in reducing the influence of the researcher, but the use of multiple analysts would have increased the dependability of the outcomes.

In addition, three further studies used member checking in order to verify the researcher’s understanding of the participants’ views (Hodgetts et al., 2007; Roscoe et al., 2015; Thomson & Johnson, 2016) increasing the dependability and trustworthiness of the outcomes. The remaining studies did not discuss the use of credibility checks, reducing the rigour and credibility of the research (Cunningham et al., 2004; Russell & Siesmaa, 2016; Slater, 2017).

## Ethical Considerations and Reflexivity

Ethical considerations (e.g. ethical approval, consent, and debriefing) were not considered in one study (Cunningham et al., 2004). Five studies provided limited information regarding ethical considerations, stating ethical approval was gained but including little detail about debriefing or consent and confidentiality procedures (Barnicot et al., 2015; Hodgetts et al., 2007; McSherry et al., 2012; Perseius et al., 2003; Russell & Siesmaa, 2016). The safety for research participants is paramount in upholding ethical integrity within research (British Psychological Society, 2014), so when sufficient information regarding ethical considerations is not reported, it is difficult for the reader to know how participants have been protected.

In four studies there was no inclusion of researcher reflexivity or how the researchers may have impacted the findings (Crossland et al., 2017; Cunningham et al., 2004; McSherry et al., 2012; Roscoe et al., 2015). Researcher influence within qualitative research is inevitable (Yardley, 2008), but not to acknowledge it reduces the trustworthiness and transferability of the research as the reader is unable to assess the impact of any bias. Two studies did acknowledge some researcher influence, but did not provide discussion on its potential influence on the outcomes (Perseius et al., 2003; Russell & Siesmaa, 2016), again reducing the dependability of the outcomes. The remaining seven studies all considered researcher influence increasing the trustworthiness of the research.

Some of the researchers added further credibility checks by utilising reflective diaries (Childs-Fegredo & Fellin, 2018; Despreles, 2010; Roscoe et al., 2015; Slater, 2017). However, the impact of the relationships between the researchers and participants were less frequently discussed. Two studies did provide limited information (Childs-Fegredo & Fellin, 2018; Despreles, 2010), but only two studies considered the possible impact of these relationships on the outcomes (Barnicot et al., 2015; Slater, 2017). Transparency into the nature of these relationships is important to fully understand how bias may have influenced the research. This lack of information limits the reader’s ability to interpret the outcomes within context, reducing transferability and trustworthiness.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Author(s)  **Table 1**  **Summary of included studies**  (Year)  Country | Aims | Sample & Setting  Characteristics | | Intervention | Methodology | Key Findings | CASP Score (/20) |
| 1. Perseius, Öjehagen, Ekdahl, Àsberg, & Samuelsson.  (2003)  Sweden | To describe service user and therapist perceptions of receiving and giving DBT | Participants  Age range  Primary recorded diagnosis  Organisation Type  Service Setting | Female (N=10)  22-49 years  BPD  NR  Community; adult mental health | Complete DBT programme  Involvement for 12+ months | Individual focused interviews  Qualitative  content analysis | Participants found DBT to be life-saving and as having a positive impact on their lives.  Participants and therapists found the therapy provided respect and understanding alongside valuable skills.  Many participants felt DBT was a more positive experience than previous care they had received. | 16 |
| 2. Cunningham, Wolbert, & Lillie.  (2004)  USA | Understanding why DBT is a successful treatment for people with BPD | Participants  Age range  Primary recorded diagnosis  Organisation Type  Service Setting | Female (N=14)  23-61 years  BPD  Private: non-profit  Community; adult mental health | Complete DBT programme  Involvement ranged from 6 month – 3 years | Semi-structured interviews  Thematic analysis (TA) | All participants positively experienced DBT.  DBT made significant differences to participant’s lives.  They found they were able to manage emotions and behaviour more easily as a result. | 11 |
| 3.Hodgetts, Wright, & Gough.  (2007)  UK | To explore service user experiences of DBT and the impact upon their lives | Participants  Age range  Primary recorded diagnosis  Organisation Type  Service Setting | Female (N=3), Male (N=2) (Total N=5)  24-48 years  BPD  NHS  Community; adult mental heath | Complete DBT programme  Involvement for 6 months +  N= 3; completed treatment  N=1; on-going treatment  N=1; terminated treatment | Semi-structured interviews  IPA | Participant’s reported positive experiences of DBT.  Skills development led to behavioural change and improved self-acceptance.  Participants felt DBT was more effective than previous experiences of psychotherapy.  Participants felt there was a lack of alternative therapeutic options, and felt that DBT could be a rigid approach. | 15 |
| 4. Despreles.  (2010)  UK | To explore unique experiences of the inpatient DBT process | Participants  Age range  Primary recorded diagnosis  Organisation Type  Service Setting | Female (N=9)  26-37 years  BPD  Private (funding NR)  Inpatient, adult mental health | Completed DBT programme  Involvement for 12 months + | Semi-structured interviews  IPA | Participant’s reported that DBT encouraged skills for the future.  DBT promoted feelings of validation, better self-awareness, and improvements in relationships.  Participants recognised some of the challenges of completing this within an inpatient setting, such as dual staff roles. | 17 |
| 5. McSherry, O’Connor, Hevey, & Gibbons.  (2012)  Ireland | Examine services users perspective on the effectiveness of an adapted DBT programme | Participants  Age range  Primary recorded diagnosis  Organisation Type  Service Setting | Female (N=6) Male (N=2) (Total N=8)  32-55 years  BPD  NR  Community; adult mental health | Adapted DBT programme (9 months in length)  Length of involvement NR | Semi-structured interviews &  Focus groups  TA | DBT provided a better understanding of difficulties and increased control over behaviour.  DBT provide a renewed sense of identity, hope for the future and positively impacted relationships.  It was reported that some of the material and language could be difficult to understand and the approach could be rigid. | 11 |
| 6. Smith.  (2013)  UK | Explore the experiences of women engaging in dialectical behaviour therapy and understand if DBT can shape a ‘life worth living’ | Participants  Age range  Primary recorded diagnosis  Organisation Type  Service Setting | Female (N=6)  22-30 years  BPD  NHS  Community, adult mental health | Complete DBT programme  Involvement for 6-16 months | Semi-structured interviews  IPA | DBT skills group provided validation and peer support.  Participants reported positive impacts of the therapists; being non-judgemental yet provided useful challenge.  DBT provided a variety of skills to reach personal goals.  DBT was considered a challenging therapy, and that group dynamics could be difficult to manage. | 17 |
| 7. Barnicot, Couldrey, Sandhu, & Priebe.  (2015)  UK | To explore experiences of DBT, what are the barriers to DBT skills training and how participants felt they overcame these barriers | Participants  Age range  Primary recorded diagnosis  Organisation Type  Service Setting | Female (N=34), Male (N=6), (Total N=40)  NR  ‘Personality disorder’ diagnosis  NHS  Community; adult mental health | Complete DBT programme (interview focused on skills development)  Involvement for 12 months (completers), 1-11 months (drop outs) | Semi-structured interviews  TA | The skills groups were seen as supportive and validating. It was felt that the therapist also played an important role in skill development.  Participants felt that negative feelings when struggling to learn skills were a barrier to engaging in DBT.  It was felt that commitment to attending DBT, practicing and personalising the skills was the best way to get over any barriers. | 19 |
| 8. Roscoe, Petalas, Hastings, & Thomas  (2015)  UK | To explore the views of DBT from female inpatients who have a diagnosis of ‘personality disorder’ and LD | Participants  Age range  Primary recorded diagnosis  Organisation Type  Service Setting | Female (N=10)  19-57 years  ‘Personality disorder’ and LD  Private (funding NR)  Inpatient; LD service | Complete DBT programme – adaptions for LD participants  Involvement for 3-23 months | Semi-structured interviews  IPA | DBT provided life skills (e.g. better communication) and improved confidence.  Participants felt that DBT helped to improve relationships.  Some anxieties when starting the skills group were reported but peer support considered helpful.  Participants felt that DBT could be difficult to understand at times, and high levels of motivation were needed. | 15 |
| 9. Russell & Siesmaa.  (2016)  UK | Explore experiences of adapted DBT for males within a community forensic service | Participants  Age range  Primary recorded diagnosis  Organisation Type  Service Setting | Male (N=6)  34-61 years  ‘Personality Disorder’ diagnosis  Probation: Government funded  Community; forensic adult | Complete DBT programme  Involvement for 12 months + | Semi-structured interviews  TA | DBT provided motivation to change.  Participants reported shared learning from both peers and therapists, and felt it reinforced other techniques learned previously.  Participants felt supported by DBT, the therapist and peers, and it provided a sense of achievement.  Participants felt the learning from DBT resulted in lifestyle changes. | 13 |
| 10. Thomson & Johnson.  (2016)  UK | Explores women’s experience of engaging with a newly introduced DBT programme within a secure setting | Participants  Age range  Primary recorded diagnosis  Organisation Type  Service Setting | Female (N=7)  NR  BPD and LD  NHS  Inpatient; LD service | DBT consisting of skills groups and individual sessions.  Length of involvement NR | Semi-structured interviews  IPA | Participants reported a good understanding of DBT.  Participants initially felt negatively towards DBT but this changed as the intervention continued.  DBT provided multiple skills to manage difficulties, and peer support.  It was felt that staff could be given more training to support participants between sessions. | 16 |
| 11. Crossland, Hewitt, & Walden.  (2017)  UK | To evaluate a community based DBT skills intervention using qualitative and quantitative measures | Participants  Age range  Primary recorded diagnosis  Organisation Type  Service Setting | Female (N=3), Male (N=1) (Total N=4)    24-48 years  LD  NHS  Community; LD service | Skills groups only  Involvement for 18 weeks | Quantitative data:  Standardised measures  Descriptively explained  Qualitative data:  Semi –structured interviews  TA | Qualitative outcomes:  DBT resulted in improvements in interpersonal relationships.  Participants felt that some concepts were difficult to understand.  Support staff were helpful in practicing outside of the groups.  Quantitative outcomes:  Showed improvement in wellbeing after the group, and some improvements maintained at follow-up. | 14 |
| 12. Slater.  (2017)  UK | To explore the experience of DBT from an individual, carer and therapist perspective within a learning disability service. | Participants  Age range  Primary recorded diagnosis  Organisation Type  Service Setting | Female (N=3/ participant group only)  NR  LD  NHS  Community; LD service | DBT consisting of skills groups and individual sessions.  Involvement for 6 months minimum | Focus groups  IPA | Participants reported increased acceptance of self, emotional control and changes within relationships as a result of DBT.  Participants reported feeling that change is possible and that sharing experiences with others was validating.  However participants recognised that it could be a difficult process. | 15 |
| 13. Childs-Fegredo & Fellin.  (2018)  UK | Explore service user experience of 12-week adapted DBT programme | Participants  Age range  Primary recorded diagnosis  Organisation Type  Service Setting | Female (N=4) Male (N=1) (Total N=5)  NR  No primary diagnosis required  Private – insurance funded  Community; adult mental health | Skills group only  Involvement for minimum of 12 weeks | Semi-structured interviews  IPA | Participants considered DBT to be better than previous therapies.  Participants felt that DBT taught life skills and empowered people to use them.  DBT was considered a validating process from both peers and therapist.  Some participants felt they needed to go through the group a second time to gain real change.  Some participants reported difficulties understanding some of the abstract concepts. | 17 |

## Credibility of the outcomes

All of the studies offered something of value to the evidence base. However, there was a lack of researcher reflexivity, information situating the sample, and variation in the quality of the methodological rigour. Whilst it is understood that published research, in particular, is subject to a limited word count, it is important to provide the reader with this information in order to fully understand outcomes within the specific context. This is arguably one of the most important elements of qualitative research (Yardley, 2008). Therefore the credibility of the research is variable and any conclusions drawn should take into account the above limitations.

# Findings

The synthesis of the literature identified a shared positive narrative of the experiences of DBT. There was a general sense of a change that occurred through the process of DBT, with participant’s gaining insight and skills, and although experiencing some challenges along the way, generally reported life changing outcomes. The synthesis summarises and discusses three prominent areas and associated sub-sections that were identified consistently within the literature.

## The Elements of DBT

*DBT as a whole*

Of the studies evaluating complete DBT programmes (Barnicot et al., 2015; Cunningham et al., 2004; Despreles, 2010; Hodgetts et al., 2007; McSherry et al., 2012; Perseius et al., 2003; Roscoe et al., 2015; Russell & Siesmaa, 2016; Smith, 2013; Slater, 2017; Thomson & Johnson, 2016), five studies commented on the usefulness of the 1:1 therapy. Many participants suggested that this was helpful in consolidating information from the skills groups and exploring their own understanding (Cunningham et al., 2004; Hodgetts et al., 2007; McSherry et al., 2012; Smith, 2013; Thomson & Johnson, 2016). It was highlighted that some participants had mixed feelings about engaging with both the skills groups and the 1:1 therapy, some reporting that the combined approach was helpful, whilst others felt that it was emotionally challenging and required high levels of commitment to complete both sessions each week (e.g. Hodgetts et al., 2007; Thomson & Johnson, 2016).

There was limited information about the telephone coaching present in the literature, with only three studies discussing it (Cunningham et al., 2004; Perseius et al., 2003; Smith, 2013). It was evident that the telephone coaching provided support to help participants to use the skills when they were unable to initiate them independently. Conversely, it was also highlighted that participants were often reluctant to use the service due to fear of being an inconvenience to the therapists. Given that many participants across the literature described experiencing invalidating environments from services previously, this could go some way to explaining the fear of inconveniencing the therapists.

*Skills Groups*

Twelve of the studies reviewed identified that the skills groups provided participants with a sense of peer support with the exception of Thompson and Johnson (2016). Alongside learning relevant skills, the literature highlighted that sharing their experience with people in similar circumstances provided a sense of validation. This was also prevalent in the more heterogeneous group (Childs-Fegredo & Fellin, 2018), where participants acknowledged they did not share diagnostic labels but shared similarities in life experiences and management of emotions, highlighting the limits of working exclusively within a single diagnostic category. Furthermore, participants reported the importance of learning from peers. For example, Russell and Siesmaa (2016) stated that many participants reported that they were able to learn from how other group members had used the skills and this helped to improve their own application of them.

*The Therapist Role*

The approach of therapist within the DBT interventions was also something that appeared commonly throughout the studies, with all but four papers (McSherry et al., 2012; Roscoe et al., 2015; Slater, 2017; Thomson & Johnson, 2016) referencing the benefit of the non-judgemental and validating approach. Whilst the importance of the therapeutic relationship is not unique to DBT (Flückiger, Del Re, Wampold, & Horvath, 2018), the alliance is seen as a crucial element of the approach (Linehan, 1993). The therapeutic relationship aims to oscillate between acceptance (e.g. validation) and change (e.g. problem solving) in order to support skills development (Köhler et al., 2017). It was noted that the therapist’s non-judgemental stance allowed for enhanced personal disclosure and difficult but helpful challenges from the therapists (Hodgetts et al., 2007; Perseius et al., 2003; Smith, 2013).

Further, the therapists’ use of self-disclosure within the sessions added to the feeling of a non-judgemental approach (e.g. Cunningham et al., 2004). Participants reported that the use of self-disclosure allowed for them to see how the therapists were using DBT skills, and how this allowed for a non-hierarchical sense within the sessions (e.g. Smith, 2013). It was reported that this type of therapist’s approach felt different from that of their previous therapy experiences, allowing participants to feel that communication was transparent, providing a sense of safety (e.g. Desperles, 2010). Moreover, the therapeutic relationship did appear to be an important factor in increasing participant’s motivation and helped to overcome barriers to engaging with DBT (e.g. Barnicot et al., 2015; Cunningham et al., 2004).

## Gains

An increase in emotional regulation, distress tolerance and interpersonal skills was prevalent in all studies. These improvements were only identified through behavioural changes (e.g. reduction in frequency of self-harm) in one study (Perseius et al., 2003) contrary to the focus on reduction in self-harm noted frequently in the quantitative data. Participants reported changes as increases in skills and knowledge, and how that impacted on their daily lives (e.g. improvements in communication of needs, managing difficult emotions, quality of relationships). Furthermore, many participants did not find all the skills helpful, but suggested that the variety of the skills taught allowed participants to identify ones that worked best for them (Barnicot et al., 2015; Childs-Fegredo & Fellin, 2018; Hodgetts et al., 2007; McSherry et al., 2012; Perseius et al., 2003; Russell & Siesmaa, 2016; Smith, 2013; Thomson & Johnson, 2016). Moreover, this appeared to be supported by the use of the skills groups, which allowed people to share ideas and adaptations to skills allowing for more effective use (Smith, 2013). This could go some way to explaining why the development of DBT skills did not appear to be hindered by attending the skills groups only. Conversely, the longevity of any changes was not discussed, and therefore it is not possible to compare any possible differences between the types of intervention received.

Nine studies reported improvements in both personal and professional relationships, discussing improvements in communicating their needs, understanding themselves and others within relationships as a direct consequence of the DBT skills they had learned (Barnicot et al., 2015; Childs-Fegredo & Fellin, 2018; Crossland et al., 2017; Cunningham et al., 2004; Despreles, 2010; McSherry et al., 2012; Perseius et al., 2003; Roscoe et al., 2015; Smith, 2013). Further to this, eight studies also reported greater self-acceptance, with participants reporting this as one of the most positive outcomes of DBT (Childs-Fegredo & Fellin, 2018; Cunningham et al., 2004; Despreles, 2010; Hodgetts et al., 2007; McSherry et al., 2012; Perseius et al., 2003; Russell & Siesmaa, 2016; Slater, 2017). Interestingly, the concept of self-acceptance was noted in just one of the four LD population papers. This could suggest that this was not a gain for this population; however, it might be due to the difficulties for people with an LD identifying this change, and discussing this within a semi-structured interview without more specific prompts.

## Challenges to engaging with DBT

In response to the skills groups, two main challenges were raised. Overall, 10 papers highlighted difficulties in understanding some of the concepts and language used, making it difficult to engage with and increasing the need for 1:1 support. Whilst the need for adaptations to the language and abstract concepts in DBT has been documented throughout the wider LD literature (Lew et al., 2006; Charlton & Dykstra, 2011) and continues to be supported in this review (Crossland et al., 2017; Roscoe et al., 2015; Slater, 2017; Thomson & Johnson, 2016), it is important to note that this is not something exclusive to an LD population. A further six studies pertaining to mainstream adult populations also highlighted difficulties in understanding some of the language and therapeutic concepts (Barnicot et al., 2015; Childs-Fegredo & Fellin, 2018; Cunningham et al., 2004; Despreles, 2010; Hodgetts et al., 2007; McSherry et al., 2012).

One further challenge was that participants reported an increased level of anxiety about attending the skills group as opposed to individual therapy (Barnicot et al., 2015; Despreles, 2010; Roscoe et al., 2015; Smith, 2013; Thomson & Johnson, 2016). Despite positive outcomes for group therapy approaches for mental health difficulties (e.g. Depression; Feng et al., 2011), some research has suggested that people often prefer to attend individual therapy and this can lead to low engagement and high attrition in group therapy approaches (e.g. Goodman & Santangelo, 2009).

The literature also highlighted that DBT is a challenging therapy to complete (Barnicot et al., 2015; Hodgetts et al., 2007; Perseius et al., 2003; Slater, 2017; Smith, 2013; Thomson & Johnson, 2016). It was inferred that for participants to engage in DBT, they needed high levels of motivation to engage meaningfully with the intervention (Hodgetts et al., 2007; Perseius et al., 2003; Russell & Siesmaa, 2016). Barnicot et al. (2015) who, when discussing the barriers to engaging in DBT, noted that if people found the therapy too difficult, it resulted in more negative thought patterns around the utility of DBT and the person’s ability to complete the programme. Such thought patterns were said to increase the likelihood of disengagement. This could go some way to explaining the high drop-out rate in DBT reported in the wider evidence base (Landes, Chalker, & Comtois, 2016).

