

Research Report



What are the qualitative experiences of clients with a diagnosis of Borderline Personality Disorder; who have completed the Manning Dialectical Behaviour Therapy ‘Moving Forward’ Stage 1 Program in the last two to five years?

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MDC	Love, life and for our universe.



Abbreviations

BPD	Borderline Personality Disorder
DBT	Dialectical Behaviour Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
HETI	Health Education and Training Institute, NSW
HNELHD	Hunter New England Local Health District (previously HNE Area Health Service)
HNEMHS	Hunter New England Mental Health Services
HNEHREC	Hunter New England Human Research Ethics Committee
IRCST	NSW Institute of Rural Clinical Services and Teaching (now known as HETI)
MHS	Mental Health Services
MSE	Mental State Examination
RCT	Randomised Controlled Trials
RSP	Research Study Participant



**NB The terms ‘*patient*’ and ‘*client*’ are used interchangeably throughout this document – both are defined as ‘*the person receiving health care*’.



Front Cover Photograph: Courtesy of Focus Magazine Manning-Great Lakes, downloaded from <http://focusmag.com.au/mgl/featured/manning-river-a-portrait>
The painting shows the SS Maianbar travelling up the Manning River on her maiden voyage from the shipyards of Glasgow, Scotland to Wingham, NSW in 1910/11.



Table of Contents

Acknowledgements	2
Abbreviations	2
Abstract	4
Executive Summary	5
Introduction	7
Background	7
Literature Review	10
Rationale	14
Theoretical Perspective and Methodology	14
The Research Question	15
Aims of the Study	15
Methods	15
Participant Selection Process	16
Data Collection	17
Data Analysis	19
Ethics	20
Findings and Discussion	20
Limitations	26
Conclusion and Recommendations	26
References	27
Appendices:	
1. Letter of Invitation	31
2. Information for Participants Sheet	32
3. Interview Prompt Questions Sheet	35
4. Study Participant Consent Form	36
5. Research Interview Checklist	37
6. Analysis Coding Sheet, Version 1.	38
7. Analysis Coding Sheet, Version 2.	39
8. Glossary	41

Abstract

Dialectical Behaviour Therapy (DBT) is a current therapeutic intervention used to assist people with Borderline Personality Disorder (BPD). Research literature to date has mainly focussed on independently measurable treatment effects of DBT, rather than the patient experiences of clients in this diagnostic group. This exploratory qualitative study aims to illuminate the experiences of clients who have completed Stage 1 of the Manning 'Moving Forward' DBT program in the previous two to five years.

Dialectical Behaviour Therapy program graduates from a small rural coastal NSW town were invited to participate in the study; with four people agreeing to attend for an interview. The interview explored participants' experiences prior to DBT; the helpful and unhelpful aspects of the DBT program; and the effects DBT has had on their lives since completion. The interview transcripts were then analysed for recurrent and varying themes.

Participants readily enlarged on the chaos, distress and instability existing in their lives prior to DBT. Helpful aspects of the DBT centred on 'the Group' value and on improved awareness and emotional control. Unhelpful aspects pertained to concepts of 'self' and commitment to the program. The post DBT benefits reported by participants extended into many aspects of their lives; including better overall health; more stable mental health with decreased levels of self-harm and suicide attempts; increased opportunities for employment and social inclusion; and, improved significant relationships. All participants reported using various DBT core skills as an ongoing aspect in their lives.

Through this exploratory study it is evident that participants view DBT as a beneficial therapeutic intervention. While more formal and in-depth research is warranted in this area, the therapeutic effects linked to DBT are evident in the 'voices' of the participants; and, in taking the time to listen, as health care researchers, we can increasingly assist others with this concerning disorder.

Keywords: borderline personality disorder, dialectal behaviour therapy, qualitative research, patient experiences, recovery.

Executive Summary

Introduction

This is a report on a research study undertaken in 2009-2011, which was small and exploratory in nature, which aims to increase the knowledge and understanding of the patient experience for people diagnosed with Borderline Personality Disorder (BPD), who have undergone a specific healthcare/psychotherapeutic intervention, namely Dialectical Behaviour Therapy (DBT); and, who are in a two to five year post-intervention phase.

Background

Borderline Personality Disorder (BPD), has an estimated prevalence of 1-2% of the general population; and from the 1990s on, psychotherapy is considered to be the primary intervention for BPD (Gunderson, 2009). Dialectical Behaviour Therapy (DBT), one treatment intervention, is a structured multimodal cognitive-behavioural psychotherapeutic program, which is designed to treat the emotional, cognitive, behavioural, self and interpersonal issues that are created by the dysregulation of BPD, (Linehan,1993).

Literature Review

Much of the located research literature document the symptoms that clients can experience, but often do not record the depth and breadth of the chaos, distress and impact of the disorder and the experience of recovery in qualitative terms of the patient experience. Three relevant articles have a major focus on the patient experience of the ‘DBT program’ process, with minimal focus on the client’s post therapy aspects relevant to recovery and social inclusion.

Methodology

The research study design uses the theoretical perspective of the constructivist-interpretive approach, that does not seek to uncover a single ‘truth’, but seeks knowledge by observation and inductive interpretation, such as those offered by personal interviews, and which do not necessarily lend themselves to quantitative studies.

The Research Question

What are the qualitative experiences of clients with a diagnosis of Borderline Personality Disorder; who have completed the Manning Dialectical Behaviour Therapy “*Moving Forward*” Stage 1 Program in the last two to five years?