Whilst less frequently noted, the rigidity of the approach was highlighted as a challenge of DBT (Crossland et al., 2017; Despreles, 2010; Hodgetts et al., 2007; McSherry et al., 2012). Participants reported frustrations at wanting to address past experiences and concerns about the future (McSherry et al., 2012). Further challenges lay in the lack of alternative therapeutic options available and little choice about engaging with the therapy (Hodgetts et al., 2007; Roscoe et al., 2015).

# Discussion

The research was collated, critiqued, and synthesised to explore views about the process and outcomes of DBT within a range of populations. Overall, participants felt that they had improved skills in managing emotions and communication which appeared to allow for greater satisfactions in personal relationships. This could be understood as increasing quality of life and reducing life-interfering behaviours, in line with the aims of DBT (Dimeff & Linehan, 2001; Swales, Heard, & Williams, 2009). DBT has been shown to be a helpful approach in facilitating improvements in emotional regulation skills (Little et al., 2017), and this review suggests that this is not only a useful skill for those with a diagnosis of BPD, but something that can benefit people presenting with a wider range of mental health presentations (Lingu & Linehan, 2016).

The review found the skills group’s content was met with mixed reviews. Most of the literature highlighted the value in being able to choose a personalised combination of the skills taught but also concluded that there was difficulty accessing some of the language and abstract concepts. This was not highlighted within the individual therapy sessions, and tellingly some participants referenced the benefit of the individual sessions as a place to ask questions and gain further understanding of the concepts. The appreciation of peer support within the skills groups was universally emphasised. Whilst peer support is not something unique to DBT, it has been shown to improve social functioning, reduce stigma, and provide a sense of acceptance within clinical settings (Repper & Carter, 2011).

The feelings of anxiety associated with the group sessions were noted throughout the synthesis. This was reported across both community (e.g. Smith, 2013) and inpatient settings (Despreles, 2010; Roscoe et al., 2015; Thomson & Johnson, 2016), however a higher prevalence was noted in the latter. Participants within this setting reported feeling resistant to being vulnerable within the group and having difficulty trusting their peers, whilst also trying to manage the boundaries of living within an inpatient setting (Despreles, 2010; Thomson & Johnson, 2016). This could be because those requiring inpatient care are likely to be experiencing more acute levels of distress, and therefore feeling more unsafe. Some participants suggested that higher levels of containment and reassurance within these early stages could be beneficial in supporting them to engage more effectively with a DBT intervention (Despreles, 2010).

The relationship with the therapist was highlighted as a vehicle for change within DBT. This relationship is considered imperative, irrespective of therapeutic approach (Flückiger et al., 2018), but the unique approach within DBT was reported as positive across the literature. Participants found value in both the validating and challenging position of the therapist and found this helped to promote change. Cunningham et al. (2004) highlighted the relationship with the therapist mediated how much challenge the participants would tolerate within sessions. This was also pointed out in the review by Little et al. (2017), who stated that within a BPD population, specific factors within the therapeutic relationships may be vital to effecting change. However, it is difficult to make such conclusions as not all participants reported positive therapeutic relationships and the impact of this on the outcomes from therapy were not explored.

The role of the telephone coaching was only discussed in a limited number of studies, and therefore it is difficult to make conclusions. However, it was noted that when used this was a helpful tool, though there were a number of barriers to accessing this. One of the most difficult elements was feeling like an inconvenience to the therapist (e.g. Smith, 2013). As Manning (2011) suggests, a common mistake when setting up the telephone coaching process is failing to promote the correct use of the system, possibly explaining some of the resistance to using the support.

Acceptance was another key theme identified in the literature, which seemed to be linked to the validating environment provided both by the therapist and the skills groups. Through DBT, people are encouraged to accept their difficulties whilst being provided with the skills and encouragement to change unhelpful behaviours (Trupin et al., 2002). The acceptance of difficulties is promoted within other therapeutic approaches. For example, Acceptance and Commitment Therapy (ACT) suggests that the presence of negative feelings is not the problem, but how that feeling is interpreted and given meaning (Hayes, 2004). Accepting difficulties has been shown to have a positive impact for those with a diagnosis of BPD (Rosenthal et al., 2005). This review, however, provides evidence that this is a process that impacts those engaging in DBT regardless of the diagnostic label. In the existing literature, DBT is considered to have a high rate of attrition (Landes et al., 2016) but the challenges to DBT were less explored in this review. There are a number of possible reasons for this; overly positive samples with little or no inclusion of those who had disengaged with DBT, difficulties discussing negative elements of an approach with people working with/associated with the service, and any feared consequences regarding current or future treatment.

It is noted that behaviours associated with the use of DBT, such as self-harm and suicidality, were seldom discussed in the literature. It is possible that this is more important to professionals than those experiencing them. Participants reported a sense of achievement through feeling more in control of their emotions and increased relationship satisfaction (e.g. Russell & Siesmaa, 2016). As Little et al. (2017) highlights, this is dissimilar to the quantitative research, which focuses on more tangible change such as reduction in the frequency of mental health inpatient care (e.g. Panos et al., 2014). As DBT aims to create change through behaviour, it is understandable that the quantitative research would focus on this but it is possible that the data is only collecting a partial picture of the change that occurs.

## Limitations

There are a number of limitations that should be considered. First, only four studies interviewed people who had dropped-out of DBT and only three of these indicated how many participants had not completed therapy. This will have reduced the sensitivity to an overall experience of DBT, biasing the result towards those who were continuing/had completed DBT and likely providing a more positive narrative. Further, all but one study (Roscoe et al., 2016) recruited participants from a single service. Although qualitative research supports understanding the experience of more homogenous groups, this does reduce variation of experiences and the ability to explore any contradictory outcomes.

All studies were evaluated using the CASP (2018), with scores ranging from 11-19. The critical review highlighted a lack of reflexivity, sample/intervention information, and variation in methodological rigour. It was felt that the CASP did not always provide a sufficient structure to reflect these limitations and therefore the use of this single tool may have over-inflated the quality scores of the research. The use of an additional tool, such as the Evaluative Tool for Qualitative Research (Long & Godfrey, 2002), may have provided a framework for a more in-depth evaluation, increasing the validity of this review.

The studies varied in relation to quality, and therefore the weighting of the outcomes should be considered appropriately. The review aimed to reduce publication bias with the inclusion of grey literature, but this research has not been subject to expert scrutiny and thus the overall quality should not be considered equal to that of published research. Furthermore, two service evaluations were also included. Although they have been through a peer-reviewed process, service evaluations are subject to a more narrow focus of evaluating a particular service, and therefore are more influenced by service context.

Another limitation of this review is the influence of the author’s bias. The search strategy, critical review, CASP ratings, and synthesis were completed only by the author. It was not possible to perform credibility checks with a second reviewer, and therefore each stage of the review will have been subject to bias, reducing the reliability and validity of the review. In attempts to increase reliability, information regarding the search strategy is included to allow for replication.

## Clinical Implications

This review shows DBT to be a helpful approach across diverse populations and clinical settings. However, one of the challenges highlighted in accessing DBT was the use of complex language and abstract concepts. Practitioners should consider adaptations to the language used, and further explanation of the more abstract concepts (e.g. radical acceptance) to promote more meaningful engagement in DBT (Little et al., 2017). Real life examples of the concepts can aid understanding and use of common sense language should be encouraged. Clinicians might encourage feedback and questions within skills groups to help reduce the possibility of anyone leaving confused and enhance group understanding.

The rigidity and inability to discuss past events were also cited as frustrations with the approach (Hodgetts et al., 2007; McSherry et al., 2012). As difficulties with emotional regulation are associated with experiences of trauma (e.g. Dvir, Ford, Hill, & Frazier, 2014), it is unsurprising that some of those engaging with DBT want to discuss difficult life experiences. This may be something for practitioners to consider when discussing DBT as an option with service users. Moreover, motivation was highlighted as a much-needed factor in order to effectively engage with DBT. It might, therefore, be helpful for clinicians to consider the use of motivational interviewing (Miller & Rollnick, 2012) and consider how to promote this throughout the intervention.

The role of telephone coaching should also be discussed with those starting DBT. Manning (2011) suggests allowing people to practice within sessions to gain a better understanding of the system and to provide a more concrete explanation in attempts to limit reluctance and reduce the feelings of being inconvenient to the therapist. Clinicians should also consider the lack of the information pertaining to the barriers to engagement with DBT and consider ways to promote feedback in practice. Better understanding of barriers to this approach could allow for better informed interventions, resulting in improved outcomes and reduced attrition rates.

## Future research

Future research could focus on exploring the experiences of those who have decided to end DBT prematurely. Whilst the difficulties in contacting people after they have withdrawn from a service have been highlighted (Smith, 2013), this would be valuable research to help develop a better understanding of the challenges associated with this approach. Asking for service user’s consent to be contacted regarding research at the beginning of therapy may help to facilitate this.

As highlighted by Little et al. (2017), future research would benefit from exploring more specific elements of the DBT approach such as the use of telephone coaching, in order to create a more detailed understanding of the elements of DBT. Whilst a range of presentations have been explored in this review, the voices of young people remain unrepresented in the literature. Future research could focus on this population to further expand the understanding of DBT and provide a complementary view to the quantitative research base in this area.

# Conclusion

The aim of the review was to explore the accounts of those who had experienced DBT to provide a greater understanding of the processes and outcomes involved with this approach. Research across a range of adult populations and clinical settings was reviewed. Despite the heterogeneity of the sample, the findings were mostly similar. The review showed that DBT facilitated change to lives of the participants, showing improvement in emotional control, self-acceptance, and improvements in relationships. The role of the therapist and peer engagement within the skills groups served to further enhance the impact of the approach. The challenges of DBT were limited within the literature, which is potentially a result of sampling bias. The research does show that DBT can be an effective approach but would benefit from further research into why people disengage with DBT and the experiences of different clinical populations.

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# Paper 2: Empirical Research Paper

# “You’ve got to have the right mind-set, if you really want to change you’ve got to work at it”: Exploring young people’s experience of Dialectical Behaviour Therapy for Adolescents (DBT-A) in a community child and adolescent mental health service

**Word Count: 7998 (excluding figures, references, and appendices)**

**This paper has been written in line with the University requirements for thesis submission and with the intention of submission for publication in *Journal of Child and Adolescent Mental Health*. Author guidelines for submission can be found in Appendix D.**

# Abstract

Background: Growing research suggests Dialectical Behaviour Therapy for Adolescents (DBT-A) is beneficial in supporting young people to better manage a range of mental health difficulties. Previously, research has focused on quantitative outcomes, and little is known about how young people experience this approach.

Method: Semi-structured interviews were completed with eight young people, aged 14-18 years old engaging in DBT-A in a Child and Adolescent Mental Health Service (CAMHS) in the UK. Thematic analysis was used to analyse the data.

Results: Four themes were identified: ‘taking responsibility’, ‘change is complicated’, ‘hard work pays off’, and ‘DBT is tough, but it’s worthwhile’. The study found that DBT-A was an intense but useful therapy experience. Participants reported that the skills were particularly useful in helping them to better manage their difficulties and improve their relationships. Participants were highly motivated to engage in therapy, and trusted others around them to assist them in reaching their goals. There were a number of potential barriers to engagement; feeling resistant to change and life getting in the way.

Conclusion: Participants reported DBT-A was a useful therapy experience but recognised a need for high levels of personal and external resources to engage with it. Future research should focus on the experiences of young people who disengage with therapy to gain further understanding of the process of engaging with DBT-A.

**Key words:** DBT-A; DBT; experience of therapy; adolescence; young people

## **Key Practitioner Message**

* DBT-A has been shown to be an effective intervention in supporting young people with a range of difficulties but little is known about how this population experiences the therapy
* Young people have valuable insights into the process of therapy and are best placed to identify barriers and resources needed to improve practice
* Therapists can support young people to maintain motivation for engagement, encourage discussion around barriers, adapt terminology, and encourage support from family and peers

# Introduction

A 2017 UK survey showed that 12.8% of young people aged 5-19 years old, met the diagnostic criteria for at least one mental health difficulty, with the majority experiencing emotional difficulties (e.g. anxiety, low mood, mood instability) (NHS Digital, 2018). In recent years, the UK government has put forward legislation to increase access to mental health care for young people, as it was recognised that the consequences of inadequate care can result in poor educational outcomes and risks to health through behaviours such as substance misuse (Department of Health [DoH], 2015). The impact of early contact with mental health services in later life remains unclear (Neufeld et al., 2017), but research has indicated that meaningful early intervention may prevent mental health difficulties occurring in later life; indicating the importance of young people having access to evidence-based therapeutic interventions to meet their needs (Asselmann et al., 2014).

## Dialectical Behaviour Therapy

Dialectical Behavioural Therapy (DBT) (Linehan, 1993a; 1993b) is an evidence-based intervention that was originally developed to support women engaging in self-harming and suicidal behaviour with a diagnosis of ‘borderline personality disorder’ (BPD). DBT is underpinned by a biopsychosocial theory that posits that difficulty managing overwhelming emotions (‘emotional dysregulation’) is the core problem that results in distress driven behaviours (Linehan, 1993a). The theory states that ‘emotional dysregulation’ occurs when there is biological vulnerability to high felt emotions (e.g. experiencing emotions more intensely, resulting in reactivity and slow decreases in emotional arousal) that interacts with invalidating environments (e.g. when emotions are punished, trivialised, or dismissed) (Miller et al., 2007).

If a child is continually exposed to invalidating environments, it can prevent them from learning mechanisms to effectively manage their emotions, resulting in unhelpful and ineffective strategies (Miller et al., 2007). Research with adult populations has demonstrated that DBT successfully assists in reducing the frequency of inpatient mental health admissions (e.g. Carter et al., 2010; Linehan et al., 1991), reducing self-harming behaviours in the community (e.g. Linehan et al., 2006) and within inpatient mental health settings (Bohus et al., 2004), reducing substance misuse (Linehan et al., 2002), and improving eating related difficulties (Safer & Jo, 2010).

Historically, there had been no established treatment for young people experiencing suicidal ideas (Miller et al., 2007). Due to success in supporting adults, it was considered that DBT could also help young people (under the age of 18) with similar difficulties. Preliminary research showed that with some adaptations, DBT was more successful in reducing reliance on inpatient mental health care, suicidal ideation, interpersonal difficulties, and increasing therapy retention for young people when compared to treatment as usual (TAU) (Miller et al., 1997; Rathus & Miller, 2002). DBT continued to be offered to young people experiencing overwhelming emotions and suicidal ideation (e.g. Katz et al., 2004), with reductions in the length of intervention, number of skills taught, and adaptations to the use of language to account for developmental differences (Rathus & Miller, 2015). Research evidence and clinical experience was used to outline an adapted model of DBT: ‘DBT for Adolescents’ (DBT-A) (Miller et al., 2007).

DBT-A is aimed at young people (typically 13-18 years old) who are unable to manage overwhelming emotions, and are experiencing multiple difficulties, such as self-harming behaviour or substance misuse (Miller et al., 2007). It aims to decrease life-threatening behaviour and improve quality of life by increasing skills in emotional regulation, distress tolerance, mindfulness, and interpersonal effectiveness to replace harmful or unhelpful behaviour (Miller et al., 2007). A further module was introduced for DBT-A; ‘walking the middle path’. It addresses the conflicting ideas that lead to invalidating environments and ineffective behavioural change within parent-child relationships (Rathus & Miller, 2015).

In the UK, DBT-A is a recommended intervention for young people experiencing self-harming behaviour and ‘emotional dysregulation’ (National Institute for Health and Care Excellence [NICE], 2009). Research has indicated that DBT-A has resulted in reduced suicidal and self-harming behaviour, interpersonal difficulties, low mood, and accident and emergency visits (Fleischhaker et al., 2011; Flynn et al., 2018; Woodberry & Popenoe, 2008). DBT-A has also been shown to be effective across a range of difficulties and therapeutic settings, for example, reducing self-harm and use of psychiatric medication in inpatient mental health settings (Katz et al., 2004; McDonell et al., 2010), improving eating related difficulties (Salbach-Andrae et al., 2008), managing mood for young people with a diagnosis of bi-polar disorder (Goldstein et al., 2015), and improving feelings of low mood and reducing self-harming behaviours for those residing in foster care (James et al., 2011).

Although DBT-A has a positive evidence base, the use of randomised control trials (RCTs) are limited. Mehlum et al. (2014) conducted the first RCT, finding that it was superior to TAU in reducing self-harm, suicidal ideation and improving low mood. Outcomes were re-evaluated one year and three years’ post-intervention and effects were maintained, but DBT-A only remained superior in reducing self-harm, and there were no significant group differences for suicidal ideation or low mood (Mehlum et al., 2016; Mehlum et al., 2019). A more recent RCT supported this outcome, finding DBT-A more effective than TAU in reducing self-harming behaviour, which was maintained at the six month follow-up (McCauley et al., 2018). A meta-analysis assessing the efficacy of DBT-A, found it was more beneficial in reducing low mood, anxiety, self-harming behaviour and suicidal ideation when compared to control groups or alternative treatments, but effect sizes were small and a need for more high quality research was identified (Hunnicutt-Hollenbaugh & Lenz, 2018).

As DBT was originally developed for adults with a diagnosis of BPD, questions are raised about the use of diagnostic labels for young people being referred to this intervention. BPD still remains a controversial diagnosis as, for example, there is no evidence of a biological basis for this diagnosis (Gunderson, 2009). It has been argued that diagnoses may increase access to appropriate interventions (Miller et al., 2008), but the stigma associated with this diagnosis, and the role of personality development in this age group cannot be discounted (Chanen et al., 2004; Knaak et al., 2015). Therefore, consistent with the researcher’s view and the supporting service, the young people participating will not be described in a context of BPD.

## Aims & Objectives

Arguably, people accessing therapies are better placed to understand the mechanisms for change and what individual factors can encourage (or discourage) engagement (Newton et al., 2007). For DBT, the evidence base is predominantly built on quantitative research. This research assumes a positivist stance and holds assumptions that measurements and observations reflect an external reality (Miller, 1999). This type of research can be useful in attempts to evaluate therapeutic interventions, and lends itself to the evidence-based practice movement that informs NICE guidance and health provision in the UK (Harper, 2017).

Conversely, young people’s experience of their health care is often lacking in research (Bury et al., 2007). Qualitative research can present a rich picture of lived experience and examine individual meaning and patterns across datasets to provide an in-depth understanding (Braun & Clarke, 2013). It has been suggested that involving young people in health care research can offer unique insights that can contribute to a more person-centred development of services (McLaughlin, 2015). Overall, the literature indicates a good evidence base for DBT-A. O’Connell and Dowling (2014) suggest that future research should focus on the lived experience of those taking part in DBT to enhance the understanding of this intervention. At present, there is limited qualitative research, and to the researcher’s knowledge, there is no current research exploring young peoples’ experience of DBT-A.

This study, therefore, aims to give voice to young people’s experiences of taking part in DBT-A within a CAMHS service. The study aims to go beyond the outcomes of DBT-A by considering the process of engagement and reflections on the model. The researcher hopes to offer a balanced perspective and where applicable challenge the existing evidence base. It is hoped that this research will provide a much needed platform for young people to express their views regarding their health care, and that in exploring shared experiences, clinicians will gain new insights to improve practice and service provision (DoH, 2015).

# Method

## Design

An inductive thematic analysis (TA) design was employed (Braun & Clarke, 2006) utilising semi-structured interviews to facilitate discussion about how young people experience DBT-A. This method of TA was considered to ensure that the analysis was giving voice to the participants’ experiences, by drawing meaning from the data as opposed to relying on existing theory. Semi-structured interviews provide a level of flexibility, enabling participants to explore their experiences, and giving the researcher an opportunity to encourage deeper reflection.

TA is a theoretically flexible and accessible approach (Braun & Clarke, 2006). It was chosen as opposed to other qualitative research methods, as the researcher was interested in understanding shared meaning across the data-set from a social constructionist epistemology. This was considered important as it allowed for the participants experiences to be understood within the socio-cultural context (Willig, 1999).

*Participants*

Eight young people took part in the study; demographic information is provided in Table 1. All participants had experienced therapeutic support in some capacity before starting DBT-A; seven of the participants had received this within a CAMHS service, and one attended counselling provided by a local charity provision. Participants were required to be currently engaged in DBT-A (minimum 12 weeks to have sufficient experience), or to have completed the intervention within the last six months. Participants were eligible from the multi-family and ‘teen-only’ skills groups; as both follow the same manualised approach, both experiences were considered relevant in answering the research question. Those who had disengaged from the intervention were excluded.

Table 1

Participant Characteristics

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name  (pseudonyms) | Age  (at time of the interview) | Gender | Ethnicity | Type of DBT | Previous Therapeutic Support | Length of Involvement |
| Victoria | 18 | Female | White-British | Teen-only | CBT | Completed |
| Katie | 16 | Female | White-British | Multi-Family | CBT | 22 weeks |
| Alice | 14 | Female | White-British | Multi-Family | ‘counselling’ | 20 weeks |
| Julia | 17 | Female | White-British | Teen-only | ‘counselling’ | 12 weeks |
| Aria | 15 | Female | White-British | Teen-only | “CAMHS support” | 16 weeks |
| Sienna | 17 | Female | White-British | Multi-Family | CBT | 12 weeks |
| Freya | 17 | Female | White-British | Teen-only | CBT, art therapy,  ‘counselling’ | Completed |
| Eliza | 18 | Female | White-British | Teen-only | CBT, ‘counselling’ | 12 weeks |

## Procedure

*The* *DBT Service*

All participants were recruited from a single NHS community CAMHS service in the West Midlands. The service provides a 24-week DBT-A intervention (Rathus & Miller, 2015), which includes a multi-family and a ‘teen-only’ skills group; the young person selects their preferred option. All interventions consist of a weekly one-hour individual session and 1.5-hour group session; for the multi-family group, one parent is required to attend the skills session. Telephone coaching is available with a DBT therapist (Monday-Friday 9am-5pm).

In order to be considered for DBT-A, the young person must be: aged between 12 – 17 years old (at the start of the intervention), to have engaged in at least one act of self-injurious behaviour in the past 16 weeks or experienced suicidal ideas, have received previous professional support for mental health needs, and experienced difficulties managing emotions that impacts on daily life. The team consists of two Clinical Psychologists and one Psychological Therapist; all were trained via ‘The British Isles DBT Training’.

*Recruitment*

In line with TA, purposive sampling was used (Braun & Clarke, 2013). DBT therapists were responsible for providing information about the research to all eligible young people in contact with the service (appendix E), and providing information sheets to anyone interested in participating (appendix F). If the participant was less than 16 years old, a parental opt-out letter was provided and parents had a right to withdraw them from participation (appendix H). If the young person remained interested, they could contact the researcher directly or provide a therapist with their consent to be contacted. The researcher discussed the study further, and if the person still wished to participate, an interview was arranged. A total of 14 eligible young people were identified: four declined to take part, one disengaged with DBT-A, and nine were invited to interview. One person did not attend the interview, so a total of eight interviews were completed.

*Interviews*

Seven interviews took place in a private room at a local CAMHS service. The interviews lasted, on average, 30 minutes (range 24-40 minutes). One participant wished to take part but due to social communication difficulties requested a remote interview which was completed via a series of text messages. Although this likely impacted engagement with the interview, as the study aimed to give voice to young people’s experience, it was considered important to offer adaptations for all young people wishing to take part. Seven consent forms (appendix G) were completed prior to the interview, confirming all participants were able to provide informed consent. One consent form was completed via post, with a telephone call to ascertain full understanding before beginning the remote interview. An optional demographic form was completed (appendix I) to allow greater understanding of the participant context. All interviews were completed by the lead researcher and seven were audio recorded. Interviews were supported by the interview schedule (appendix J). Participants were reminded of their right to withdraw from the study without consequence. Each participant was debriefed, and a CAMHS clinician was available to offer support to any distressed participants, but this was not required.

## Analysis

The TA followed the stages outlined by Braun and Clarke (2006). Audio recordings were transcribed verbatim and identifiable information was anonymised. The researcher took a social constructionist position to the analysis. This position assumes that that there is no one single reality but that there are multiple perspectives and ascribed meaning is created through interactions with others (Braun & Clarke, 2013). The researcher approached the analysis with a curiosity towards the language used to convey meaning and considered how the shared experiences may have challenged the ‘understood knowledge’ in regards to DBT-A (Burr, 1995).

The transcripts were coded at a semantic level, only recognising the explicit content of the data and not inferring implicit meaning (appendix L). A computer programme (NVivo 12) was used to assist with coding. Codes were assessed for relevance to the research question and revised or discarded and overlapping codes were merged or discarded. Codes were analysed to generate themes that the researcher understood to reflect shared experiences across the data-set, pertinent to the research question. The themes were continually reviewed until the researcher was satisfied that they best represented the data-set, before being defined and named.

In order to maintain methodological rigour, the researcher kept a journal detailing personal responses that occurred in relation to the data. The journal was used to reflect on all stages of the analysis, and to attempt to bracket assumptions. Credibility checks to ensure themes were grounded in the data were conducted with the academic supervisor and an independent researcher with knowledge of TA. Peer reviewers also examined themes to challenge the researcher’s initial conceptions and encouraged deeper reflection.

## Reflexivity

The researcher is a White-British female, who is currently in the final year of Clinical Psychology training. They have worked with young people in variety of health care settings. As a Trainee Clinical Psychologist, the researcher takes an anti-diagnostic view and is critical of the use of diagnostic labels. This has resulted in the researcher taking a more reproving stance towards the wider DBT literature, undoubtedly impacting on their overall view of the model.

The researcher has not received accredited DBT training but has provided DBT informed interventions as a practitioner. The researcher believed this was useful in this research, as it allowed for focus on participant experiences, without heavily relying on DBT theory. As a practitioner, the researcher is also interested in the influence of power, believing that young people are in a less powerful position in comparison to service and family structures, often resulting in the researcher aiming to elevate the voices of young people.

Such ideas inevitably influenced the researchers understanding of the data and the themes generated, but in order to minimise this and stay close to the expressed experiences, a reflexive journal and credibility checks were used throughout (appendix M for further information).

## Ethical Considerations

Ethical approval was granted by Staffordshire University’s Research Ethics Committee in June 2019 (appendix N). Further approval was granted by the Yorkshire & the Humber Leeds West NHS Research Ethics Committee and the Health Research Authority in September 2019 (appendix O), before local NHS Trust capacity and capability approval in November 2019 (appendix P).

# Results

The data represents the views of eight young people accessing DBT-A in CAMHS. Four themes were identified, all consisting of smaller subthemes: ‘*taking responsibility’, ‘change is complicated’, ‘hard work pays off’, and ‘DBT is tough, but it’s worthwhile’.* Each theme is explained individually; however, the themes are interlinked as demonstrated in the thematic map (*figure 1*). Quotes are provided to illustrate each theme, pseudonyms are used throughout (further quotes can be found in appendix K).

## 

## **Theme 1: “If I want to change, I’ve got to try my hardest”; Taking responsibility**

This theme represents how all participants discussed their active role in engaging with DBT-A. All participants reported feeling highly motivated to achieve change, and discussed how they used their own resources and others to support their engagement.

*Attitude to therapy*

This subtheme highlights how all participants recalled their attitude to DBT-A, stating that they were highly motivated to achieve their goals.

“*I’m very very motivated*” – Alice

*“I want to change like the way I view things and the way I feel about things… because I really struggle” –* Sienna

Although previously unhelpful therapy experiences did pose a challenge to engagement (*see theme 2),* interestingly, five participants described that their open mindedness and motivation helped them to overcome this.

*“I had doubts because the CBT hadn't worked so I was thinking that maybe… DBT wouldn't work but obviously I had to keep the mind set of that if I want change I've got to try my hardest and I've got to try my best for a good outcome” –* Katie

Aria phrased this as having to believe in the model and trust that it was going to work for her.

***“****I think you just have to be positive about it and like not doubt it… I've just had to have a belief in it and just dedicate myself to it” –* Aria

Furthermore,it appeared that for three participants, their previous experience had contributed to their choice to engage with therapy.

*“I do feel quite motivated because obviously this isn't my first time going through sort of counselling and I suppose you get a bit fed up of it [laughs], so yeah just wanna make everything better” –* Julia

*“I've changed my mind-set completely when I was in hospital because when you're in there you see a lot of sick people… seeing all those people made me realise I need to change” –* Sienna

Five participants reported how they were able to utilise their personalities and existing skills to their advantage when engaging in DBT-A.

*“I don't take things very seriously. I'm quite a joker… I think that's helped because even when I've had a shit day and I'm like ‘ooh I need to do this homework now’, like taking the piss out of it, and then I'll sit and I'll do it” –* Eliza

*“I learned a lot of grounding techniques when I was in hospital… which helps me to stay present so that I'm able to like contribute to the group…” –* Sienna

*Accepting help*

This subtheme highlights how all participants used the support around them to achieve change. All participants felt that the therapeutic relationships assisted their engagement with DBT-A.

*“The therapists they're all really friendly and everything, and I think it's really helpful because the way they approach things” –* Aria

*“…very validating and they're very cheery like I could walk in here with a gloomy face and I'll come out with a massive smile on my face”* *–* Katie

Six participants felt that the therapists made them feel respected, provided a comfortable environment, and mediated their understanding, further increasing engagement.

“*[They don’t] make any judgements on what I’ve done… I don’t feel judged by anyone” –* Julia

*“I think that is it just the way [they] explain it is good, that's helped me a lot because obviously if it's not explained very well… I'm not going to want to do it”* - Eliza

Whilst the approach of the therapists was helpful, there was a sense that participants had to accept help and trust in the therapists.

*“You need to accept that you do need the help and that everyone needs help sometimes”* - Eliza

Further to the therapists support, participants found support from their peers in the skills groups, describing it as a validating and positive learning environment.

*“…sometimes you can relate… one person might say something and you be like yeah I can relate to that and obviously that then like validates each other… like I'm not on my own basically” –* Katie

*“For other people who I know to need that same stuff, it's kind of making me feel like I'm not alone because other people… need this as much as I do”* – Alice

All three participants in the multi-family skills group also found support in their parents.

*“…when I'm in a distressing situation and I can't physically use [skills] myself then like they know how to do it so it's a lot easier…” –* Katie

# *Theme 2: “In a real life situation when you’ve got loads on… it’s hard”; Change is complicated*

This theme represents seven participants that were motivated to make changes but recognised that achieving this was challenging.

*Resistance to change*

Six participants recalled noticing resistance towards possible change throughout DBT-A. This was understood as participants finding change difficult, but also a sense of wanting to resist it.

*“Obviously people are set a certain way. People are who they and trying to change that is always going to be difficult” –* Julia

*“You don't want to change it… it is what you've always known… so when they're trying to change it you're like no” –* Sienna

Victoria suggested that sometimes the encouragement to change felt like others did not accept her and this increased her resistance.

*“Some days I wake up and I'm angry at [DBT]… like so what I feel like this, it doesn't matter, people should just accept it… it's not my fault I feel like this… I just felt like people were trying to say that you need to change and need to conform, you need to manage these emotions” –* Victoria

Resistance to change was understood in the context of previously negative therapeutic experiences, and a lack of understanding towards participants’ difficulties. Five participants reported how these previous experiences had resulted in challenges in therapy.

*“Oh, I'm the only one, no one else knows, no one understands, everyone probably thinks I'm weird” –* Julia

*“Obviously I had a kind of I had doubts because the CBT hadn't worked so I was thinking that maybe like the DBT wouldn't work” –* Katie

Further, four participants noted that challenges in accepting their difficulties and need for help, furthered the resistance to change.

*“Because I'm stubborn and I like to think, oh yeah, I'll be fine on my own but I won’t” –* Eliza

*“I think coming to terms with my unhealthy behaviours and how some of my actions were not giving me or other people a good quality of life… It was almost a reality check” –* Freya

*Life gets in the way*

This subtheme represents six participants that discussed how their life circumstances impacted their engagement. Four participants talked about the difficulties of giving time to DBT-A when juggling education, employment, and a social life.

*“It's hard to balance between college life and work and driving lessons…I had to come here… I'd be missing classes that was difficult” –* Victoria

*“I had an argument today with one of my friends and it was very hard to come to therapy because I was like oh I feel so low there's no point” -* Alice

Trying to juggle social demands had previously prevented accessing therapy all together.

*“I left my ex-boyfriend [laughs]… there was things going on at the time that was literally preventing me from even coming to the sessions so it was just the switch happened when I left him” –* Eliza

Four participants discussed importance of timing when engaging with DBT-A, noting how their mental health impacted their ability to engage.

*“Unfortunately, my situation was worsening towards the end of DBT… so I think it was a difficult situation to go towards a full structured session.” –* Freya

*“Yeah like if I'd have done this therapy a year ago it wouldn't have worked because I had such a mind-set that nothing would have changed it” –* Sienna

Furthermore, there was reference to the challenges of engaging in DBT-A when experiencing multiple difficulties.

*“I have such bad low self-esteem and it's horrible for me because I can't see any good in myself… when I'm trying to validate myself… it's just [like], no thank you… it helps me in terms of emotions but not self-esteem, it just still feels quite low and difficult” –* Alice

## **Theme 3: “I feel like I can handle it because of DBT”; hard work pays off**

This theme represents the changes all participants recognised as a result of their engagement with DBT-A.

*“New therapy, new me”*

All participants discussed noticing improvements in the way they approached and managed their emotions since starting DBT-A. Participants felt they had more options to deal with difficult feelings due to the new learning.

*“I think I'm just a lot more positive and I think it's easier to approach my emotions and stuff and understanding my emotions and just having that different response to them” –* Aria

Four participants discussed their increased ability to tolerate unhelpful emotions.

*“My urges… I know how to deal with them and like how I can make them manageable and stuff… I don't have as much anxiety about it when I feel negative emotions that I'm going to basically end up back in hospital… because I know that I've got people I can fall back on and I've got skills I can use…” –* Katie

Three participants specifically reference how DBT-A had increased their management of life threatening behaviour.

*“You make healthier choices because if I hadn't gone to there and I’d probably still be self-harming… struggling to walk along the main road without wanting to throw myself in front of a car” –* Victoria

These behavioural changes also appeared to improve participants’ ability to better engage with educational and work demands.

*“…I think it makes school a bit easier for you… when you learn skills you can always use them any time…” –* Aria

*“I used to miss work like a lot. I have my job and I'd call in sick and I wouldn't go in… going to DBT, that helped… learning how to cope with those emotions so l could like carry on with my day to day life” –* Victoria

Learning new skills appeared to bring with it a new sense of confidence in their ability to cope in the future.

*“I still greatly struggle with my unhealthy behaviours but I do feel that my confidence has grown and the will for me to move on with my life in ways such as finding a job.” –* Freya

*“Relationship goals”*

All participants discussed how they had recognised improvements in their relationships. Some of these improvements appeared to have resulted from the participants having more skills to manage their emotions.

*“I think it's easier with family and stuff because you know you can deal with your emotions better with the skills and stuff… it's not as much as a strain on your family” –* Aria

*“…the examples and roleplays which I did in group sessions has lingered at the back of my mind, so I can visualize a better way of interacting in difficult social situations” –* Freya

Six participants discussed how they felt that they had gained a better understanding of their own needs which allowed them to communicate more effectively with others, thus improving their relationships.

*“All the skills that they teach us, it was very beneficial to what I use in my everyday life now and it helps me to not only help myself but also communicate with others and understand people” –* Alice

Six participants also explored improved relationships with their parents. This was not exclusive to those in the multi-family skills group, although all three participants in this group also reported improvements.

*“In the house it’s a lot more peaceful because it was actually me and [mum] just constant [arguing] so I think it's better for my brothers and sisters as well it's just a lot more peaceful now… now we just get on a lot better and we go out and we do things” –* Eliza

*“Well, we were already really close but I do think that having her come with me has brought us together a bit more” –* Sienna

Participants discussed improvements in their friendships, with five participants stating that they felt more able to evaluate their friendships.

*“It's definitely helped with friendships… I think DBT helped because it helped me understand what was happening, which helped me be able to communicate that to other people” –* Victoria

Moreover, the increased ability to better evaluate friendships appeared to be supported by a more compassionate understanding of themselves.

*“Bad friendships, I can kind of see them more now…I was kind of blinded like, oh, am I overreacting or is this my fault sort of thing whereas now I kind of see it for what it is… you're not actually in the wrong and you're not being overdramatic that they've upset you… you are being reasonable…” –* Eliza

## **Theme 4: “It was a struggle, definitely… but it does really make a difference”; DBT is tough, but it’s worthwhile**

This theme highlights participants’ responses to DBT-A as a therapeutic model. All participants are represented within this theme.

*A different approach*

All participants reported that DBT-A was a useful experience, but that it could be difficult. Most participants indicated that it is unique in comparison to other therapy approaches.

*“I would definitely say that it was an intense experience. I've not been through anything like that before” –* Victoria

*“It's like a different approach to any other type of therapy I've had before” –* Aria

*“I generally found it quite refreshing from other therapy types as it had a more unique and open mind-set…” –* Freya

Six participants found the use of individual and groups sessions helpful. They were seen to serve different roles, and there was a sense that individually, the sessions would have been less effective.

*“I think because we have it every week and we just have the group and stuff and it's kind of like I think you're motivated to do it because… it's so often like it's every week so we are prompted and stuff like that” – Aria*

*“I think it's a good balance because I think if you only did the emotions [individual], you might forget that your actions can help just as much and obviously if you just do the behaviours [group] you might forget that the emotions are there” –* Julia

Six participants did report that starting the skills groups was an anxiety provoking experience, although this did not appear to deter engagement and overall it was considered a helpful experience (*see theme 1)*.

*“When I first got there my anxiety was through the roof like no one's going to like me… but the people there were really nice… I really like everyone there.” –* Alice

*“I was really nervous because obviously new people, don't know what to expect… but when I realised that everyone was sort of similar age, everyone's there… essentially to get help, so it was nice like everyone sort of worked with each other… the group are really welcoming”* – Julia

The uniqueness of DBT-A, also appeared to impact the understanding of some of the terminology used, with three participants suggesting the terminology could make it more difficult to engage with.

*“I think that simplifying the names for modules and skills would be easier to take in and be more memorable, increasing the chance of applying the skills to situations” –* Freya

*It’s all about the skills*

A message shared by all participants was the importance of the skills in DBT-A. As represented in “new therapy, new me”, the skills resulted in behavioural change for all participants. The variety of skills was found particularly useful.

*“There is so many different skills and approaches to things… they help you to manage different emotions”* – Katie

Most participants were aware that not every skill would be helpful, but because there were a wide variety of skills, some of them were going to be effective.

*“I'm aware that not everything is going to help because not everything works for everyone but… other things will help me” –* Julia

*“…if one thing doesn't work there's always like three other things that you could try” –* Sienna

Seven participants named mindfulness as the most helpful skill. No other skills were named specifically by multiple participants.

*“I'd say mindfulness has been really good, the senses thing, when you're listening to something or you're looking at something a bit harder than you normally do” –* Victoria

*“Definitely mindfulness… it can be anything from sitting on the bus and looking at everything that's outside or it can be specific like eating...” –* Katie

All participants in the multi-family skills groups suggested that the skills helped parents to manage their own needs too.