Aims of the Study

This research study aims to explore our understanding of the participants’ experiences of their lives prior to undertaking therapy; of the participants’ experiences of the helpful and hindering aspects of participation in and completion of Stage 1 of the Manning DBT “*Moving Forward*” program; and, of the participants’ experiences of the impact of DBT on their current levels of recovery and social inclusion.

Methods

The research study design involved a ‘case series’ design, identifying six potential study participants whom fulfilled the inclusion criteria. Contact was initiated with a ‘Letter of Invitation’ and four potential participants consented to be part of the research study. Four interviews were conducted and the data was analysed using a discourse analysis approach within a phenomenological perspective. In this way, analysing narratives can involve searching for patterns, then clustering these patterns based on the theoretical underpinning of the relevant literature, such as the fundamental theoretical concepts of DBT. These clusters can then be considered in relation to the original research questions and used to form the

findings. In this way, the categorisation process of discourse analysis is useful to exploring and improving healthcare practices rather than developing new theory.

Ethics

In May 2010, a National Ethics Application Form was submitted and approval to conduct the research was granted in August 2010.

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Findings and Discussion

The findings of the research study are categorised into the identified aspects of pre-intervention, during the intervention and after the intervention. Within the pre-intervention aspects, the findings concurred with the research literature. Certainly the comments of the study participants; describing the chaos, the impulsivity and their means of coping echo the criteria for a BPD diagnosis as set out by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000). All of the research study participants described instances of stigma and discrimination as a result of their diagnosis of BPD.

In relation to the aspects of undertaking the DBT program; the findings show the majority of comments related to the program being more 'helpful' than 'unhelpful'; that the 'helpful' comments centre on 'group' aspects rather than on individual therapy sessions; and, that 'unhelpful' aspects were more about the level of program commitment, including acceptance of the diagnosis, the need to be in treatment, and the fluctuating belief that the program could help. All of the participants' comments are reflected in Araminta's comprehensive study (2000) and Persius' (et al., 2003) study, where there was agreement that increased awareness was a 'salient' aspect of the therapy; as well as the support and assistance received, the skill attainment and the acceptance of the Group environment.

Post-intervention, participants described being able to move forward in their lives. The intent of the research study was not aimed at directly attributing 'recovery' to the DBT program; the participants' comments are evidence that they have been able to develop improved skills in distress tolerance, emotion regulation and interpersonal effectiveness to make improvements in their quality of life; with increased opportunities for employment, social activity and significant relationships.

Conclusion and Recommendations

The study provides stories of personal transformation that occurred during and after DBT. Participants reported having a more positive outlook on life and improved health. The Manning 'Moving Forward' DBT program (Boaden & Macauslane, 2004) has also provided Health Care providers with a pathway of care for those clients with BPD.

The 2012 publication of the 'Clinical Practice Guideline for the Management of Borderline Personality Disorder' by the Australian National Health and Medical Research Council (NHMRC, 2012) includes a number of key recommendations. Many of which are actively being undertaken in the Manning 'Moving Forward' DBT program (Boaden & Macauslane, 2004) and within the Manning Mental Health Service, HNELHD.

Further research into BPD and DBT is needed and is currently occurring. Each piece of research information can then potentially be used to improve the outcomes for clients with a diagnosis of BPD.



Introduction

This document reports on a research study undertaken in 2009-2011, under the auspices of the NSW Clinical Education & Training Institute, Rural (CETI) (formerly the NSW Institute of Rural Clinical Services and Teaching) and the Hunter New England Local Health District (HNELHD). Following a literature search and review; the researcher determined that there was minimal relevant literature in the area of interest and that no similar research study could be located. The research study, while small and exploratory in nature, aims to increase the knowledge and understanding of the patient experience for people diagnosed with Borderline Personality Disorder (BPD), who have undergone a specific psychotherapeutic intervention, namely Dialectical Behaviour Therapy (DBT); and, who are in a two to five year post-intervention phase.

Background

Borderline Personality Disorder

Borderline Personality Disorder (BPD), as a diagnosis, was originally included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980 (Gunderson, 2009). It is defined by the American Psychiatric Association as a psychiatric disorder, which includes:

'a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked by impulsivity beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following criteria: abandonment fears, unstable/intense relationships, identity disturbance, impulsivity, suicidal and/or self-injurious behaviours, affective instability, emptiness, anger, and/or paranoid ideation/dissociation' (DSM-IV-TR, 2000).

The prevalence of BPD is estimated to be 1-2% of the general population; with an estimated 10% prevalence in community psychiatric populations and an estimated 19-20% in acute inpatient psychiatric units. In gender differentiation, females account for 70-75% of all BPD diagnoses (DSM-IV-TR, 2000; Gunderson, 2006; Kernberg & Michels, 2009). People with a diagnosis of BPD are known to be high users of health services; with varying levels of use in community health services, in presentations to Emergency Departments, and then increasing to approximately 40% of all inpatient psychiatric services (Fallon, 2003; WHO, 1997; Lieb et al., 2004; Linehan, et al., 2006; Bender et al., 2001).

Treatments for Borderline Personality Disorder

During the 1970s, the literature on treatment for BPD was almost exclusively about psychoanalytical psychotherapy (Gunderson, 2009). In the 1980s, there were questions about the efficacy and benefits of psychoanalytical psychotherapy and treatments looked more to pharmacotherapy and other therapies that were offered using multimodal approaches. In using pharmacotherapy for the treatment of BPD, rather than there being one particular medication regime for all instances of BPD; it is now recognised that medication has an adjunctive or secondary role to target specific cluster symptoms, such as anger, anxiety, impulsivity and cognitive-perceptual disturbances (Webber & Farrell, 2008). From the 1990s on, there has been substantial development in the psychotherapies and that it is now considered to be the primary intervention for BPD (Gunderson, 2009). Some of these therapies include: DBT, Mentalization-based Treatment, Transference-based Psychotherapy (Gunderson, 2009; Linehan, 1993; Oldham, 2006; Kernberg, 2006; Bateman & Fonagy, 2008; Lieb et al., 2004).

Dialectical Behaviour Therapy

Dialectical Behaviour Therapy (DBT), the treatment intervention, was developed by Marsha Linehan in the late 1980s and early 1990s. Linehan (1993) defines DBT as a structured multimodal cognitive-behavioural psychotherapeutic program, which is designed to treat the emotional, cognitive, behavioural, self and interpersonal issues that are created by dysregulation. The therapy sets out to establish a therapeutic relationship between client and therapist that motivates the client to learn new skills and encourages and supports the application of these skills into everyday life (Linehan, 1993).

Dialectical Behaviour Therapy (DBT), as a cognitive-behavioural psychotherapeutic treatment, is underpinned by two theoretical concepts; namely the 'dialectics' of DBT and the Biosocial theory. 'Dialectics' is defined by Linehan as 'the reconciliation of opposites in a continual process of synthesis' (Linehan, 1993). Dialectics is one specific world view on the nature of reality and on human behaviour, that stresses the characteristics of interrelatedness and wholeness; that reality is not static but continually comprised of internal opposing forces; and, that the nature of reality leads to a wholeness continually in the process of change (Linehan, 1993). For DBT therapists, the most fundamental dialectic is the necessity of accepting patients just as they are while trying to encourage them to change. For clients, the DBT approach focuses on the dialectics of the disorder; such as emotional vulnerability versus invalidation, active passivity versus apparent competence, and unremitting crises versus inhibited grief (Linehan, 1993; Nehls, 2000).

The second theoretical concept, the Biosocial theory, centres on the core problem of BPD, being the individual's reduced ability to regulate their emotions. This deficit is considered to be due to a biological vulnerability in combination with unfavourable social and environmental factors. The deficit is persistent and pervasive in the lives of these individuals, as it is maintained by the ongoing interactions between the individual's emotional vulnerability and the environment's pattern of invalidating the individual. The Biosocial theory explicitly supports a nonpejorative stance towards these individuals that is aimed at validating them and their lives (Linehan, 1993; Nehls, 2000; Swenson et al., 2002; Swift, 2009 a, b).

The Manning 'Moving Forward' Dialectical Behaviour Therapy program

The Centre for Psychotherapy in Newcastle, Australia has been running a successful DBT program over the last ten years and as part of the Hunter New England Area Health Service, staff from the Community Health Services in the Manning applied to undergo the DBT training in 2004 and then established the Manning 'Moving Forward' DBT program (Boaden & Macauslane, 2004). Clients began in the DBT Stage 1 program in early 2005 and since then, there have been more than 30 client graduates.

The Manning 'Moving Forward' DBT program (Boaden & Macauslane, 2004) is a comprehensive service, that incorporates the weekly individual therapy session; the weekly Group session; DBT Phone Coaching; and the Therapists Consultation group which meets weekly. Individual sessions with the client's allocated therapist are aimed at assisting the client with their Group work, dealing with current issues; dealing with skill attainment and generalising the use of skills into everyday life. Weekly Group sessions consist of two one hour sessions, with the first focusing on homework tasks and the second, on learning new skills. The DBT Phone Coaching Service is available to clients to ring for assistance, validation and support as they undertake the program, operating Monday – Sunday 08.30 am to 10.00 pm and is staffed by rostered DBT therapists. Therapists also

attend a Consultation meeting each week to review clients' progress, inform all therapists of clients' status, and to support and validate one another in optimal clinical practice.

Learning modules in the Group sessions consist of mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation. Clients undertake each module twice in the 12 months of therapy; firstly so they gain an awareness and knowledge of the module while the second time aims to embed the knowledge and encourage use of the learnt skills into everyday situations. Clients are also informed about the concepts of validation and radical acceptance and in problem solving techniques. Each of the distress tolerance, interpersonal effectiveness, and emotion regulation modules are delivered over six–eight weeks, interspersed with two weeks of the '*core skill*' of mindfulness. In this way, the commencement of the mindfulness module allows for new participants to enter the Group sessions and for graduates to exit with a presentation and luncheon. The Program also operates on a number of rules, including a failure to attend four individual or Group sessions in a row will result in a temporary exclusion; clients who have partially completed the program can reapply for inclusion after a six month period; clients in the Group may not be or become involved with one another in an intimate relationship; clients are not to attend Group in an intoxicated state (Linehan, 1993; Boaden & Macauslane, 2004).

The patient experience

Over the last twenty years, there has been a growing body of qualitative research studies that can allow for a more complete understanding of phenomena. While quantitative research is no less important; undertaking research with qualitative studies that rely on the linguistic data rather than numerical data, allows for other aspects to be studied (Elliott, 2008a, b). These include: the ability to study phenomena in its own right rather than through an external and often isolated view; the open, exploratory questions allow for unlimited emergent description options rather than the closed perspective of percentages, ratings or scales; and finally, there is the possibility of discovering new information rather than confirming what is hypothesised (Elliott, 2008b).