*“It's really helped him get over this divorce that he's going through, it's really helped him a lot and I'm happy that he's still here and DBT really helps him” –* Alice

# Discussion

The present study offers insight into how young people experience DBT-A in an NHS community CAMHS service. DBT-A has a good evidence base, but this qualitative method allowed participants to go beyond outcomes and explore the process of engaging with the intervention, the influences upon that, and review the model. The themes provide an example of the experiences for young people who are seeking to better manage their mental health through DBT-A.

All participants reported that the therapy was a useful experience, supporting individual and relational change. The study found the variety of skills in this approach gave participants more options for managing difficult emotions, increasing the likelihood of finding an effective skill in varying situations. It was reported that this improved confidence in the ability to independently manage their wellbeing. Adult participants have also referenced the variety of skills in DBT as beneficial, reporting that it allowed for the development of a skill set pertinent to each individual (Childs-Fegredo & Fellin, 2018). In this study, participants’ highlighted mindfulness as the most helpful skill, as it helped to promote feelings of calm and could be easily applied in different situations. Some participants indicated that mindfulness was helpful in an education setting and supported concentration. There have been promising results for the use of mindfulness in education (Kuyken et al., 2013), and more recently the UK Government have provided funding for further research (Barr, 2019).

Unique to this study was the focus on the improved relationships with parents and peers appearing to be a result of participants approaching conflict differently, consistent with interpersonal effectiveness skills (Miller et al., 2007). Some participants reported solely having a better understanding of their own emotions allowed them to communicate more effectively with others. The improvement also occurred independently of family involvement, suggesting that individual change for the young person is enough to facilitate some change within their family system. This supports the idea that participants were taking responsibility, and were autonomous in influencing the change they wanted.

Interestingly, five participants reported feeling more able to recognise unhelpful friendships. This is particularly important for young people, as emotional support is often provided through friendships (Bukowski et al., 1998), and better quality friendships have been linked to lower levels of anxiety and low mood (Waldrip et al., 2008). Furthermore, this decreases the risk of relationships influencing possible future difficulties. The increased understanding of friendships appeared to be linked to a more compassionate understanding of self as well as an increased understanding of others and relationships. This study aimed to consider experiences of DBT-A outside of observable outcome measures. It was noteworthy that within this exploration participants discussed change in the context having more understanding of self. It is possible that accessing a therapy that is more accepting of complex difficulties provided a level of validation that prompted change.

DBT-A was considered a unique approach in comparison to other therapeutic approaches that the participants had experienced. The varied methods of delivery were noted, and found to be helpful, each adding something different. The skills groups were reported as a useful experience by most participants. Barnicot et al. (2015) reported that for adults, anxiety around the skills groups served as a barrier to engaging with DBT. This was not replicated in this study, as although participants did report initial anxiety, this was not maintained; partly due to the environment curated by the therapists, but also the positive relationships with peers in the group. Many participants reported feeling validated by their peers and able to learn from them.

Although positive changes were noted, the researcher was struck by the dedication and motivation all participants showed in their engagement with DBT-A. This is consistent with adult experiences, where participants have echoed a need to be highly motivated in order to engage effectively with this approach (Barnicot et al., 2015; Hodgetts et al., 2007). It was notable that all participants had experienced therapy in some form prior to starting DBT-A. Whilst this did pose some challenges to initial engagement, previous support appeared to contribute to motivation for some participants, as they aimed for a different future. The researcher considered that participants may have understood unsuccessful therapy as an individualised problem and wondered what narratives of mental health and societal expectations were influencing this. Further in the UK, most CAMHS services only provide care up to 18 years old. As such, participants in the current study may have experienced pressure to change before reaching this cut off which may have produced self-perceptions of what it means to become an 'adult'.

Therapeutic relationships are considered important in all therapeutic approaches (Flückiger et al., 2018), and all participants in the present study believed the relationship with the therapists assisted their engagement. Undoubtedly the therapists’ approach contributed to this, but there was also a sense that participants put a level of faith in the process allowing them to better engage. Given that previous experiences of therapy were mostly described as unhelpful, it appeared that participants’ willingness to work hard to achieve their goals helped them to overcome any doubt and highlighted the faith that participants invested into DBT-A and its support systems.

The challenges of the approach were less frequently reported in this study. Despite the reported high levels of motivation, all participants found DBT-A to be an intense experience, and most recalled feeling resistant to change at points throughout the therapy. DBT-A is a demanding intervention in regards to time commitments and emotional investment. Participants discussed their mental health, and life events impacting on their ability to engage with the therapy, perhaps in contrast with the objectives of the intervention. DBT-A aims to support ‘high-risk’ young people, experiencing suicidal ideation, self-harming behaviour, as well as behaviours that interfere with both therapy and quality of life (Miller et al., 2007).

The cause of this resistance was not fully explored, but participants recognised that change was difficult to achieve and suggested at times it felt more comfortable maintaining their pre-existing ways of coping. The researcher considered how much external pressure to change had been experienced by the participants. It was expressed throughout the interviews that the majority of participants had experienced a lack of understanding from others around them. Young people are often in a lesser position of power compared to the adults around them, and if others have struggled to contain them, they may have felt they were at fault contributing to some ambivalence towards change.

Furthermore, when considered in the context of life as a teenager, there are various demands to ‘do better’ educationally and socially. It is possible that participants may have experienced this in therapy, making engagement more challenging. One participant articulated that she could feel anger towards the encouraged change, as she conceptualised this as others not accepting her as she was. This is interesting considering that DBT-A aims to balance validation with promoting change. It could therefore be suggested that the resistance was experienced when there was a higher need for validation.

It was also expressed that the terminology and concepts could be hard to understand, and that comprehension was reliant upon the therapist. This is not unique to young people, with adults also reporting similar difficulties in understanding the concepts used in DBT (McSherry et al., 2012; Barnicot et al., 2015); however, DBT-A has already attempted to make the concepts more accessible for young people (Miller et al., 2007).

## Clinical Implications

In this study, motivation to achieve change through DBT-A was a salient factor to engagement. All participants discussed how high levels of motivation and commitment were required to manage the demands of this approach. It would therefore be useful for practitioners to emphasise this to young people before starting DBT-A, and consider ways to encourage and maintain motivation. This could include highlighting early changes and focusing on goals. It could also be useful to discuss motivation in the skills groups, and using the peer support already available. Furthermore, almost all participants experienced feelings of resistance towards the therapy. Only one person in this study stated that they discussed this experience with their therapist, and therefore naming it for young people could give permission to discuss this more openly and possibly reduce attrition.

Difficulties understanding DBT-A terminology was noted. Therapists should therefore provide accessible explanations, and check understanding. One participant suggested that encouraging young people to name the skills themselves could improve retention of the skill, increasing its application. Finally, DBT-A should consider how it promotes the generalisability of skills, particularly for those in the ‘teen-only’ group. It was suggested that increased contact with the therapist between sessions could offer coaching and help to maintain motivation in the absence of parental involvement. Use of text messaging or access to online support could further assist with this.

## Limitations

Recruitment remained in the recommended sample size for TA methodology (Braun & Clarke, 2013), but a wider range of young people’s voice would have expanded the understanding of the experience of DBT-A. Young people who had disengaged from therapy were excluded from the current study, as it was not possible to contact them regarding research once they are no longer part of the service. This likely resulted in a more positive narrative within the research.

This had implications for the participants that did engage in the study; TA methodology aims to find patterns across the data resulting in some individual experiences being lost. For example, one participant highlighted the toll of being around peers with similar difficulties, as it could be a trigger for her own mental health. Although an unavoidable consequence of the setting, this could be a barrier to engagement for some young people. The researcher was aware that this participant had to accept that their experience was not as positive as that perpetuated by the evidence base. As this was an individual experience, the researcher felt that they were also invalidating the difficult and challenging experience this participant had. Moreover, all participants were White-British females. This is representative of the service provision, but it limits the variation as to which young peoples’ voices are heard through research. It serves to uphold dominant narratives as opposed to recognising varied experiences. This could have been mediated by recruiting from multiple CAMHS services, which would have also strengthened the research.

Further, the recruitment strategy is likely to have aligned the researcher with the DBT therapists; participants were reminded that the researcher was not part of the DBT team, but they were employed by the same Trust and receiving support from the therapists to conduct the research, adding to the power imbalance. This likely limited engagement from those finding DBT-A less helpful and restricted the responses of those that participated.

## Future Research

Future research may wish to consider consent processes in conducting research with young people. Although it is not known to have hindered this study, the recommended option for parental withdrawal for those under the age of 16 could have prevented participation (BPS, 2014). It is important that young people are empowered to engage in research. The researcher reflected that measures in conducting this research were possibly over cautious, resulting in a lack of flexibility and likely furthering the power imbalance. This may have limited engagement from participants. Future research would benefit from involving young people in the planning of research to minimise this.

Future research should focus on exploring the circumstances around disengagement, as this could allow for further insight into the requirements for change within DBT-A. The majority of participants in this study were still engaging with DBT-A or had only recently ended; considering the experience of young people post-intervention would add value to the evidence by considering the mechanisms that may support any sustained change. Finally, there are no studies comparing outcomes between the ‘teen-only’ and multi-family skills groups, this may help understand more about the role of parental support.

# Conclusion

The young people in this study found DBT-A to be a useful therapy experience, albeit one that requires high levels of motivation and personal investment. The therapy offered young people a range of skills that had a positive impact on how they approached their difficulties and their relationships. DBT-A does come with challenges but young people found support in their therapists, parental involvement, and their peers within therapy. The young people included in this study appeared to have the motivation and resources to engage in DBT-A, but little is known about the experiences of those who have disengaged from the therapy, which are likely to provide further insight into the barriers and resources required to engage with this therapy.

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# Paper 3: Executive Summary

**Word Count: 2479 (excluding title page, contents page, glossary and references)**

**This paper is not intended for publication. It has been produced as a report primarily aimed at young people, and also professional working within Child and Adolescent Mental Health Services**

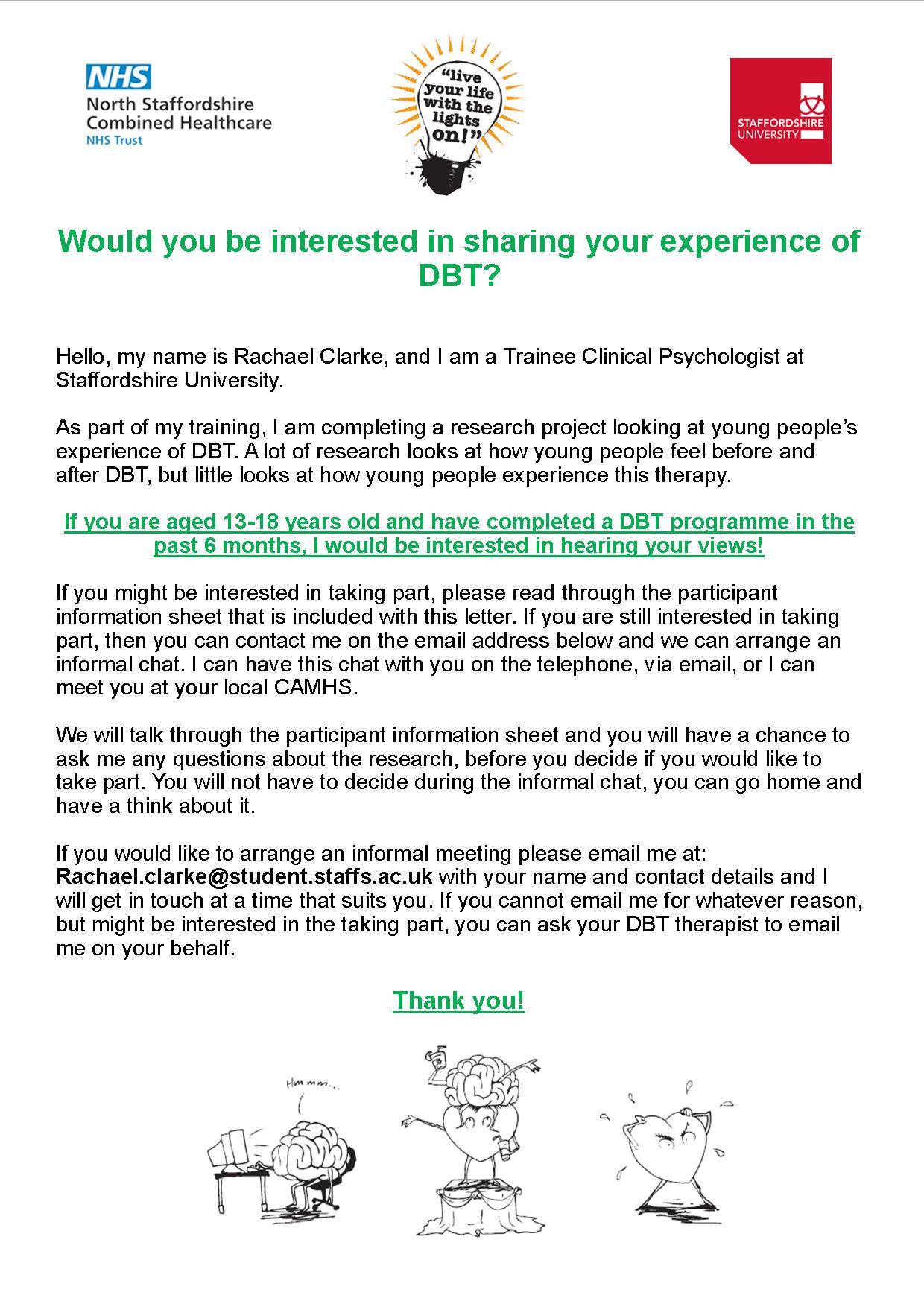


# Research Summary

# “You’ve got to have the right mind-set, if you really want to change you’ve got to work at it”:

# Exploring young people’s experience of

# Dialectical Behaviour Therapy for Adolescents (DBT-A) in a community CAMHS service



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**This Research Summary**

This summary has been prepared for young people aged 13 and over and professionals working in CAMHS. Due to the Covid-19 pandemic, it was not possible to share this report with young people currently attending Dialectical Behaviour Therapy for Adolescents (DBT-A) for comment; however five young people, aged 13-16 years old read the report to ensure readability.

This summary will outline a research study that explores how young people experience DBT-A. The study was completed as part of the Staffordshire University Clinical Psychology Doctorate. Approval for the study was granted by Staffordshire University and NHS ethics.

The outcomes of this study will be shared with participants and the service that supported the research. The research will be submitted to the ‘Journal of Child and Adolescent Mental Health’ to be considered for publication.

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# The Background to DBT for Young People

**Young people’s mental health in the UK**

In 2017, a survey showed that around 1 in 8 young people, aged between 5 and 19 years old met the criteria for one mental health difficulty, and 1 in 20 young people met the criteria for two mental health difficulties (NHS Digital, 2018).

This highlights the importance of mental health services for young people. The UK Government has promised more money for young people’s mental health services to allow for better access to the right care (Department of Health, 2015).

There are different therapies available for young people to help them to manage their mental health and research has shown that DBT can help with a range of difficulties.

**Dialectical Behavioural Therapy for Young People**

DBT was developed by Clinical Psychologist, Marsha Linehan. She developed the therapy to support women who were struggling to manage extreme emotions and experiencing thoughts of suicide (Linehan, 1993). A number of research studies found that after engaging in DBT, adults felt more able to cope with their emotions, were self-harming less often, and experiencing less suicidal thoughts (Carter et al., 2010).

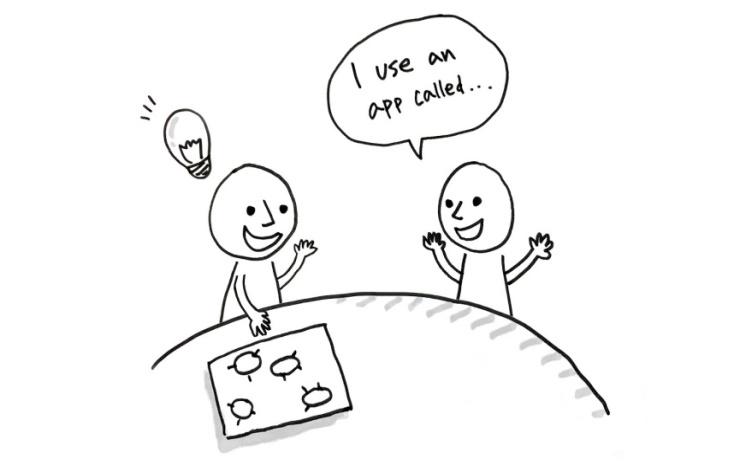
DBT was adapted to help with young people (aged 13 to 18) with similar difficulties; DBT for Adolescents (DBT-A) (Miller et al., 2007). DBT-A is based on the idea that trouble managing overwhelming emotions (sometimes called emotional dysregulation) is the main difficulty that leads to unhelpful and sometimes harmful behaviours, like self-harm. So, DBT-A aims to help young and their parents/carers to learn and practice new skills to manage their emotions in a less harmful way.

DBT-A involves weekly individual sessions and group sessions, and offers telephone coaching; connecting the young person to a DBT therapist to talk through a problem they are struggling to manage on their own.

DBT-A offers skills in five areas:

* Distress tolerance: skills that help to manage difficult emotions when the problem cannot be solved straight away
* Mindfulness: skills that encourage you to observe what is happening inside, and around you. Mindfulness allows a person to be present in the moment instead of focusing on the past or the future
* Emotional regulation: skills in helping you to recognise and manage reactions to emotions in a more helpful way
* Interpersonal effectiveness: combines social, assertiveness, listening, and negotiating skills to help people to communicate better within relationships
* Walking the middle path: designed for young people and their families, these skills encourage everyone to see a situation from a different viewpoints and develop a new solution together

DBT-A does aim to involve families in the group sessions when possible, as families can help the young person outside of therapy, but this is not required (Rathus & Miller, 2015).



**Research for DBT-A**

Research has shown that DBT-A can help young people with a range of difficulties.

**DBT has helped young people in foster care to reduce low mood, hopelessness, and self-harming behaviour**

(James et al., 2011)

**Research showed that young people in inpatient mental health care reduced self-harming and use of medication after attending DBT**

(Katz et al., 2004; McDonell et al., 2010)

**Following DBT, young people showed reductions in suicide attempts, self-harm and relationship difficulties**

(Fleischhaker et al., 2011)

**Young people showed improvements in eating related difficulties with the support of DBT**

(Salbach-Andrae et al., 2008)

**More recently, a study found that following a 16-week DBT-A programme, young people showed reduction in self-harm, suicidal ideation, low mood and used A&E departments less often. These benefits were maintained 16 weeks after the therapy ended**

(Flynn et al., 2018)

**Is DBT-A always helpful?**

Although there is a lot of research that tells us DBT-A can be helpful for young people; this is not the same for everyone. There still needs to be more research into DBT-A. Some adults have said that DBT can be a difficult therapy to complete. They said it takes up a lot of time, and sometimes it can be hard to understand the ideas in DBT (Barnicot et al., 2015).

# Aims of the Research

A lot of previous research has focused on using questionnaires to measure how someone is feeling before and after taking part in DBT-A, but little is known about how young people might experience DBT-A. Young people can offer unique and thoughtful insights into their own health care, and it is important that we hear those views (McLaughlin, 2015).

This study aimed to explore young people’s experience of taking part in DBT-A in a CAMHS service. The study focused on what young people may have gained from the intervention, what might have been challenging, and what they thought about DBT-A as a therapy. The purpose was to try to develop a better understanding of DBT-A, so that it could inform services how they can better support young people.

# How we conducted the study

The study was open to young people who were taking part in or had recently finished DBT-A at a CAMHS service in the West Midlands.

If any young people wanted to take part, they were given information about the research. Each participant had to sign a consent form to take part.

Each participant completed an interview with the researcher. Some interviews were completed at a CAMHS and audio recorded. Some interviews were completed via text message.