Within psychotherapy research, there is a need to gain greater knowledge about psychotherapy within its own context – a context that centrally consists of behaviours and vocalisations by clients. Research seeks to better understand those meanings given to these behaviours and voices of the people who undergo or participate in a process or intervention. Phenomenological research studies centre on the 'experiences' of people and seek to gain better understanding of phenomena that is not readily subject to quantitative statistical studies (Elliott, 2008a, b; Macran et al., 1999).

Research studies on the patient experience of people acknowledges that clients, consumers, carers and health care providers are not the passive recipients of and participants in health care but are active contributors and in the case of the clients, are the only ones who are able to give a perspective on the entire journey and its outcomes (Elliott, 2008; Macran et al., 1999; Saunders & Girgis, 2010). Within the phenomenological perspective, the researcher's close proximity to participants facilitates a genuine interest in learning and understanding about their experiences as well as providing an avenue for the participants' voices to be heard (Hodgetts et al., 2007; Fallon, 2003).

In health care services today, there is an ongoing and significant need to consider healthcare costs from many aspects. As such, there is more and more evidence that the patient experience of patients and clients is considered valuable and that these stories are able to give realistic views on healthcare processes (NSW Health 2008, Hodgetts & Wright, 2007; Saunders & Girgis, 2010). Within NSW

Health, staff can refer to a guide for collecting patient and carer stories, as well as the availability of a 'Patient and Carer Experience' internet site that not only provides access to resources but public access to patient and carer experiences of the NSW Health system (NSW Health, 2006: NSW Health 2008). It is increasingly evident that patients and clients experiences have a major contribution to make to healthcare.

Recovery and Social Inclusion

The Fourth National Mental Health Plan 2009 – 2014 has identified '*Recovery and Social Inclusion*' as the first priority in mental health service provision within Australia (Department of Health and Aging, 2009). The term recovery can have different meanings within healthcare, but within the context of mental illness, it is defined as:

'A personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually-identified essential services and resources' (Department of Health and Aging, 2008).

Within the contexts of recovery and of mental illness; it is well recognised that there is a need to include strategies to improve the level of social inclusion for each client (Slade et al., 2009). Social inclusion policies and strategies are aimed at reversing the circumstances or habits that lead to social exclusion. Indicators of social inclusion are that 'all Australians are able to secure a job; access services; connect with family, friends, work, personal interests and local community; deal with personal crisis; and have their voices heard' (Department of Health and Aging, 2009).

Within mental health services, there is an ongoing understanding and development of recovery principles; which for clients is much more than clinical care, is not just a lessening of symptoms, and is not readily synonymous with a complete cure. Adopting a recovery approach includes developing pathways of care that holistically promote mental health and wellbeing not only in the domain of health but also in relation to the social domain to promote community engagement and connectivity. This approach emphasises the importance of hope, empowerment, choice, responsibility and citizenship while working to reduce individual difficulties while maximising personal potential (Department of Health and Aging, 2009). In this way, the principles of and approaches to recovery shift the control of healthcare provision back to the person who is recovering (Nehls, 2000).

Literature Review

Search strategy

An electronic search was conducted for available evidence in peer-reviewed literature, strategic and policy documents, and in publications from mental healthcare and support internet sites; from 1990 to June 2011. Searches were conducted in CINAHL, EMBASE, Ovid MEDLINE, PsychINFO, APAIS and state and government health department websites. Search terms used were: borderline personality disorder, treatments for borderline personality disorder, dialectical behaviour therapy, the patient experience, qualitative research (in healthcare), and, recovery and social inclusion.

There was a range of literature found in relation to the search terms; falling into relevant literature for qualitative research; phenomenological aspects of the 'patient experience'; for the diagnostic aspects of BPD; as well as literature relevant to randomised-controlled trials in DBT that examined both efficacy and outcome. In this way, both a snowballing technique and a limiting technique were used to locate literature that specifically meets the study requirements. The identified literature was

then subject to the 'COREQ' (Tong et al., 2007) qualitative research guidelines for interviews and focus groups; to determine the efficacy, similarities and the qualitative stance taken by the authors in their research designs.

Borderline Personality Disorder

There is expansive research literature available on BPD; it is more extensively studied and reported on than any other personality disorder (Oldham, 2005:1; Gunderson, 2006, 2009). These studies include those pertaining to the constructs of the disorder; involving the current criteria and the possibility of inclusions and exclusions to those criteria; as well as the potential to give more weighting to some criteria over others (Kernberg, 2006; Kernberg & Michels, 2009;). There is further debate and studies in relation to the current allocation of BPD to Axis II on the DSM Axial Tree (DSM-IV-TR, 2000). Currently, Axis I represents the presence of a serious mental illness, such as Schizophrenia, Bipolar Disorder Type I, Agoraphobia. It acknowledges the potential severity of the disorder and incorporates and acknowledges the ongoing functioning of the person and their lives. Axis II includes Personality Disorders and Developmental Disorders. Studies have shown that the severity of BPD can be as great, if not greater at times, than those considered to be serious illness such as Schizophrenia (Oldham, 2005; Gunderson, 2006, 2009; Hoffman, 2007).