Eight young people, 14 to 18 years old, agreed to take part in the study. All participants were female. Two participants had completed the therapy, and six were still attending DBT-A.

Once the interviews were completed, the researcher conducted a ‘thematic analysis’. This involved going through the interviews and identifying the key ideas that each participant had talked about and finding similarities and differences across all of the interviews.

# What the research found

After completing the thematic analysis, the researcher developed ‘themes’. The themes represent the ideas that were most talked about across all of the interviews.

This study identified **4** themes:

**1: Taking responsibility**

**2: Change is complicated**

**3: Hard work pays off**

**3: DBT is tough, but it’s worthwhile**

**Each theme is supported by participant quotes from each interview.**

**All the participants’ names have been changed to protect their identity.**



**Theme 1:**

**Taking responsibility**

This theme represented how participants took responsibility for making changes in their lives. Participants discussed how they were motivated to make changes, and how they accepted help from others to reach their goals.

* Motivation is key; you need to want change and be willing to work hard for it
* Some participants were motivated by their previous experiences
* Personality traits and the skills that participants already had were helpful
* The therapist helped participants to use DBT-A
* For the participants who had their family attend, they felt that their family supported them
* Participants were supported by the other young people in the group setting

*“I do feel quite motivated because obviously this isn't my first time going through counselling and I suppose you get a bit fed up of it [laughs]… just wanna make everything better” –* Julia

“I think it's important for my mum to know skills as well so if I forget them she can help with them” – Sienna

**“**I feel like it really helps to be able to talk to someone just by yourself and know it's confidential” – Alice

**“**I think you just have to be positive about it and like not doubt it… if you actually give it a try it can really help you… I've just had to have a belief in it and just dedicate myself to it” – Aria

*“…like no one really understood the emotions I was feeling, why I was feeling like that, I didn't even understand it” –* Victoria

“Obviously… I had doubts because the cognitive behavioural therapy hadn't worked, so I was thinking that maybe the DBT wouldn't work” – Katie

“I understand that you have to go for it for it to work but I think in a real-life situation when you've got loads going on like college, work… it is hard to keep track of” – Eliza

“I think coming to terms with my unhealthy behaviours and how some of my actions were not giving me or other people a good quality of life... It was almost a reality check.” – Freya

**Theme 2:**

**Change is complicated**

This theme represented participants’ views that changing required lots of hard work, and that there were sometimes obstacles that prevented them from engaging with DBT-A. Participants discussed sometimes feeling like they didn’t always want to change, and how accepting their difficulties was hard.

* Timing of DBT; it is hard to take part in DBT with lots of other things going on, like juggling this with school/college and possibly part-time work
* Others not understanding their difficulties and previous therapy had been unhelpful, so it was hard to trust another therapy
* Change is hard; sometimes it feels more comfortable to stay as I am
* Accepting difficulties can feel like a reality check
* It can be hard to engage in DBT-A when struggling with your mental health

**Theme 3:**

**Hard work pays off**

This theme showed the changes participants believed they had made since starting DBT-A. Participants’ reported positive changes in how they managed their feelings, and in their relationships.

Participants noted improvements in:

* Gaining a better understanding of their difficulties
* Managing their feelings better
* More helpful thinking patterns
* Developing more skills
* Understanding others better
* Better at communicating their feelings to others
* Having better relationships with family
* Being more able to recognise unhelpful friendships

“Bad friendships, I can kind of see them more now…I was kind of blinded like oh am I overreacting… whereas now I kind of see it for what it is… you're not being overdramatic that they've upset you… you are being reasonable…” – Eliza

“Things aren't good right now but I feel like I can handle it because of DBT” – Alice

“I still greatly struggle with my unhealthy behaviours but I do feel that my confidence has grown and the will for me to move on with my life in ways such as finding a job.” – Freya

“I just reflect on my own week like how I've been feeling and why I've been feeling that way and looking at how I could have changed certain things to help me feel differently” – Julia

**Theme 4:**

**DBT is tough, but it’s worth while**

This theme related to what participants thought about DBT-A as a therapy. There were different likes and dislikes, but most participants agreed that DBT-A was a unique therapy that was hard work, but worth it.

* All participants found DBT-A to be useful in some way
* Having both the group and the individual sessions is helpful.
* Participants felt nervous starting the group, but most participants found the group a useful part of the therapy and felt support by other young people in their group
* Participants liked that there were lots of different skills in DBT; mindfulness was the most helpful
* Participants did say that DBT was hard work and thought the language could be complicated

“It's like a different approach to any other type of therapy I've had before” – Aria

“Definitely like mindfulness… so like it can be anything from like sitting on the bus and looking at everything that's outside or it can be specific like eating...” – Katie

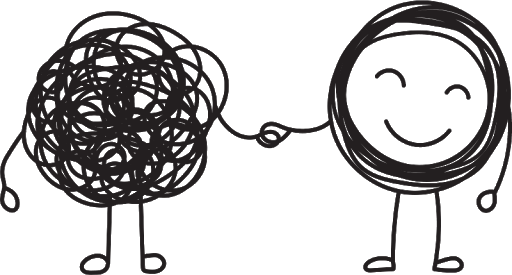
“I would definitely say that it was an intense experience, I've not been through anything like that before” – Victoria

“…if one thing doesn't work there's always like three other things that you could try” – Sienna

# What do the findings mean?

The young people in this study said DBT-A was a useful therapy but said that you needed high levels of motivation, and support from others to use it in a meaningful way to reach your goals.

Participants found that DBT-A offered a lot of skills that helped them to manage their difficulties and improved their relationships. DBT-A comes with some challenges which professionals can help to address.



# What can professionals do to help?

Therapists could try to motivate young people by highlighting what they are doing well, and how they are reaching their goals. Therapist could also use the group sessions to help young people to encourage one another.

Therapists can also recognise that young people might have times throughout therapy when it feels hard to change. This could be talked about in individual sessions to help the young person manage these feelings better.

DBT therapists can continue to evaluate DBT-A, and ask a range of young people for their views to help improve the service.

# How could this study be improved?

Having more participants would increase the number of young people’s views; more views gives a better understanding of the experience of DBT-A.

Most participants in this study had a positive experience of DBT-A and people who had dropped out of therapy were not included. The viewpoint of these young people would help to understand more about what is challenging about DBT-A and why some people drop-out.

The participants were asked to take part in this study by their DBT therapist, which might have put some people off taking part, especially young people who were not enjoying DBT-A.

# How could future research help?

Future research could focus on the experiences of young people who dropped out of DBT-A to understand more about what helps and what prevents change in this therapy.

Research could also follow-up with young people after they have completed DBT-A. This would find out if any of the changes from DBT-A were maintained over time.

# Conclusion

The young people in this research found DBT-A to be an intense but mostly useful therapy experience in helping them to reach their goals. They think that other young people need a lot of motivation to engage with this therapy. There are things professionals could do to support young people in DBT-A, and future research is needed to continue to understand young people’s experiences of this therapy.

# Glossary

**Consent form:** is a form that is signed by a participant before taking part in any research. The form explains what is involved in the research and any risks that might be involved. It makes sure that participants know what the research will include before they agree to take part

**‘et al’:** this is used to describe research with three or more authors. It uses the first authors name and the remaining authors are described as et al. For example, for this research summary it would be Clarke et al (2020), the other authors (Dr Helen Scott and Dr Heather Mason) would be seen in the reference list

**Participant:** someone who takes part in research

**Thematic analysis:** is a research method used to analyse written information like interviews or diary entries. It aims to find patterns in the information that express how a group of people feel about a topic. In this case, how young people feel about DBT-A

**Themes:** a concept that represents a pattern of ideas that appear frequently across a data set (e.g. interviews) that help to answer a particular research question.

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# Appendix A – Journal Submission Guidelines for Paper 1



From: <https://onlinelibrary.wiley.com/page/journal/10990879/homepage/forauthors.html>

*Clinical Psychology & Psychotherapy*aims to keep clinical psychologists and psychotherapists up to date with new developments in their fields. The Journal will provide an integrative impetus both between theory and practice and between different orientations within clinical psychology and psychotherapy. *Clinical Psychology & Psychotherapy*will be a forum in which practitioners can present their wealth of expertise and innovations in order to make these available to a wider audience. Equally, the Journal will contain reports from researchers who want to address a larger clinical audience with clinically relevant issues and clinically valid research. The journal is primarily focused on clinical studies of clinical populations and therefore no longer normally accepts student-based studies.

This is a journal for those who want to inform and be informed about the challenging field of clinical psychology and psychotherapy.

Submissions which fall outside of Aims and Scope, are not clinically relevant and/or are based on studies of student populations will not be considered for publication and will be returned to the author.

**2. MANUSCRIPT CATEGORIES AND REQUIREMENTS**

**Research articles:** Substantial articles making a significant theoretical or empirical contribution (submissions should be limited to a maximum of 5,500 words excluding captions and references).

**Reviews:** Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies (review submissions have no word limit).

**Assessments:** Articles reporting useful information and data about new or existing measures (assessment submissions should be limited to a maximum of 3,500 words).

**Practitioner Reports:** Shorter articles (a maximum of 2,000 words excluding captions and references) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

**3. PREPARING THE SUBMISSION**

**Parts of the Manuscript**  
The manuscript should be submitted in separate files: title page; main text file; figures.

***File types***

Preferred formats for the text and tables of your manuscript are .doc, .docx, .rtf, .ppt, .xls. LaTeX files may be submitted provided that an .eps or .pdf file is provided in addition to the source files. Figures may be provided in .tiff or .eps format.

*New Manuscript*  
Non-LaTeX users: Upload your manuscript files. At this stage, further source files do not need to be uploaded.  
LaTeX users: For reviewing purposes you should upload a single .pdf that you have generated from your source files. You must use the File Designation "Main Document" from the dropdown box.

*Revised Manuscript*

Non-LaTeX users: Editable source files must be uploaded at this stage. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files.  
LaTeX users: When submitting your revision you must still upload a single .pdf that you have generated from your revised source files. You must use the File Designation "Main Document" from the dropdown box. In addition you must upload your TeX source files. For all your source files you must use the File Designation "Supplemental Material not for review". Previous versions of uploaded documents must be deleted. If your manuscript is accepted for publication we will use the files you upload to typeset your article within a totally digital workflow.

The text file should be presented in the following order:

1. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's [best practice SEO tips](http://www.wileyauthors.com/seo));
2. A short running title of less than 40 characters;
3. The full names of the authors;
4. The author's institutional affiliations where the work was conducted, with a footnote for the author’s present address if different from where the work was conducted;
5. Conflict of Interest statement;
6. Acknowledgments;
7. Abstract, Key Practitioner Message and keywords;
8. Main text;
9. References;
10. Tables (each table complete with title and footnotes);
11. Figure legends;

Figures and appendices and other supporting information should be supplied as separate files.

***Authorship***  
Please refer to the journal’s [Authorship](https://onlinelibrary.wiley.com/page/journal/10990879/homepage/forauthors.html#authorship) policy in the Editorial Policies and Ethical Considerations section below for details on author listing eligibility.

***Acknowledgments***  
Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned, including the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s). Thanks to anonymous reviewers are not appropriate.

***Conflict of Interest Statement***Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the [Conflict of Interest](https://onlinelibrary.wiley.com/page/journal/10990879/homepage/forauthors.html#conflict) section in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

***Abstract***

Enter an abstract of no more than 250 words containing the major keywords. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

***Key Practitioner Message***

All articles should include a Key Practitioner Message of 3-5 bullet points summarizing the relevance of the article to practice.

***Keywords***  
Please provide five-six keywords (see [Wiley's best practice SEO tips](https://authorservices.wiley.com/author-resources/Journal-Authors/Prepare/writing-for-seo.html)).

***Main Text***

1. The journal uses US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.
2. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

***References***References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in-text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the [APA FAQ](http://www.apastyle.org/learn/faqs/index.aspx).

***Endnotes***  
Endnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should be numbered in the list and referred to in the text with consecutive, superscript Arabic numerals. Keep endnotes brief; they should contain only short comments tangential to the main argument of the paper.

***Tables***  
Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and \*, \*\*, \*\*\* should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

***Figure Legends***  
Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

***Figures***Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. Click [here](http://media.wiley.com/assets/7323/92/electronic_artwork_guidelines.pdf) for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

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**Additional Files**

***Appendices***Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

**General Style Points**

The following points provide general advice on formatting and style.

1. **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
2. **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the [Bureau International des Poids et Mesures (BIPM) website](https://www.bipm.org/en/about-us/) for more information about SI units.
3. **Numbers:** numbers under 10 are spelled out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
4. **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

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The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. **If the authors have no conflict of interest to declare, they must also state this at submission**. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

**Funding**  
Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: <https://www.crossref.org/services/funder-registry/>

**Authorship**

The list of authors should accurately illustrate who contributed to the work and how. All those listed as authors should qualify for authorship according to the following criteria:

1. Have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data;
2. Been involved in drafting the manuscript or revising it critically for important intellectual content;
3. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; and
4. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in the Acknowledgements statement on the title page (e.g., to recognize contributions from people who provided technical help, collation of data, writing assistance, acquisition of funding, or a department chairperson who provided general support). Prior to submitting the article all authors should agree on the order in which their names will be listed in the manuscript.

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Joint first or senior authorship: In the case of joint first authorship, a footnote should be added to the author listing, e.g. ‘X and Y should be considered joint first author’ or ‘X and Y should be considered joint senior author.’

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# Appendix B - Critical Appraisal Skills Programme Qualitative Checklist

The CASP (2018) can be accessed here:

<https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf>

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CASP (2018) Quality Checklist – Qualitative Research** | **Study and scores received** | | | | | | | | | | | | |
| Perseius et al. (2003) | Cunningham et al. (2004) | Hodgetts et al. (2007) | Despreles. (2010) | McSherry et al. (2012) | Smith. (2013) | Barnicot et al. (2015) | Roscoe et al. (2015) | Russell & Siesmaa. (2016) | Thomson & Johnson. (2016) | Crossland et al. (2017) | Slater. (2017) | Childs-Fegredo & Fellin. (2018) |
| 1. Clear Aims? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 2. Qualitative methodology appropriate? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 3. Research design appropriate? | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 2 |
| 4. Recruitment strategy appropriate? | 1 | 0 | 1 | 1 | 1 | 2 | 2 | 1 | 1 | 2 | 1 | 1 | 1 |
| 5. Was data collection method appropriate? | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 2 |
| 6. Relationship between researcher and participant considered? | 1 | 0 | 0 | 1 | 0 | 1 | 2 | 0 | 0 | 1 | 0 | 1 | 1 |
| 7. Ethical issues considered? | 1 | 1 | 2 | 2 | 1 | 2 | 1 | 2 | 1 | 2 | 2 | 2 | 2 |
| 8. Data analysis rigorous? | 2 | 1 | 1 | 2 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 1 | 2 |
| 9. Clear statement of finding? | 1 | 0 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 1 | 1 |
| 10. Is the research valuable? | 2 | 1 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 1 | 1 | 2 | 2 |
| **Total Score** | **16** | **11** | **15** | **17** | **11** | **17** | **19** | **15** | **13** | **16** | **14** | **15** | **17** |

# Appendix C - Quality scores for qualitative research

Each paper was scored out of a total of 20 points. Papers were awarded 2 points for fully meeting the question criteria, 1 point for partially meeting the criteria, and if papers were award ‘no’ or ‘can’t tell’ in response to a question, 0 points were awarded.

# Appendix D – Journal Submission Guidelines for Paper 2



From

<https://onlinelibrary.wiley.com/page/journal/14753588/homepage/forauthors.html>

**Author Guidelines**

1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Measurement Issues; Innovations in Practice; Narrative Matters; Debate Articles.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original submission, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.  
  
3. Manuscripts should be submitted online. For detailed instructions please go to: [**http://mc.manuscriptcentral.com/camh\_journal**](http://mc.manuscriptcentral.com/camh_journal) and c*heck for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal c*reate a new account.* Help with submitting online can be obtained from the Editorial Office at ACAMH (email: [**publications@acamh.org**](mailto:publications@acamh.org))  
  
4. Authors’ professional and ethical responsibilities *Disclosure of interest form*  
All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.  
  
*Ethics*  
Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the [***Ethical principles of psychologists and code of conduct***](http://www.apa.org/ethics/code/index.aspx) (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts  of the International Committee of Medical Journal Editors ([**ICJME**](http://www.icmje.org/urm_main.html)) and is also a member and subscribes to the principles of the Committee on Publication Ethics ([**COPE**](http://www.publicationethics.org/resources/code-conduct)).

*Informed consent and ethics approval*  
Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county. Within the Methods section, authors should indicate that ‘informed consent’ has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

*Preprints*CAMH will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article. Please find the Wiley preprint policy [**here**](https://authorservices.wiley.com/author-resources/Journal-Authors/open-access/preprints-policy.html?1).

*Note to NIH Grantees*Pursuant to NIH mandate, Wiley-Blackwell will post the accepted version of contributions authored by NIH grant-holders to PubMed Central upon acceptance. This accepted version will be made publicaly available 12 months after publication. For further information, see [**www.wiley.com/go/nihmandate**](https://www.wiley.com/WileyCDA/Section/id-321171.html).

*Recommended guidelines and standards*  
The Journal requires authors to conform to CONSORT 2010 (see [**CONSORT Statement**](http://www.consort-statement.org/consort-2010)) in relation to the reporting of randomised controlled clinical trials; also recommended is the [**Extensions of the CONSORT Statement**](http://www.consort-statement.org/extensions/) with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of the main text, and in the online manuscript submission. Trials must be registered in one of the ICJME-recognised trial registries:  
  
[**Australian New Zealand Clinical Trials Registry**](http://www.anzctr.org.au/)  
[**Clinical Trials**](http://www.clinicaltrials.gov/)  
[**Netherlands Trial Register**](http://www.trialregister.nl/trialreg/index.asp)  
[**ISRCTN Registry**](https://www.isrctn.com/)  
[**UMIN Clinical Trials Registry**](http://www.umin.ac.jp/ctr/)  
  
Manuscripts reporting systematic reviews or meta-analyses will only be considered if they conform to the [**PRISMA Statement**](http://www.prisma-statement.org/index.htm). We ask authors to include within their review article a flow diagram that illustrates the selection and elimination process for the articles included in their review or meta-analysis.  
  
The [**Equator Network**](http://www.equator-network.org/resource-centre/library-of-health-research-reporting/library/) is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work [**http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields**](http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields) and on quasi-experimental [**http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research**](http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research) and mixed method designs [**http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond**](http://www.equator-network.org/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond)  
  
*CrossCheck*An initiative started by *CrossRef* to help its members actively engage in efforts to prevent scholarly and professional plagiarism. The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscripts to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

5. Manuscripts should be double spaced and conform to the house style of *CAMH*. The title page of the manuscript should include the title, name(s) and address(es) of author(s), an abbreviated title (running head) of up to 80 characters, a correspondence address for the paper, and any ethical information relevant to the study (name of the authority, data and reference number for approval) or a statement explaining why their study did not require ethical approval.

*Summary:* Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.    
  
*Key Practitioner Message:* Below the Abstract, please provide 1-2 bullet points answering each of the following questions:

* **What is known?** - What is the relevant background knowledge base to your study? This may also include areas of uncertainty or ignorance.
* **What is new?** - What does your study tell us that we didn't already know or is novel regarding its design?
* **What is significant for clinical practice?** - Based on your findings, what should practitioners do differently or, if your study is of a preliminary nature, why should more research be devoted to this particular study?

*Keywords:*Please provide 4-6 keywords use **[MeSH Browser](https://www.nlm.nih.gov/" \t "_blank)** for suggestions

6. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Articles should adhere to journal guidelines and include a word count of their paper; occasionally, longer article may be accepted after negotiation with the Editors.   
  