Other studies include those associated with the prevalence of the disorder; the risk factors that can potentially contribute to the emergence of the disorder; neurological aspects; biological and genetic factors; as well as the psychological factors that impact on this disorder. Although these studies have not identified any one specific factor contributing to the emergence of the disorder, each study has contributed to our understanding of BPD and what successful outcomes can be achieved (Oldham, 2005; Kernberg, 2006).

Within every piece of the available research literature on BPD; what is very evident is the existence of the chaos, impulsivity, dissociation, past abuse and ongoing trauma, self-harm and suicidal actions, the distress and consequences of personally dealing with this disorder. A large percentage of the research literature does focus on the quantitative aspects of the disorder, but there is a growing body of qualitative research literature that focuses on the 'voice' of the individuals who are diagnosed with BPD.

Many of the formal research literatures relating to BPD; such as the formal criteria as described by the *Diagnostic & Statistical Manual (DSM-IV-TR, 2000)*; the American Psychiatric Association's *Practice Guideline For The Treatment Of Patients With Borderline Personality Disorder (2001)* and the United Kingdom's NICE *Borderline Personality Disorder: Treatment And Management, National Clinical Practice Guideline Number 78 (2009)* do give adequate and reliable description of the social, emotional and psychological status of clients dealing with the disorder. Literature by Gunderson (2006, 2009); Oldham (2006, 2009); Linehan (1993); Lieb et al. (2004); Kernberg et al. (2009); Hoffman (2007); Conklin and Westen (2005) and many others detail the chaos of the borderline personality disordered client as well as the chaos of dealing with these clients, often in a pejorative and punitive way. Woollaston and Hixenbaugh (2008:703) after interviewing nurses who care for clients with BPD, identified the central theme of nurse-patient interactions as the 'the destructive whirlwind' [referring] to the nurses' perceptions of these patients as a powerful, dangerous, unrelenting force that leaves a trail of destruction in its wake'.

Other qualitative studies also document the ongoing invalidation, stigma and marginalisation by others, including by those working within healthcare services. Fallon (2003) documents the patient experience of clients with BPD who use public mental health services; detailing the negative

aspects of stigma and marginalisation encountered as well as the strategies these clients use to negotiate their way around the system. Nehls (2000) advocates that there needs to be greater attention and care provided to these vulnerable clients, given the degree of stigma, marginalisation, and prejudice they face even within mental health services. Hoffman (2007) and Kealy and Ogrodniczuk (2010) provide details of the ongoing marginalisation for clients with BPD, describing the pervasive attitudes, the notion of the disorder's illegitimacy, the lack of suitable care pathways and the burden on healthcare clinicians. Saunders et al. (2011) undertaking a systematic review of staff attitudes towards people who self-harm; found that general hospital staff, especially doctors, continue to have mostly negative view towards this population. Perseus et al. (2006) were able to highlight the health-related quality of life impairments that could be directly attributable to the disorder. These health-related quality of life indicators are very similar to the recovery principles, as previously described.

Treatments for Borderline Personality Disorder

Binks et al. (2006) undertook a Cochrane Collaborative meta-analysis review of the efficacy of randomised-controlled treatment studies of psychotherapies; and subsequently determined that no one psychotherapy was more efficacious than the other. However, the review did show that the increasing availability of these psychotherapies was having some positive outcomes on the lives of individuals undergoing these interventions. Other multi-wave meta-analysis reviews of psychotherapy include Ost's (2007) review which examined various 'third wave' therapies including Acceptance and Commitment Therapy (ACT) and DBT; concluding that these two therapies showed moderate sized effects on targeted outcomes. Bartak et al. (2007) examined the available research literature for evidence of the cost-effectiveness and effects of psychotherapies in relation to treating personality disorders. Bartak and her colleagues concluded that there is evidence of efficacy both in terms of costs for healthcare providers as well as improvements in client outcomes. Levy (2008) concludes that many of the current therapies and treatments for BPD, including mentalization-based treatment and DBT are able to obtain varying levels of remission than what can be attained through the natural course of the disorder.

Dialectical Behaviour Therapy

Since the first randomised-controlled trials (RCT) were undertaken and reported on by Linehan and her colleagues in 1991 (Linehan et al., 1991) and the emergence of DBT in 1993 (Linehan, 1993); there has been substantial research studies undertaken in this particular psychotherapy. Research literature is available in both quantitative and qualitative aspects of DBT (Scheel, 2000; Feigenbaum, 2007; Ost, 2007; Blennerhasset & O'Raghallaigh, 2005).

Other more qualitative research literature centre on those experiences and perceptions of clients and/or therapists of DBT. Three research papers were identified as relevant to the proposed study design; namely Araminta's research study (2002), Perseus et al. (2003), and Hodgetts et al. (2007). Araminta's doctoral thesis (2000) uses a contextual analysis to explore both client and therapists experiences of DBT and how clients perceived their lives before undertaking DBT. There were 10 client study participants who were at least four months or more into a DBT program. Araminta's study (2000) centres on the collected qualitative perceptions into many of the process aspects of the DBT program comparing the results between the clients and the therapists. Perseus et al. (2003) examined the perceptions of patients and therapists of DBT, using a content analysis, to undertake a study of pre-, during, and post-DBT perceptions with therapists and 10 clients who had been in a DBT program for 12 months or more. Their findings point to positive client outcomes, focusing on the central components that included: 'the systemized understanding, respect and confirmation in

combination with the “toolbox” of techniques and constructive skills the patients are provided and trained to use' (Perseus et al. 2003). Hodgetts et al. (2007) used an interpretative phenomenological analysis to explore perceptions of DBT with four clients, three of whom had completed DBT and one person was currently in a DBT program. Hodgetts and colleagues (2007) found three dominant themes emerged from the data; joining the DBT program with experiences ranging from disbelief to full commitment; experiences of DBT, both positive and negative; and, evaluation of DBT focusing on benefits and ongoing needs.