7. Authors who do not have English as a first language may choose to have their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at [**http://authorservices.wiley.com/bauthor/english\_language.asp**](http://authorservices.wiley.com/bauthor/english_language.asp). All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.  
  
8. Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.  
  
9. All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:  
  
*Study funding:* Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.  
  
*Contributorships*: Please state any elements of authorship for which particular authors are responsible, where contributorships differ between author group. (All authors must share responsibility for the final version of the work submitted and published; if the study include original data, at least one author must confirm that he or she had full access to all the data in the study and takes responsibility for the integrity of the data in the study and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked. *Conflicts of interest:* Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".  
  
10. For referencing, *CAMH* follows a slightly adapted version of APA Style [**http:www.apastyle.org/**](http://apastyle.org/). References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.  
  
References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.  
  
11. Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.  
  
12. Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file. See [**http://authorservices.wiley.com/bauthor/illustration.asp**](http://authorservices.wiley.com/bauthor/illustration.asp) for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.  
  
13. Footnotes should be avoided, but end notes may be used on a limited basis.

# Appendix E – Invitation for participants

# Appendix F – Participant Information Sheet

****

**Participant Information Sheet**

**Young people’s experience of adapted dialectical behaviour therapy (DBT) in a community CAMHS setting**

**Name of researcher: Rachael Clarke (Trainee Clinical Psychologist)**

**Overview of the study**

I am a currently training to be a Clinical Psychologist at Staffordshire University. As part of my course, I am doing a research project to explore young people’s experience of taking part in dialectical behaviour therapy (DBT).

**What is the point of the study?**

DBT is a well-researched approach and studies show that it is an effective type of therapy for supporting both adults and young people with a variety of difficulties. A lot of these studies focus on how people feel before and after taking part in a DBT programme, but little is known about how people might experience DBT and what impact it might have.

I am interested in thinking about how young people experience DBT within a CAMHS service and what impact it has on the lives of young people. I think it is important that young people get to talk about their experiences and have their voices heard.

**What would taking part in the study involve?**

To be involved in this study, you need to have completed the DBT programme within North Staffordshire Combined Healthcare CAMHS in the last 6 months.

If you might be interested in taking part, you can contact me to arrange an informal discussion. You can contact me via email to arrange this, or you can ask a DBT therapist to contact me on your behalf. You can choose if you would like to meet me at your local CAMHS or if you would prefer me to contact you via telephone. I will go through the information about the study, and you can ask me any questions.

If you would still like to take part in the study, I will arrange to meet you at your local CAMHS to conduct an interview about your experiences of DBT. The interviews will last approximately 1 hour and they will be audio-recorded.

At the interview, you will be asked to sign a consent form agreeing to take part. If you are under the age of 16, your parent or guardian will be informed of your potential participation in the study and you will need their permission to take part.

In the interview, you will be asked some background information (such as your age, time with CAMHS) and the interview will consist of some questions about your experience of DBT. The interview will mainly focus on parts of DBT you found helpful, less helpful, and any differences you have noticed since taking part. You will not have to answer any questions or give any information that you do not want to.

**Do I have to take part?**

No. It is up to you if you decide to take part. If you decide to take part, you are free to withdraw from the research up to 3 weeks after taking pat without having to give a reason. Withdrawal after this date will not be possible as the information collected will have begun to be analysed. Any care you currently receive or may receive in the future will not be affected by your decision to take part, or not to take part.

**What’s good about taking part?**

It is hoped that this research will further the understanding of how DBT might be for young people. It will be a chance for you to share your experiences and this study could help to inform how DBT is delivered to young people in the future. The outcomes of this study will be shared with North Staffordshire Combined Healthcare Trust and hopefully shared nationally.

**What might be difficult about taking part?**

For some young people, discussing your experiences of this therapeutic intervention (DBT) could be distressing or anxiety provoking. However, if at any point you find taking part in the study too distressing, you have the right to end the interview. You will be given information about local support services and will have the option to speak with a CAMHS professional. With your permission we can also notify family, friends or a CAMHS worker for further support.

What you say in the interview will remain confidential, unless it is felt that there is a significant risk to you or to others. If it is felt that there is a significant risk, confidentiality will be broken and the appropriate safeguarding routes will be followed. You will be kept informed about this process wherever possible.

**Data protection and my rights**

Your information will be managed in line with the General Data Protection Regulation, 2016 (GDPR). For this project, Staffordshire University will manage your data. The University will hold your personal information for the purpose of the research outlined above only. The legal basis for using your personal information for research purposes under GDPR is a ‘task in the public interest’. You can provide your consent for the use of your personal information in this study by completing the consent form that you will be given before starting the research interview.

You have the right to access any information held about you, this is in line with the GDPR regulations. You also have other rights over your information; for example you have the right to correct any false information held about you, the right to be forgotten and have your information removed, and if you think your information is not being used for what you agreed to then you have the right to ask that your information stopped being used. More information about your rights can be found at [www.ico.org.uk](http://www.ico.org.uk).

Any questions or requests about your personal data can be sent to the Staffordshire University Data Protection Officer, more information at [www.staffs.ac.uk/data-protection](http://www.staffs.ac.uk/data-protection). If you wish to lodge a complaint with the Information Commissioner’s Office, please visit [www.ico.org.uk](http://www.ico.org.uk).

**What happens after the study?**

After the interview has taken place, the information will be anonymised and stored securely at Staffordshire University for 10 years before being destroyed. The results from the study may be used for research publication, conferences or teaching session, but all information will be anonymised and no one will be able to identify you. You have the right to withdraw from the study up to 3 weeks after taking part.

**Contact information**

If you would like to contact me about the study, please email me at [rachael.clarke@student.staffs.ac.uk](mailto:rachael.clarke@student.staffs.ac.uk)

If you prefer, you can contact Dr Helen Scott, the research supervisor, you can email her at [h.scott@staffs.ac.uk](mailto:h.scott@staffs.ac.uk) or telephone on 01782 294007 (office contact available between 8 -4pm, Tuesday to Friday)

**Thank you very much for taking the time to read through this information!**

**Local Support Services**

**CAMHS Hub**

The hub is the initial contact point if you are looking for support with any mental health difficulties. You can make referrals via this number.

**Telephone Number:** 0300 123 0907 (choose option 4, weekdays 9-5pm)

**Website:** [www.combined.nhs.uk](http://www.combined.nhs.uk)

Image result for twitter **@combinednhs**

[](http://www.changesyp.org.uk/)**Changes YP**

**Changes YP is a peer support service promoting the recovery of young people in mental distress throughout Stoke-on-Trent and Staffordshire. They offer guidance and support for young people experiencing a range of difficulties from low self-esteem to anxiety and depression.**

**Telephone Number:** 01782 413355, for more information

**Website:** [www.changesyp.org.uk](http://www.changesyp.org.uk)

Image result for twitter **@YPChanges**

**Younger minds**

Younger Mind offers emotional support to young people aged up to 18 years who live in Stoke-on-Trent and North Staffordshire including the Staffordshire Moorlands. They provide a range of support for both young people and their parents.

**Telephone Number:** 01782 262100 (Stoke on Trent), 01782 618803 (Newcastle-under-Lyme), 01785 283440 (Stafford).

**Website:** <http://nsmind.org.uk/support-for-young-people/younger-mind/>

Image result for twitter **@NorthStaffsMind**

**Dove**

Dove provides counselling and support groups for people who have experienced bereavement. Dove offers specialist services for young people.

**Telephone Number:** 01782 683155

**Website:** [www.thedoveservice.org.uk](http://www.thedoveservice.org.uk)

Image result for twitter **@thedoveservice**

**Galaxy**

Galaxy is a youth group in Stoke-on-Trent for people aged 13-18 who identify as lesbian, gay, bisexual or transgender (LGBT), or people questioning their sexuality or gender.

**Telephone Number:** 0300 123 0970

**Website:** <http://www.lgbtstoke.co.uk/galaxy>

**Savana**

Savannah offers support in the North Staffordshire area to anyone who is affected by or has experienced sexual violence. Savannah now offers specialist support for young people.

**Telephone Number:** 01782 433205

**Website:** [www.savana.org.uk](http://www.savana.org.uk)

Image result for twitter **@savana25th**

# StaffsUni Red print versionAppendix G – Participant consent form



**CONSENT FORM**

**Young people’s experience of adapted dialectical behaviour therapy (DBT) in a community CAMHS setting**

Before you agree to take part, please make sure you read the participant information sheet (version 4, 13/04/2019) carefully. If you have any questions, please ask the researcher before you agree to take part. Please read each of the following statements carefully and initial the box, if you agree.

|  |  |
| --- | --- |
| **Statement** | **Initials** |
| I have read and understood the information sheet (version 4, 13/04/2019), I have been given time to consider the information, ask any questions, and I am happy with the answers given. |  |
| I understand that my participation in this study is entirely voluntary. |  |
| I understand that I can withdraw from the study at any time and up to 3 weeks after taking part without having to give an explanation and without this affecting my care now or in the future. |  |
| I understand that the interview will be audio-recorded and only the researcher (Rachael Clarke) and the academic supervisor (Dr Helen Scott) will have access to this recording. |  |
| I understand that my personal details (name, date of birth, address) will be shared with the researcher (Rachael Clarke) for agreed communication only. If you would like a summary of the research, your personal details will be held for up to three months after the end of the study so that the information can be forwarded to you. After this it will be destroyed. |  |
| I understand that data collected could be used for publication, and that data will be anonymised and my personal details will not be included. |  |
| I consent to quotes of what I have said being used in a publication; I understand that I will not be named and any identifiable characteristics will be edited to protect my identity, but understand that there is a risk I could be identified based on the quote used. |  |
| I understand that the data collected will only be used for this study, as titled on this consent form. I understand the data may be audited by Staffordshire University for quality purposes. |  |
| I understand that all interview data will be stored safely on a password protected computer (electronic data) and locked away securely (written copies of data) for 10 years before being destroyed. |  |
| I have read and understood the information about data protection and my rights to my personal information. |  |
| I understand that my confidentiality will be broken if I disclose a serious risk to my own life, someone else’s life or if I am at risk of being harmed by someone else. |  |
| I agree to take part in the above study |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Participant (print) Date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Researcher (print) Date Signature

# Appendix H – Parental Opt-out Form



Date:

**Research Information Sheet**

**Opt-out letter**

Dear Parent/Guardian,

I am writing to inform you that your child has been offered the opportunity to participate in a research study. The study is looking at young people’s experience of the adapted dialectical behaviour therapy (DBT) programme. The study is being conducted by Rachael Clarke, a Trainee Clinical Psychologist from Staffordshire University. As your child has engaged with the DBT programme with CAMHS, they may be interested in sharing their experiences as part of this study.

**Details of study**

*What is the study about?*

Dialectical behaviour therapy or DBT is a well-researched therapeutic approach that has been shown to support both adults and young people with a variety of difficulties. Most of the studies focus on how helpful the therapy has been (usually using questionnaires), and only a small number of studies have explored how people have experienced the therapy. Up to now, no studies have looked at how young people experience engaging in a DBT programme.

This study hopes to explore young people’s experience of DBT and think about any impossible impacts of this therapy for them. This will help to provide a new perspective to the literature and give young people more of a voice when thinking about therapeutic interventions and possibly service design.

*What would my child have to do?*

Each participant is required to have an informal conversation with the lead researcher. This can take part over the telephone or face to face at your local CAMHS. This will provide your child with the required information to help them to understand what would be involved in the research and consider if they would like to take part.

If they still wish to take part, I will ask that they contact me to confirm this and I will arrange a single face to face interview. This will take place at your local CAMHS. The interview will last up to 60 minutes, and I will arrange this at a convenient time for your child within the CAMHS operating hours (Monday-Friday, 9-5pm). Once the interview has finished, your child will asked if they would like to receive feedback on the study and how this will happen. Any further support required as a result of the interview will also be discussed.

*What are the possible benefits and the risks of taking part?*

It will be a chance for your child to share their experience experiences and hopefully help to inform how DBT is delivered to young people in the future. It is aimed that the outcome of this study may be published nationally but the outcome will also be shared locally with North Staffordshire Combined Healthcare Trust and the CAMHS service, helping them to think about how services are delivered.

It is also understood that discussing personal experiences could be distressing or anxiety provoking for your child. However, please be assured that should your child become distressed at any point throughout the interview, they have the right to stop the interview without consequence. Information about the support available to your child will also be shared with them.

*What do I need to do now?*

If you are happy for your child to take part in this research, you do not need to do anything. However if you would like to opt your child out of taking part, please let us know within 2 weeks of the date of this letter.

If we do not hear from you within 2 weeks of the date on this letter, an interview slot will be arranged for a convenient time. Please note, that you are able to withdraw your child from the research up to 3 weeks after the interview has taken place. Further information of the withdrawal process is provided in your child’s participant information sheet.

You can inform us of the withdrawal by:

* Returning this form to the reception of your local CAMHS
* Emailing the lead researcher at [rachael.clarke@student.staffs.ac.uk](mailto:rachael.clarke@student.staffs.ac.uk) with your child’s name and date of birth.

You **do not** need to provide a reason for opting your child out of this research.

If you have any questions about the research, you can contact the email address above, or alternatively you can contact Dr Heather Mason (Clinical Psychologist and CAMHS DBT Lead) on 0300 123 0987.

Yours Sincerely

*Rachael Clarke*

*Trainee Clinical Psychologist*

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

I ……………………………………………(name) have read the information above and decided that I would like to opt out my child ………………………………………(child’s name) from the above study.

Signed: ………………………………………… Date:………………

# Appendix I – Demographic Information Sheet

**Demographic Information**

There is no requirement to complete this form. It is optional. You can answer as many questions as you feel comfortable answering. All the information you give will be anonymised and stored securely.

|  |  |
| --- | --- |
| Age |  |
| Age at time of commencing DBT  (if different to above) |  |
| Gender identified as |  |
| Type of DBT completed |  |
| Length of DBT involvement to date |  |
| If you have completed DBT, how long ago did you finish it? |  |
| Have you been involved with any other types of therapy? If so, which ones? |  |

# Appendix J – Proposed Interview Schedule

**Semi-Structured Interview Schedule**

This is a proposed interview schedule. It provides 6 broad questions and some prompts that may be used throughout the interview. In line with the design of the research, this proposed schedule is to act as a guide and not to be rigidly adhered to (Braun & Clarke, 2013). Participants will be given the opportunity to discuss their topics of interest in relation to the research question, which is felt important to them. This guide will be continually reviewed throughout the interview process and updated and adapted if required.

**Before interview begins:**

Brief review of the participant information and consent form to be completed.

Reminder given about the right to withdraw, and right not to answer questions.

Confidentiality discussed.

**Background information gathering:**

Age?

Gender?

Ethnicity?

Time with CAMHS?

Previous therapeutic support/on-going therapeutic support?

**Possible Interview Questions:**

1. **Tell me about your experience of DBT**

Possible further prompts:

* How did you find the theory/approach of DBT
* How did you find the delivery/format of DBT

1. **What (if anything) did you find the most helpful about DBT**
2. **What (if anything) did you find the least helpful about DBT**

Possible further prompts for questions 2 & 3:

* Specific questions about how helpful/unhelpful elements of the skill areas (mindfulness, interpersonal effectiveness, distress tolerance, emotional regulation?
* Specific question about how helpful/unhelpful were group skills workshops, individual therapy?
* If not covered, ask why those elements were more helpful or unhelpful?

1. **Are there any elements of the DBT programme you would like to change?**

Possible prompts

* If so, why?
* What difference do you think this might have made for you? For others?

1. **How, if at all, do you feel your life has changed since taking part in DBT?**

Possible prompts:

* If so, which areas of your life do you feel have changed most?
* Do you think other people have noticed a change in you? If so, how?

1. **If you were to do DBT (or another type of therapeutic intervention) again, is there anything you would do differently?**

Possible prompts:

* If so, what difference to do you think might have had on your experience?
* What advice might you give to someone who is starting DBT?
* Is there anything you think would be helpful for the DBT therapist to know?

1. **Is there anything that we have not spoken about through this interview that you feel would be important for others to know? Is there anything else you would like to add?**

# Appendix K – Supporting Quotes

Extended and additional quotes to support each theme.

|  |  |
| --- | --- |
| **Theme** | **Supporting Quote** |
| **Theme 1: Taking responsibility** |  |
| Attitude to therapy | ***“****I think you know you just have to be positive about it and like not doubt it… if you actually give it a try it can really help you… I've just had to have a belief in it and just know dedicate myself to it” – Aria*  ***“****To go in with an open mind and don't be stubborn and just think yeah I'm going to give this a shot” – Eliza*  *“Motivation, like I'm not going into the group thinking oh this is pointless I'm sort of going in there with a okay this could work this could help me and I supposed I'm aware that not everything is going to help because you know not everything works for everyone but I do appreciate and understand that that is the case but other things will help me” – Julia*  *“There's been times where I've thought like this isn't helping or this isn't going to help or anything like that, I think it's helped the fact that I still want to feel better in myself that I want to make a change in my life so that I like have a life worth living” - Katie* |
| Accepting help | *“it's obviously when I can't when I'm in a distressing like situation and I can't physically use them myself then like they know how to do it so it's a lot easier…” – Katie*  *“[They’re] very positive and very like I've known [therapist] like a year now so [they] know what I've been through and stuff and [they] just makes it so that you can be comfortable in there and [they] kind of puts into perspective” – Eliza*  ***“****I can honestly say [therapist] was the best therapist I've ever worked with. [They] shared a lot of views on mental health topics and recovery and being realistic and dialectical.” – Freya*  *“I think it's important for my mum to know skills as well so if I forget them she can help with them” –* Sienna |
| **Theme 2: Change is complicated** |  |
| Resistance to change | ***“****But sometimes DBT can feel like they're trying to change your mind-set and that what kind of upset me a little bit…like I still struggle with that now because I'm such a different person it's hard to come to terms with almost” – Victoria*  *“Because if you like a couple of weeks ago I went into a session and I was set on how I was feeling like he told me a few skills but I just didn't use them because I just want I almost wanted to feel the way I felt” – Sienna*  *“It can take some time because teenagers are pretty stubborn” – Katie*  *“…no one really understood the emotions I was feeling, why I was feeling like that, I didn't even understand it” –* Victoria |
| Life gets in the way | *“I understand that you have to for it for it to work but I think in a real-life situation when you've got loads going on like college, work, everything it is hard to keep track of” – Eliza*  *“It's hard when you're not used to opening up to someone it's hard to start… you have to let them have that time to kind of process what's going on because sometimes we don't know what's going on so we can't explain it…” – Katie*  *“I didn't understand what I was thinking and I didn't understand what I was feeling why I was feeling it I was just confused and I had so much on my plate and I was just stressed out” – Victoria*  *“Sometimes yeah when I've had a bad week and… my mind just hasn't been on it” - Eliza* |
| **Theme 3: Hard work pays off** |  |
| “New therapy, new me” | *“I just felt better in myself and I felt like I'm happier I felt happier I felt like I valued things a lot more than I did before” – Victoria*  *“I'm a lot more chill now I feel like now I'm 18 as well I needed to kinda relax and be able to regulate my relations a bit better because obviously I can't just be getting angry all the time because I'm no longer a child so I think it's kind of made me grow up a bit” – Eliza*  *“I feel a lot better within myself” – Katie*  *“You know because the whole point of DBT is to reduce life threatening behaviours and to live a life worth living so you know it's like using the skills on a daily basis and stuff it just helps you manage life a lot easier” - Aria* |
| “Relationship goals” | *“I think for example if I was having an argument with my parents or something you know there would still be an argument there but I'd be able to manage it differently rather as if you know I was just feeling quite upset and stuff I could have a completely different approach to it to how I usually would before I started DBT” – Aria*  *“like it's just good with your relationships as well you can kind of step back and think oh no this isn't right so I'm going to do this instead you know what I mean it's easier now to put things into perspective” – Eliza*  *“Like I said me and my mum don't really get on err but now we can hold like three minute conversations and that's nothing but it's still progress” – Victoria*  *“I am now better in explaining myself and how I feel and have gained more confidence in expressing myself socially…” – Freya* |
| **Theme 4: DBT is tough, but it’s worthwhile** |  |
| A different approach | ***“****Because you have to open up quite a bit you have to be completely honest with yourself… so it's quite intense” – Sienna*  *“Yes, I did find it more easier to learn am take in information in my individual sessions as I think that the fact that it is one to one puts on a positive pressure to speak and interact.” – Freya*  *“You know at the start when nobody would even speak to each other by the end we were all role playing like little scenarios and stuff and I thought that was lovely” – Victoria*  *“I think that simplifying the names for modules and skills would be easier to take in a more memorable increasing the chance of applying the skills to situations” – Freya*  *“I first got there my anxiety was through the roof like no one's going to like me… but the people there were really nice… I really like everyone there.” – Alice*  *“Err I like the way that it's delivered to be fair like everyone's involved and you don't feel singled out at any point it's a comfortable environment so you don't feel like you're sat in school or anything” – Julia* |
| It’s all about the skills | *“I think it would probably be helpful yeah if they knew about the mindfulness definitely maybe they could start applying it to their own lives” – Julia*  *“it's helpful that so many different types of skills because you know some you might feel help at the time” - Aria*  *“there's different skills like tip skills so that like using temperature and stuff like that are really helpful and they work if you're really distressed and stuff like that” – Sienna*  *“Yeah because if one thing doesn't work there's always like three other things that you could try” – Sienna*  *“I think mindfulness is just helpful because you can use it anywhere in any situation really and it just makes you just chill out and look at things differently and just be like right okay that's happened we can't change it now let's go in with like a new perspective” - Eliza* |

# Appendix L – Thematic Analysis

**Step 1 & Step 2: Transcription and identifying potential codes**

|  |  |
| --- | --- |
| Transcript | Initial Coding |
| Researcher: Don't worry if you can't think of everything. How did you find doing the one to one and the group sessions?  Participant: I think it's helpful because you can get a chance to speak about everything that you need to speak about, so like with your one to one if I had like a problem the week before and I needed to speak about it and get advice from it that was what my one to one session was for, a lot more personal things, whereas the group is more like generalised  Researcher: Yeah and did you find that a good balance?  Participant: Yeah yeah, I think that's what's good yeah  Researcher: Do you think it would have been helpful to have just one of those things?  Participant: I did for a period of time so, when I saw, I saw Teresa for my one to one from about October to April and it was helping, but obviously there's been more things been done and changed since I started the group as well  Researcher: Yeah, like that bit extra helped?  Participant: Yeah  Researcher: Is there anything you found unhelpful or less helpful?  Participant: I bet there was [laugh], I bet there definitely was err, at the start of group that’s when I struggled with going to group, like it doesn't help having other people around and everything, it's also its kind like a catch twenty two when you first start, when you're getting used to it. I think that's hard and I think maybe it'd be better if there was like like, obviously we have an introduction kind of, I can't think of the word when new people come like whenever a new intake, I feel like more should be done to kind of like, get people comfortable with each other cause for weeks and weeks and weeks, because there was like silence no one wants to speak up everyone's really shy in front of each other like as the weeks progressed you can obviously see that everyone's getting a bit more comfortable to feel like they can speak a bit better, and I just think maybe it would be helped if there was something more to kind of break the ice a bit. Like we did, I remember this one thing with like like a time scale, like stand at this if end if you vote for that, stand on this side if you vote for another or in the middle if you're not sure and like when you're all moving about I thought that everyone's having a laugh and everyone was getting more comfortable then like what more physical activities get people up and moving in a way you can introduce it a bit better yeah  Researcher: Did you feel you made any friendships in the group?  Participant: Err I'd say so yeah there was, err it's not really allowed, but there was a younger lad who used to go he was in year ten, he's about the same age as my sister and he came for a bit and then like I'd see him out, just randomly like not even arranged to meet, you just see him in the street and like he'd message and stuff like that and he would tell me all about his little girlfriend or something and it's not really like you're not meant to, they say at the start I'm not really meant to be friends with people but I wouldn't really say it was a friendship, but say it was more like we could hold the conversation and sort of comfortable speaking to him outside of the group  Researcher: Were there other people that you've come into contact with outside of the group? Was that ever a concern for you that you might?  Participant: Oh yeah, yeah, oh I forgot about that, there was one person that came and they were there at the start of it and they finished, err way earlier, I think they might have dropped out. And in the place I work now they come in every now and then and I find that hard like cause especially now I've finished as well, like when I see them in the shop I like panic, I'm like ‘oh my God’, I don't know what to do, like can someone come and serve I'm asking my colleagues just to come and serve but its more uncomfortable than like anything  Researcher: Do you think anything could have been done to make that easier?  Participant: Err probably the same as before, if everyone just got to know each other a little bit better then I'd say that was that would be easier to handle because like I said, I knew the other person if I see them on the street I'll say hiya I'll have a conversation but if I see the other then I'm just closed off like don't want anyone to speak to you, don’t want them to look at you, so I'd say definitely like the whole icebreaker thing really would make a difference | Combination approach is helpful  Variation in the purpose of delivery – Different elements offer something different  Combination approach is helpful  Starting the group is tough  Starting the group is tough  How to improve the group/how to improve the therapy experience  Starting the group is tough  How to improve the group/how to improve the therapy experience  How to improve the group/how to improve the therapy experience  Therapy rules  Rules hard to maintain/rules restrictive?  Group relationships are something different  Group rules are restrictive  Group peers are hard to avoid outside of therapy  Group rules are restrictive/can lead to discomfort  Group rules are restrictive/how to improve the group/how to improve the therapy experience  How to improve the group/how to improve the therapy experience |

**Step 3 – Final codes across the dataset**

A total of 203 were initially identified. With the use of Nvivo, the researcher began searching through each code that was only present within 1 participant account and was referenced 3 times or less (n=58). Each code was checked and it was then assessed for relevance to the research question. It was then decided if codes would be deleted at this stage and which would be recoded. A total of 19 codes were deleted, whilst 36 were represented within another code and recoded, and 3 remained in the data set.

This left 148 codes remaining. All codes were then reviewed. Using the coding stripe tool on Nvivo codes were assessed for overlapping content with other codes, which resulted in a further 39 codes being deleted as the meaning of the code and quotes were represented by another code. A further 12 codes were re-coded into a code of the similar meaning leaving a total of 97 codes.

The content and meaning of each of the 97 codes were assessed. Some codes were then combined and renamed when it was felt that they represented similar concepts and be brought together to make a bigger code that still represented the nuance of the data. After this process, the final 67 codes were identified.

Examples of notes made throughout this process:

Deleted ‘reflection of change’ – poorly constructed code, quotes represented in other codes

Recoded ‘Recognising change’ – ‘Noticing change is helpful’

Recoded ‘DBT promotes positive change’ within ‘Change occurs over time’

Deleted ‘frequent use of skills’ – not a fully formed code, all quote accounted for elsewhere

Deleted ‘reduce self-harm’/’reduce suicidal ideation’ = represented by different codes, and felt more latent in nature of the code and therefore difficult to represent in socially constructed themes

‘TR; vehicle for change’ and ‘therapeutic relationship is important’ combined to = ‘Therapeutic Relationship as a vehicle for change’

‘Mutual respect between T & Sus’, ‘Treated like an Adult’, and ‘Therapist anticipated YPs needs’ combined to = ‘Treated as Equals’

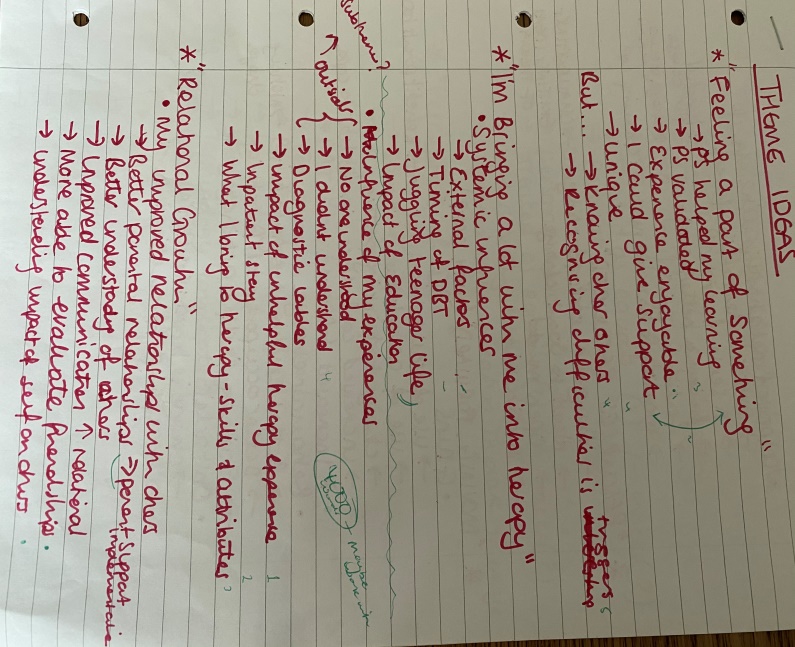
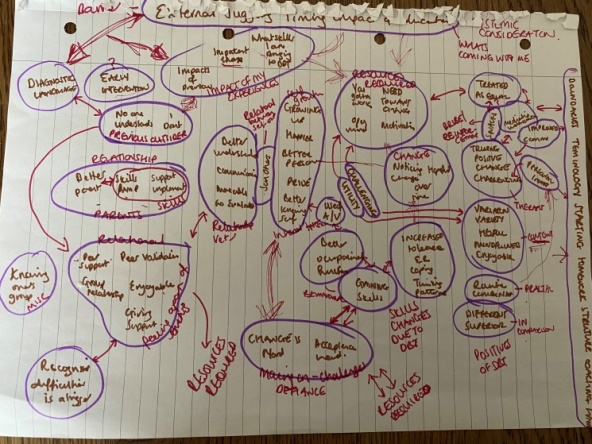
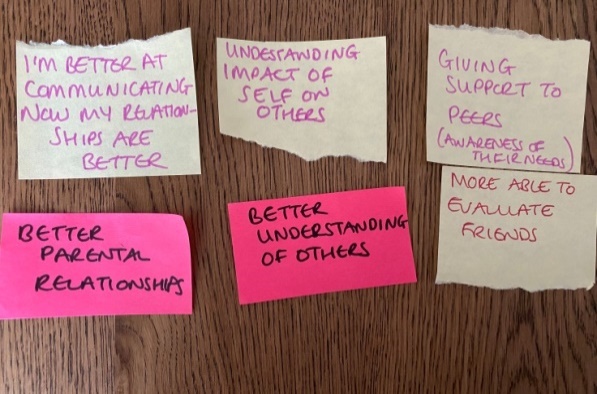
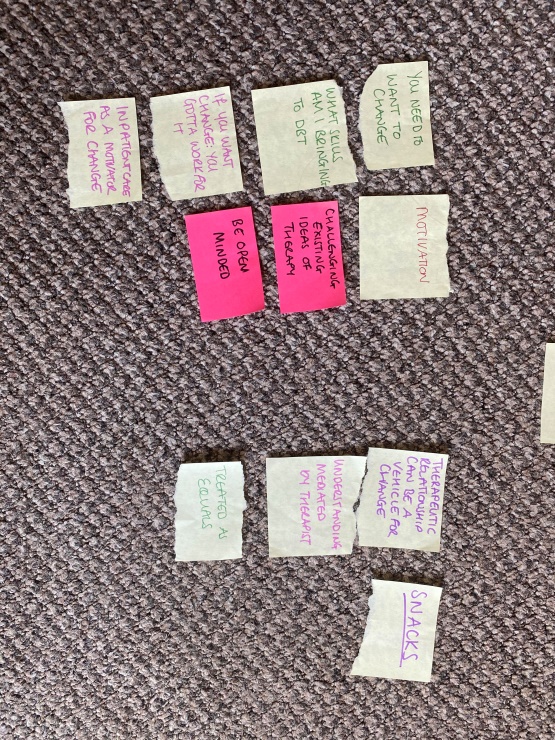
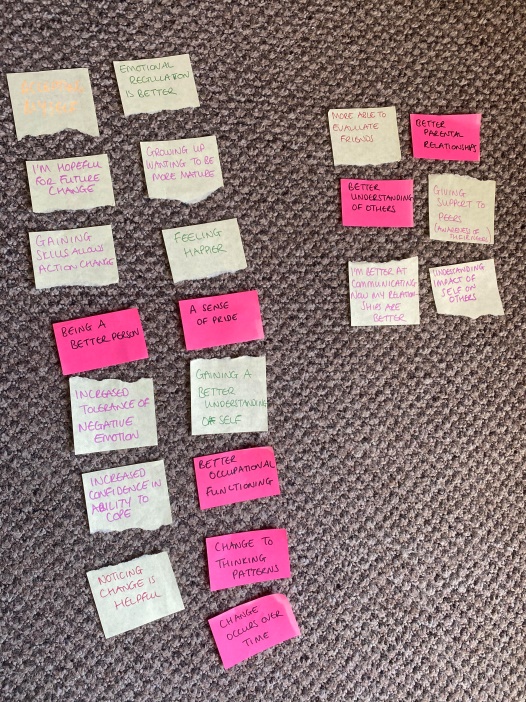
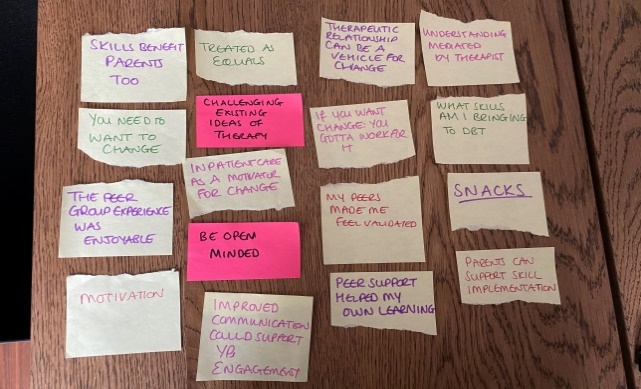
Deleted ‘Made to Feel Comfortable’ - quotes all accounted for by other more meaningful codes

**Step 3 – Final Codes**

|  |  |  |
| --- | --- | --- |
| Final Codes | Number of Participants represented | Number of references across the dataset |
| A Sense of Pride | 1 | 4 |
| Acceptance of Difficulties is Hard | 4 | 8 |
| Accepting Myself | 7 | 16 |
| Battling with the Structure of DBT | 2 | 8 |
| Be Open Minded | 4 | 8 |
| Being a Better Person | 2 | 3 |
| Better Occupational Functioning | 5 | 6 |
| Better Parental Relationships | 6 | 17 |
| Better Understanding of Others | 5 | 8 |
| Challenging Existing Ideas of Therapy | 4 | 4 |
| Change Occurs Over Time | 6 | 18 |
| Change to Thinking Patterns | 3 | 8 |
| Changing is Hard (Resistance is Called Upon) | 6 | 16 |
| Combination Approach is Beneficial | 6 | 12 |
| DBT is a Useful Experience | 8 | 26 |
| DBT is Hard Work | 6 | 19 |
| DBT is Superior to other approaches | 7 | 18 |
| DBT Terminology Can be Complicated | 2 | 5 |
| Diagnostic Language Can Feel Unhelpful | 1 | 7 |
| Don't Understand Own Feelings | 2 | 5 |
| Early Intervention is Beneficial | 1 | 3 |
| Emotional Regulation is Better | 4 | 16 |
| Feeling Happier | 3 | 3 |
| Gaining a Better Understanding of Self | 6 | 21 |
| Gaining Skills Allows us to Change our Actions | 8 | 41 |
| Giving Support to Peers (Awareness of Impact on Them) | 4 | 5 |
| Group Peer Relationships are Unique (and Pretty Hard to Avoid) | 6 | 10 |
| Growing Up and Wanting to be More Mature | 2 | 4 |
| Homework is Tough | 3 | 7 |
| If You Want Change You Gotta Work for It | 7 | 19 |
| I'm Better at Communicating and My Relationships Have Improved | 6 | 13 |
| I'm Hopeful for Future Change | 7 | 16 |
| Impact of Previous Unhelpful Therapy Experiences | 5 | 6 |
| Impact on Education | 2 | 3 |
| Improved Communication Could Support YPs Engagement | 2 | 3 |
| Increased Confidence in Ability to Cope | 4 | 5 |
| Increased Tolerance of Negative Emotion | 5 | 5 |
| Inpatient Care as a Motivator for Change | 2 | 5 |
| Juggling Demands of Teenage Life | 4 | 8 |
| Knowing Other Group Members... | 2 | 3 |
| Mindfulness is the Best | 7 | 17 |
| More Able to Evaluate Friendships | 5 | 7 |
| Motivation | 6 | 21 |
| My Peers Made me Feel Validated | 7 | 15 |
| No One Understood My Difficulties | 4 | 9 |
| Noticing Change is Helpful | 5 | 15 |
| Parents Can Support Skill Implementation | 3 | 7 |
| Peer Relational Boundaries can be Inhibiting | 4 | 9 |
| Peer Support Helped My Own Learning | 4 | 14 |
| Personal Impacts of the Therapy Setting | 6 | 15 |
| Recognising Peers' Difficulties is Triggering | 1 | 1 |
| Routine of DBT is Helpful | 4 | 4 |
| Skills Benefit Parents Too | 6 | 9 |
| SNACKS | 4 | 6 |
| Starting the Group is Tough | 6 | 10 |
| Telephone Coaching is Inconvenient | 2 | 3 |
| The Peer Group Experience was Enjoyable | 7 | 22 |
| Therapeutic Relationship Can be Vehicle for Change | 8 | 34 |
| Timing of DBT Has to be Right | 4 | 3 |
| Treated as Equals | 7 | 23 |
| Understanding Impact of Self on Others | 6 | 9 |
| Understanding Mediated by Therapist | 5 | 6 |
| Utility of Skills can Change Over Time | 2 | 3 |
| Variation in Purpose of the Delivery | 7 | 15 |
| Variety in Type and Use of Skills Helpful | 7 | 18 |
| What Skills Am I Bringing to DBT | 5 | 14 |
| You Need to Want to Change | 5 | 12 |

**Step 4 and Step 5 – Searching for and Reviewing Themes**

The coded data were grouped together around possible central organising concepts to try and identify potential themes. This was a changing process, with codes being continually rearranged in order to create themes that best represented the data. The research also relied on the support from the academic supervisor, external academic staff with knowledge of thematic analysis, and peer groups to encourage the researcher to reflect on developed themes. This was process was continued through step 5 until the research felt confident that the theme represented the data and answered the research question.