Recovery and Social Inclusion

Certainly the evidence from various RCTs of DBT are able to show significant and statistical improvements in client outcomes, while ongoing qualitative studies seek more to understand how clients and therapists experience the concepts of recovery. Zanarini et al.'s (2010) follow-up study at a 10-year interval suggest that 'recovery from BPD, with both symptomatic remission and good psychosocial functioning seems difficult to attain; ... [but if it] is attained, such a recovery is relatively stable over time'. Levy (2008) found that RCTs of DBT by Linehan et al. (1991) and Bohus et al. (2000) showed remission rates of 50% at a two year follow-up study. Zanarini and colleagues (2010) also found remission rates were lasting for 93% of all participants for at least two years; but who also call for more research on factors that contribute to psychosocial rehabilitation; that are similar to the principles of recovery as previously described.

Nehls (2000) examines recovery as a 'process of empowerment' that clients diagnosed with BPD (and therapists) need to engage in; by using the underlying assumptions that recovery is possible; is a nonlinear process; is self-defined; and, requires a partnership. In this way, clients (and therapists) will engage with a sense of hope and optimism; will progress in a gradual and flexible fashion; will recover a new sense of self and purpose; and, that healthcare providers will establish pathways of care that enable clients to have meaningful partnerships with those therapists. Nehls (2000) also states that research studies using the 'interpretive phenomenological approach' allow for interpretation of the meaning of everyday experiences to further generate knowledge about recovery that is client-centred.

For each client diagnosed with BPD, there will be a unique journey; with no two journeys alike. Certainly, a person who is dealing with BPD and who is in recovery or remission, is aptly described by a consumer, P. Deegan (cited in Hoffman, 2007), who defines recovery as

“... a process, a way of life, an attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again... The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work and love in a community in which one makes a significant contribution”.

Summary of Literature Review

In summary, the literature review has highlighted various aspects of relevant and similar literature that has the potential to influence the research study design, There is an extensive database of literature available on BPD; mostly specialising in the ontological, physiological and biological aspects as well as that of the diagnostic criteria studies that have been undertaken to ultimately improve our understanding of the BPD. Much of the research literature documents the symptoms that clients can experience, but often do not record the depth and breadth of the chaos, distress and impact of the disorder in qualitative terms of the patient experience.

Over the last 20 years, in the psychotherapy field, there has been a significant growth in the available therapies that are worthy of use in treating BPD. Certainly, there is a growing body of evidence to increase and improve the scientific knowledge of positive outcomes, both quantitatively and in the qualitative areas. While there is call for more rigorous studies in the psychotherapy field to continue to validate therapies, DBT does have a substantial amount of evidence available, both in quantitative outcomes of the pre- and post-intervention measures and focussing on mechanisms of change; as well as positive outcomes where individual studies have centred on the quantitative aspects.

However, minimal literature was located that qualitatively and phenomenologically centred on the experiences of the clients with BPD who had completed Stage 1 of DBT and who were two to five years post-intervention, with a significant focus on recovery and social inclusion aspects. The relevant papers of Araminta (2000), Perseus et al. (2003) and Hodgetts et al. (2007) offered insights into aspects that could be relevant for the proposed study design. Perseus et al. (2003) and Araminta's (2000) examined both clients and therapists, while Hodgetts et al. (2007) only examined client experiences. All three papers had a major focus on the clients' experiences of the process of the DBT program, with some focus on life experiences prior to DBT. However, all three papers had no or minimal reference to the aspects of recovery and social inclusion.

Rationale

The gaps in the available research literature review were identified as: (i) minimal amounts of research literature was identified that specifically focuses on the breadth and depth of BPD and the impact on clients within an interpretive phenomenological framework; (ii) minimal literature was located that centred more on client experiences undergoing the DBT intervention; (iii) no research literature was located that deliberately aimed to explore experiences with participants, all of whom had fully completed a DBT program in the past two to five years, in what is identified by the Cochrane Collaborating Centre as 'medium-term' post-intervention; and, (iv) no research literature was located that went beyond the BPD diagnosis and the DBT treatment to fully explore recovery and social inclusion aspects, within the 'patient experience' of the phenomenological stance.

Theoretical Perspective

The ontological stance chosen is that of the hermeneutic and relativist perspectives, which seek to understand phenomena focusing on the patient experience of humans and which examines the phenomena in a contextual fashion, incorporating variables such as background, culture, and environment. The epistemological perspective taken is that of a constructivist and interpretive approach, that seeks knowledge by observation and inductive interpretation, such as those offered by personal interviews, and which do not necessarily lend themselves to quantitative studies (Patton, 2000; Polkinghorne, 2007; Potter & Wetherell, 1989).

Methodology

The research study design uses the theoretical perspective of the constructivist-interpretive approach that does not seek to uncover a single 'truth' (Polkinghorne, 2007); but seeks an understanding of the world through the perspective of people who have a diagnosis of BPD and who have completed Stage 1 of a DBT program, some two to five years beforehand. Using this qualitative methodology; the research study design seeks to be flexible and contextual (Polkinghorne, 2007; Potter & Wetherell, 1987; Liamputtong, 2009), with a view to gaining an understanding of clients' experiences of DBT and to understand whether the therapy has made and

continues to make an impact on clients' current lives in regard to their level of recovery and social inclusion.

Within the research literature there are continuous calls for research to look more at the 'patient experience' of individuals; as advocated by Elliott (2006, 2008) to document evidence of clients acting as their own active change agents and for researchers to better understand the 'complex mediating processes by which clients actively use therapy to overcome obstacles to change' (Elliott, 2008a: 242). Research at this level, acknowledges that clients' perspectives are important and attempts to solicit information about the meaning and value of therapy for clients. This type of research accepts that clients' views and assessments of their therapy may be different or contradictory to the views and assessments of therapists or researchers (Patton, 2000; Liamputtong, 2009).

The Research Question

What are the qualitative experiences of clients with a diagnosis of Borderline Personality Disorder; who have completed the Manning Dialectical Behaviour Therapy "*Moving Forward*" Stage 1 Program in the last two to five years?

Aims of the Study

This research study aims to explore our understanding of the participants' experiences of their lives prior to undertaking therapy; of the participants' experiences of the helpful and hindering aspects of participation in and completion of Stage 1 of the Manning DBT "*Moving Forward*" program; and, of the participants' experiences of the impact of DBT on their current levels of recovery and social inclusion.

The second aim of this study is for the researcher to analyse, evaluate and report on the findings of the research; and, to disseminate these findings to interested stakeholders, to other health professionals, and to the community by way of the formal research report; potential conference presentations and publication of peer-reviewed journal articles.

Method

Study Design – Case Series

With no other similar research literature located, the study design deliberately seeks to actively understand the phenomenon with an exploratory and flexible approach. Thus four individual cases were explored for occurrences of experiences and comparisons and differences in the participants' lives. The use of data contained within transcripts of client interviews can allow for exploration of the phenomenon with minimal limitations to locate a more in-depth view of the study population's 'experiences'. The research question and the study design can remain defined by the researcher and allow for a major focus on the post-intervention evidence of recovery and social inclusion as well as a moderate focus on client experiences in relation to life prior to and during the intervention.

The research study design aims to benefit clients and the wider community by assisting healthcare providers to better understand the entire client journey and for clients, who undergo the journey of BPD and DBT, by giving them a 'voice' within the modern healthcare system. For this reason, the study design uses a discourse analysis approach; which is further discussed in the Data Analysis section. Practical factors also impact on the research study design; including the timeframe of the research scholarship being limited to 21 months, which limited the scope of the research study in order to make it achievable within the given timeframe.

Underlying assumptions

The research study was based on a number of underlying assumptions, which include: that everything is relative and that phenomenon is observed within the contexts of the population under study; that knowledge can be gained through observation and interpretation, with an inductive basis for the findings of the study; that there is an acceptance of the *complexity* of and the *interconnections* between meanings, and *uncertainty* as often providing the focal point from which researchers can search for new knowledge; that the treatment, DBT, is an effective treatment for BPD; and, that the chosen method of analysis provides a valid way of obtaining information about the phenomenon under study.

Inclusion criteria for the research study

Inclusion criteria for the research study potential participants, involved: clients, who had been given a formal diagnosis of BPD before entering the Manning DBT Program; clients who had completed the full Manning DBT Program; clients who had completed the Program within the medium term, i.e. the last two to five years (2006 - July 2008); clients who reside within the Manning Mental Health Service boundaries; with the potential to extend the study to the boundaries of the Hunter New England Local Health District, if potential participant numbers were limited; and, in order to obtain full and informed consent, participants need to have a stable mental health status.

Participant Selection Process

Sample Size

The small sample size of the potential study participants is an ongoing issue in any health research study relevant to people with a diagnosis of BPD. It is evident in the sample populations in fore-mentioned research literature, both in randomised-controlled trials and in qualitative studies. The reasons for this may include: the difficulty of engaging this client population, geographical relocation, availability and access to DBT and research studies. Thus, the population and sample population are one and the same for the research study design. The sample population of clients is recorded in a register of all clients who have been offered the Manning DBT "Moving Forward" Program.

Sampling

The final sample population was obtained after each client in the register was confirmed to have documented evidence of a formal diagnosis of the BPD by a Psychiatrist; the completion of the DBT program, as required; and that graduation from the program had occurred between 2006 – July 2008. Based on a 'captured' sample population, six potential study participants were identified and then after a repeat review of the inclusion criteria, all six graduates were considered for contact as potential participants. It must be noted that the graduates' Mental Health status was unknown at the time of the initial approach. The inclusion aspect of a stable Mental Health state could only be undertaken after the initial approach, commencing at the first point of contact (by telephone) to the final face-to-face Mental State Examination undertaken with the study participants, prior to the research interview.

The researcher/DBT therapist did discuss and alert the DBT therapists' team, of the intention to start the contact process with previous graduates of the program with a view to the graduates' potential participation in the research study. Potential participants were not identified to the DBT Therapists team; however, two potential participants did contact their previous individual therapist to discuss potential participation in the research study.

Jullie (JP) Williams

HNEHREC No.:10/05/19/4.01

Methods of Approach

The preferred method of approach was to send out a letter of invitation (see Appendix 1) and an information sheet about the research study (see Appendix 2) with a reply-paid envelope to the six potential study participants. Four potential participants responded via phone message or by mail. All four were contacted by phone, issues pertaining to the study were discussed, each gave a verbal agreement to come in for an interview, and the interview preferred-setting, day, date and time were arranged. One participant failed to attend for the interview, however with further phone contact, had forgotten the appointment and agreed to another day and time.