**Step 6 – Defining and Naming Themes**

**Final themes and the codes comprising each theme and subthemes:**

|  |  |
| --- | --- |
| Theme | Codes Used |
| **Theme 1: ‘Taking responsibility’** |  |
| Subtheme: Attitude to therapy | Motivation  Be open minded  Inpatient care as a motivator for change  You need to want to change  Challenging existing ideas of therapy  If you want change you gotta work for it  What skills am I bringing to DBT |
| Subtheme: Accepting help | Treated as equals  Therapeutic relationship can be vehicle for change  Understanding mediated by therapist  Snacks  My peers made me feel validated  Peer support helped my own learning  Parents can support skill implementation |
| **Theme 2: ‘Change is complicated’** |  |
| Subtheme: Resistance to change | Don’t understand own feelings  No one understood my difficulties  Impacts of previous unhelpful therapy experiences  Acceptance of difficulties is hard  Changing is hard (resistance is called upon) |
| Subtheme: Life gets in the way | Timing of DBT has to be right  Juggling demands of teenage life  Battling with the structure of DBT |
| **Theme 3: ‘Hard work pays off’** |  |
| Subtheme: “New therapy, new me” | Gaining a better understanding of self  Better occupational functioning  Change occurs over time  Being a better person  Gaining skills allows us to change our actions  Growing up and wanting to be more mature  I’m hopeful for future change  Feeling happier  Change to thinking patterns  Emotional regulation is better  Increased confidence in ability to cope  Accepting myself  Increased tolerance of negative emotion  Noticing change is helpful |
| Subtheme: “Relationships goals” | Giving Support to Peers  Understanding impact of self on others  Better parental relationships  Better understanding of others  I’m better at communication and my relationships have improved  More able to evaluate friendships |
| **Theme 4: ‘DBT is tough, but it’s worthwhile’** |  |
| Subtheme: A different approach | DBT is hard work  Personal impacts of the therapy setting  Combination approach is beneficial  Starting the group is tough  Group peer relationships are unique (and pretty hard to avoid)  The peer group experience was enjoyable  Variation in purpose of the delivery  Routine of DBT is helpful  DBT is a useful experience  DBT terminology can be complicated  DBT is superior to other approaches |
| Subtheme: It’s all about the skills | Skills benefit parents too  Variety In type and use of skills helpful  Mindfulness is the best |

**Step 6 – Defining and Naming Themes**

Example of theme development with supporting codes and extracts

**Theme 2: ‘Change is complicated’**

|  |  |  |  |
| --- | --- | --- | --- |
| **Participants** | **Code** | **Example Supporting Quotes** | **Notes** |
| Victoria  Katie  Julia  Sienna  Freya  Eliza | Changing is hard (resistance is called upon) | “Obviously I've not looked to all the skills but obviously people are set a certain way people are who they and trying to change that is always going to be difficult”  “I think because obviously see, I come on a Thursday I'll do it until the Tuesday or like the Monday and I'll think oh it's fine I've got until Thursday, and then I'll just kind of fall back into my old ways”  “I think coming to terms with my unhealthy behaviours and how some of my actions were not giving me or other people's a good quality of life, as I find it difficult to change my unhealthy behaviours.”  “Err sometimes my behaviours are, I sometimes need to do them, like in order to feel better in the moment, because I don't think they always understand that”  “Not good, not good, yeah because you don't want to change it, you want, because it is what you've always known to do, so you don't really want to change it, so when they're trying to change it you're like no”  “Because if you, like a couple of weeks ago I went into a session and I was set on how I was feeling, like he told me a few skills but I just didn't use them because I just want, I almost wanted to feel the way I felt”  “It felt like someone was playing with my brain like playdough, and moulding me into what they want it to look like. That was one thing that really annoyed me, but some days where I can take a step back from that thought and realise that if I hadn't done that then, it's not just about if I have an outburst, it's not just about if I'm upset or too happy, it’s about that I was a danger to myself, it was harming myself and that's not healthy”  “But sometimes DBT can feel like they're trying to change your mind-set and that what kind of upset me a little bit” | It felt like participants were recognising that changing their behaviour was difficult, but there was also a sense from some of the participants that at times they felt like they wanted to resist that change |
| Victoria  Alice  Eliza  Freya | Juggling the demands of Teenage life | “like when you miss a week or you miss three weeks you soon fall behind and it is hard to do, and it's hard to balance between college life and work and driving lessons”  “Going to DBT when I was in college, that was hard like between work, I had to come here, I had to go to college and I'd be missing classes. That was difficult, so I think if I'd gone younger then it would have been more embedded earlier definitely”  “Those other people who I'm so-called friends with, they don't really like me, they just use me but I'm trying to stay friends with them, and they're like ‘oh blah de blah’, you're this you're that… I had an argument today with one of my friends and it was very hard to come to therapy because I was like oh I feel so low there's no point”  “I understand that you have to for it to work but I think in a real life situation when you've got loads going on like college work everything it is hard to keep track of, ‘oh I need to write this down’ or ‘I need to do this’, it is just difficult to kind of try, because it is very full on the work and stuff it's difficult to put it in a real life situation “ | It was understood that participants were suggested that it could be difficult to fit DBT into the rest of the demands in their lives. This incorporated education, employment and the social lives that seemed more specific to this age group |
| Victoria  Katie  Julia  Freya  Eliza | Impacts of previous unhelpful therapy experiences | “Oh definitely when I was in CBT, I was a lot younger I was in high school and errr I probably was like 13 probably, and I can just remember when I was going, I can just remember speaking to this lady, just talking to her and it was like in DBT you speak, you write things down, you go through things”  “I liked that and you wouldn't do things like that in CBT but that's what helped me most because it might help pinpoint where it went wrong almost like where did I need to stop like in CBT there was none of that, it was just speaking”  “Yeah I think it's because when I did CBT err obviously that's meant to, it's all about challenging thoughts and stuff, err so with that, it was, it helped with the self-harm that was going on but it never helped with like the suicidal ideation and stuff so obviously I had a kind of, I had doubts because the CBT hadn't worked so I was thinking that maybe like the DBT wouldn't work”  “Another difficult part was the structure which I was not at all used to as my previous therapy was all over the place and had left a negative impression of CAMHS in my mind for a short while”  “I'd just be more open minded going in with it cause when I first did it last year err I had not the best experience, I had a bad experience last year so for me DBT wasn't working at that time because of the experiences I was going through so I went in this time thinking oh it won't work and now obviously because my experiences have changed and the position I'm in has changed it's working now”  “She's got a good approach I do like I do like her approach because obviously I've been through younger minds and obviously everyone's got a different approach to how to deliver things err but yeah I find Teresa's approach quite helpful” | All of the participants had had some kind of therapeutic support before starting DBT, but it was understood that participants previous experiences did impact on how at least how they initially approached DBT |

**Step 6 – Defining and Naming Themes**

The representation of each participant in the themes and subthemes.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Victoria | Katie | Alice | Julia | Aria | Sienna | Freya | Eliza |
| **1. Taking responsibility** |  |  |  |  |  |  |  |  |
| Attitude to therapy |  |  |  |  |  |  |  |  |
| Accepting help |  |  |  |  |  |  |  |  |
| **2. Change is complicated** |  |  |  |  |  |  |  |  |
| Resistance to change |  |  |  |  |  |  |  |  |
| Life gets in the way |  |  |  |  |  |  |  |  |
| **3. Hard work pays off** |  |  |  |  |  |  |  |  |
| "New therapy, new me" |  |  |  |  |  |  |  |  |
| "Relationship goals" |  |  |  |  |  |  |  |  |
| **4. DBT is tough, but it’s worthwhile** |  |  |  |  |  |  |  |  |
| A different approach |  |  |  |  |  |  |  |  |
| It’s all about the skills |  |  |  |  |  |  |  |  |

Key

Represented

Not represented

# Appendix M – Reflexive Statement from the Research

I am a 30 year old, white British female currently employed as a Trainee Clinical Psychologist with the NHS. I have developed an interested in working with children and young people following a number of positive placement experiences during my current training. I found that I felt passionately about early intervention to support young people and their families. I also recognised the powerlessness that young people can experience when trying to navigate their relationships at home, with their peers, and in educational and mental health systems. I found myself often feeling more strongly aligned to the young people within my work, as I often felt they needed more understanding and support to allow their voices to be heard.

As a Trainee Clinical Psychologist, I understand mental health difficulties as a combination of biological, social, and environment factors that impact on a person’s ability to manage their own mental wellbeing. I challenge the medical model of mental health difficulties and minimise use of diagnostic language wherever possible. This view did initially impact my view of DBT. I am not formally trained in the DBT model, but I have received in-house training which has supported me to deliver DBT informed interventions with both adults and young people. In my experience, they were helpful interventions but on the other hand, I have experienced difficulty engaging with DBT literature, due to its reliance on diagnostic terminology and it’s seeming encouragement of understanding people’s distress by labelling this as a ‘personality disorder’.

I recognise that I approached this research with a mixed view of DBT. I felt this more balanced view could be helpful as the wider literature is developed by researchers trained in this approach and therefore more likely aiming for positive outcomes. This view did mean that I was striving for balance (considering both the helpful and less elements of the approach) within the current research, which will have altered my focus. Measures were taken to limit this, such as credibility checks with other professionals, but this should be kept in mind when interpreting the outcomes.

The research was completed in a NHS setting with the support of professionals who are also formally trained in DBT, and who have spent a lot of their time promoting DBT for young people within their service. This will have also impacted my approach to the research, as they were my superiors and my support in completing this project, possibly also wanting to demonstrate more positive aspects of their work. Further, this is likely to have impacted my relationship with the participants. I tried to emphasise that I was completing this as part of a university project and that no one from the service would view the transcript, however it could not be denied that I am employed by the same service that were providing care. This could have limited the number of participants that wished to take part, as well limited the views shared by those participating.

To balance this, I attempted to use my clinical skills to make participants feel comfortable during the interview. As a fairly young, white British female from a working class background (with a notable accent), on the surface I had a lot in common with the participant group, and tried to use this to make participants feel comfortable within this setting. Having said this, it is hard to ignore the power difference in the room. Young people are often in areas where they hold less power than the adult, and this will have likely impacted the honesty in the response from participants, something I noted throughout my reflexive diary. I also noted that I believed that DBT would be a difficult therapy to commit to, as from my own personal perspective I would have found this hard to complete when I was at high school or college, juggling my education and part-time work. I tried to recognise my own feelings regarding this, but it is possibly that I will have recognised similar views more quickly within the data.

I am also aware that I prefer more relational psychological models in understanding difficulties, and that I am interested in the relational aspect of this model. I have a previous training in ‘systemic family therapy’, and again this will have influenced my interpretation of the data, being more drawn to the relational aspects and making conclusion based upon this. In order to limit the influence of the research setting and my individual views, I kept a reflexive journal throughout the research process and referred to this regularly. I also regularly met with my academic supervisors and sought the views of independent people unrelated to the project. This included both professionals and peers. I used these meetings to challenge my own thoughts and sought the view of others to broaden my perceptions. I believe this will have gone some way to limiting the impact of my own biases upon the research.



# Appendix N – Ethical Approval: Staffordshire University

**INDEPENDENT PEER REVIEW APPROVAL FEEDBACK**

|  |  |
| --- | --- |
| **Researcher Name** | Rachael Clarke |
| **Title of Study** | Young people’s experience of adapted dialectical behaviour therapy (DBT) in a community CAMHS setting. |
| **Award Pathway** | DClinPsy |
| **Status of approval:** | **Approved** |

Thank you for forwarding the amendments requested by the Independent Peer Review Panel (IPR)

**Action now needed:**

You must now apply through the Integrated Research Applications System (IRAS) for approval to conduct your study. You must not commence the study without this second approval. Please note that for the purposes of the IRAS form, the university sponsor is Dr Tim Horne, [tim.horne@staffs.ac.uk](mailto:tim.horne@staffs.ac.uk)

Please forward a copy of the letter you receive from the IRAS process to [ethics@staffs.ac.uk](mailto:ethics@staffs.ac.uk) as soon as possible after you have received approval.

Once you have received approval you can commence your study. You should be sure to do so in consultation with your supervisor.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

When your study is complete, please send the IPR coordinator (Dr Peter Kevern) an end of study report. A template can be found on the ethics BlackBoard site.



|  |  |
| --- | --- |
| **Signed**: Dr Peter Kevern  University IPR coordinator | **Date**: 19.6.19 |



# Appendix O – Ethical Approval: REC

**Yorkshire & The Humber - Leeds West Research Ethics Committee**

NHSBT Newcastle Blood Donor Centre

Holland Drive

Newcastle upon Tyne

NE2 4NQ

Telephone: 0207 1048 088

04 September 2019

Miss Rachael Clarke

Staffordshire University

Leek Road

Stoke-on-Trent

ST4 2DF

Dear Miss Clarke

# Study title: A thematic analysis of young people’s experience of dialectical behaviour therapy in a community child and adolescent mental health setting.

**REC reference: 19/YH/0279**

**Protocol number: N/A**

**IRAS project ID: 261288**

Thank you for your letter of 27 August 2019. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 21 August 2019

# Documents received

The documents received were as follows:

|  |  |  |
| --- | --- | --- |
| *Document* | *Version* | *Date* |
| Other [IRAS Amendments Letter] | 1 | 27 August 2019 |
| Participant consent form [Participant Consent Form] | 5 | 23 August 2019 |

# Approved documents

The final list of approved documentation for the study is therefore as follows:

|  |  |  |
| --- | --- | --- |
| *Document* | *Version* | *Date* |
| Interview schedules or topic guides for participants [Proposed interview guide] | 4 | 13 April 2019 |
| IRAS Application Form [IRAS\_Form\_25072019] |  | 25 July 2019 |
| Letter from sponsor [IPR Approval from University] | 1 | 20 June 2019 |
| Letters of invitation to participant [Invitation] | 4 | 13 April 2019 |
| Other [Parental opt-out form] |  |  |
| Other [IRAS Amendments Letter] | 1 | 27 August  2019 |
| Participant consent form [Participant Consent Form] | 5 | 23 August  2019 |
| Participant information sheet (PIS) [Participant Information Sheet] | 4 | 13 April 2019 |
| Research protocol or project proposal [Research Protocol V6] | 6 | 18 June 2019 |
| Response to Additional Conditions Met |  | 29 August  2019 |
| Summary CV for Chief Investigator (CI) [CI Research CV] | 1 | 13 April 2019 |
| Summary CV for student [Principal investigator CV] | 1 | 13 April 2019 |
| Summary CV for supervisor (student research) [CI/Academic Supervisor CV] | 1 | 13 April 2019 |
| Summary, synopsis or diagram (flowchart) of protocol in non technical language [Study flow chart] | 4 | 13 April 2019 |

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

**19/YH/0279 Please quote this number on all correspondence**

Yours sincerely

**Sarah Prothero**

**Approvals Officer**

E-mail: [nrescommittee.yorkandhumber-leedswest@nhs.net](mailto:nrescommittee.yorkandhumber-leedswest@nhs.net)

*Copy to: Ms Louise Alston, North Staffordshire Combined Healthcare NHS Trust*

*Lead Nation* - England: [HRA.Approval@nhs.net](mailto:HRA.Approval@nhs.net)

**Appendix O – Ethical Approval: Health Research Authority**



|  |  |
| --- | --- |
| Dr Helen Scott  School of Life Sciences and Eduction, Staffordshire University  Leek Road  Stoke-on-Trent ST4 2DF | Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net) [HCRW.approvals@wales.nhs.uk](mailto:HCRW.approvals@wales.nhs.uk) |

04 September 2019

Dear Dr Scott

**HRA and Health and Care Research Wales (HCRW) Approval Letter**

|  |  |
| --- | --- |
| **Study title:** | **A thematic analysis of young people’s experience of dialectical behaviour therapy in a community child**  **And adolescent mental health setting.** |
| **IRAS project ID:** | **261288** |
| **Protocol number:** | **N/A** |
| **REC reference:** | **19/YH/0279** |
| **Sponsor** | **Staffordshire University** |

I am pleased to confirm that [**HRA and Health and Care Research Wales (HCRW) Approval**](https://www.myresearchproject.org.uk/help/hlphraapproval.aspx)has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the “Information to support study set up” section towards the end of this letter.

# How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation.The relevant national coordinating function/s will contact you as appropriate.

Please see [IRAS Help](https://www.myresearchproject.org.uk/help/hlpnhshscr.aspx) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

# How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](https://www.myresearchproject.org.uk/help/hlpsitespecific.aspx#non-NHS-SSI) in accordance with their procedures.

# What are my notification responsibilities during the study?

The document “*After Ethical Review – guidance for sponsors and investigators*”, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

* Registration of research
* Notifying amendments
* Notifying the end of the study

The [HRA website](https://www.hra.nhs.uk/) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

# Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **261288**. Please quote this on all correspondence.

Yours sincerely,

Alex Thorpe

Approvals Manager

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

# List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

|  |  |  |
| --- | --- | --- |
| *Document* | *Version* | *Date* |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance] | 1 | 16 July 2018 |
| Interview schedules or topic guides for participants [Proposed interview guide] | 4 | 13 April 2019 |
| IRAS Application Form [IRAS\_Form\_25072019] |  | 25 July 2019 |
| IRAS Application Form XML file [IRAS\_Form\_25072019] |  | 25 July 2019 |
| IRAS Checklist XML [Checklist\_29082019] |  | 29 August 2019 |
| Letter from sponsor [IPR Approval from University] | 1 | 20 June 2019 |
| Letters of invitation to participant [Invitation] | 4 | 13 April 2019 |
| Organisation Information Document [OID] | 1 | 16 August 2019 |
| Other [Parental opt-out form] |  |  |
| Participant consent form [Participant Consent Form] | 5 | 23 August 2019 |
| Participant information sheet (PIS) [Participant Information Sheet] | 4 | 13 April 2019 |
| Research protocol or project proposal [Research Protocol V6] | 6 | 18 June 2019 |
| Schedule of Events or SoECAT [Schedule of Events] | 3 | 28 June 2019 |
| Summary CV for Chief Investigator (CI) [CI Research CV] | 1 | 13 April 2019 |
| Summary CV for student [Principal investigator CV] | 1 | 13 April 2019 |
| Summary CV for supervisor (student research) [CI/Academic Supervisor CV] | 1 | 13 April 2019 |
| Summary, synopsis or diagram (flowchart) of protocol in non technical language [Study flow chart] | 4 | 13 April 2019 |

**Information to support study set up**

**261288**

**IRAS project ID**

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Types of participating NHS**  **organisation** | **Expectations related to confirmation of capacity and capability** | **Agreement to be used** | **Funding arrangements** | **Oversight expectations** | **HR Good Practice Resource Pack expectations** |
| This is a single site study sponsored by Staffordshire University therefore there is only one site type. | Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study. | An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used. | No study funding will be provided to sites as per the Organisational Information Document. | A Principal Investigator should be appointed at study sites of this type. | No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance. |

# Other information to aid study set-up and delivery

|  |
| --- |
| *This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.* |
| The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.  The insurance certificate that was provided has expired. It is the responsibility of the sponsor to renew the insurance policy to cover this study. |

Template Version No: 1.4

# Appendix P – Ethical Approval: Trust Confirmation of Capacity and Capability

**Authorisation When Using This Organisation Information Document as An Agreement**

(when used as an Agreement, the Participating NHS Organisation is a “Party” to the Agreement and the Sponsor is a “Party” to the Agreement – collectively the “Parties”).

|  |  |
| --- | --- |
| **Authorisation on behalf of Participating NHS / HSC Organisation**  It is not intended that this confirmation requires wet-ink signatures, or a passing of hard copies between the Sponsor and participating NHS / HSC organisation. Instead, Sponsors are expected to accept confirmation by email from an individual empowered by the Participating NHS / HSC Organisation to agree to the commencement of research (including any budgetary responsibility, where the study involves the transfer of funds). | |
| **^ The Participating NHS / HSC Organisation confirms (by use of the drop-down box) that the Principal Investigator, where one is required, is**  **aware of and has agreed to discharge their responsibilities in line with the** [**UK Policy Framework for Research and Social Care**](https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/).**.** | Confirmed |
| **^ The Participating NHS / HSC Organisation has considered and mitigated any conflict/s of interest declared by the principal investigator.** | N/A |
| If yes, please detail conflict of interest | |

|  |  |
| --- | --- |
| **\* Authorised on behalf of Sponsor by:** | |
| **Name** | Dr Tim Horne |
| **Job Title** | Director of Research |
| **Organisation Name** | Staffordshire University |
| **Date** | 29 November 2019 |
| **^ Authorised on behalf of Participating NHS / HSC Organisation by:** | |
| **Name** | Dr Christopher Link |
| **Job Title** | R&D Director |
| **Organisation Name** | North Staffordshire Combined Healthcare NHS Trust |
| **Date** | 29 November 2019 |

IRAS Project ID: 261288

Version: 1 (16/08/2019)

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