Non-Participation

The total potential study participants numbered six, with four respondents agreeing to be interviewed. No other contact, either by phone or by mail, was forthcoming from the other potential study participants. This may have been due to a choice of non-participation, incorrect postal address on the Hunter New England Health database; or for other unknown reasons.

Participant Demographics

The four Research Study Participants (RSP) were all female; aged between 35 years and 55 years; and all were born in Australia. Two participants were married. Two participants had part or full time employment, one participant was studying; and one participant was preparing to re-enter the work force.

Data Collection

In undertaking the data collection, all the participants elected to be interviewed at the local Community Health Centre, where they had actually attended the DBT Program and for their individual therapy sessions. The four interviews took place over a four week period. The only occupants during the interviews were the researcher and the study participant. The research interview duration varied from 56 minutes to 1 hour 34 minutes with an average length of 1 hour 10 minutes in duration. The research study interview was undertaken using an Interview Prompt Questions sheet, (see Appendix 3).

The actual duration of all four research interviews excluded the time required to attend to the pre-interview and post-interview processes. The pre-interview process included: an introduction in person; ensuring comfort with water offered and location of amenities; an explanation of the 'formal' consent process and why the researcher was required to attend to the process in a formal manner; discussion with the participants about the purpose of the study; the participants' understanding of the purpose of participating in a short Mental State Examination (MSE); their willingness and comfort in doing so; the undertaking of the MSE; discussion of any issues raised (although none were evident or raised in relation to current mental health status and wellbeing); giving a verbal and written explanation of the consent process and form (see Appendix 4), especially in relation to withdrawal or cessation of their participation in the study at any time and that no explanation was required on their behalf; an explanation of the method of recording the interview, the process of transcription and the potential to check back with the client (only for the purposes of checking the actual interview transcript and not in relation in any other matter); an explanation of how the audio recorder worked; the ability to have a break in the interview if required (although no participant elected to have a break); the ability to not any answer any question, without explanation; discussion of the need for the participant to feel emotionally comfortable and that they were not required to answer anything that raised traumatic or unwanted

thoughts or feelings (this aspect was reiterated in the interview); and, finally, the actual signing of the consent form.

The post-interview process involved a further reiteration of the right to withdraw at any time; that any complaint or grievance could be directed to the local Mental Health Service Manager or to the Hunter New England Health Human Research Ethics Unit Manager; giving pamphlets with contact information on support and assistance services and avenues of complaints and compliments (with one participant declining to take the pamphlets); the next 'steps' in the research process; the long wait for the report and the potential for any research journal articles in the future; the ability to contact the researcher to discuss any issues raised by the report or journal articles. While this process may appear arduous, it did not take up too much time either pre- or post-interview – an interview checklist (see Appendix 5) was used for each interview to ensure all relevant aspects were covered. The total length of time spent with the participants ranged from 1 hour 30 minutes to 2 hours 30 minutes. Nearly all of these aspects had been previously discussed with the potential participants in the planning phone calls, prior to their attendance at the local Community Health Centre.

Data Collection by audio recording

The researcher used a new audio recorder that was in the shape of a slightly larger-than-average pen. It became a little story of introduction about its use and purpose, the ability to record and then to use the associated computer program for the research study. The recorder was placed on a small table between the researcher and the participant. The participants were aware of the formal start and end to the research interview with the starting and stopping of the audio recorder. Two participants later commented that they had forgotten the audio digital recorder was there.

Data saturation

The small number of potential Research Study Participants (RSP) was six clients; with four agreeing to participate in the study. Due to the small number, there was no opportunity to reach a data saturation point.

Instrumentation

While instrumentation included the use of data recording and transcription; the research study design deliberately sought to use the researcher as the primary instrument. Thus the researcher's perspective is twofold; namely, to *"be acutely tuned-in to the experiences and meaning systems of other – to indwell – and at the same time to be aware of how one's own biases and preconceptions may be influencing what one is trying to understand"* (Maykut & Morehouse, 1994, cited in Araminta, 2000:35).

Data Analysis

The analysis was performed according to the following steps:

1. All interviews were transcribed verbatim.
2. The four transcripts were read in their entirety several times to gain a sense of the participants and their experiences.

3. Throughout the second and subsequent readings of the transcripts, open phrases, sentences or paragraphs that bore meaning (meaning units) (Burnard, 1994) were underlined.
4. The texts were then cleaned of extraneous data, including unrelated comments, repetition of words and sounds (that were not essential to the meaning units), and any word or aspect that could lead to any identification of the Research Study Participant (RSP). The remaining comments of each transcript were searched and grouped into 'meaning units'; where grouping of words, sentences, and sometimes paragraphs of text pertaining to the participants comments on a particular aspect, theme or sub-theme of interest is separated from the next meaning unit. Each transcript and 'meaning unit' maintained its unique participant identifying number (known only to the researcher) throughout the analysis.
5. The Coding Analysis sheet, Version 1, (see Appendix 6) was entirely based on the research question and potential aspects, themes and sub-themes were identified from the literature review of BPD, DBT and of Recovery and social inclusion. With the three central aspects of pre-DBT, during DBT, and post-DBT, identified, potential themes were then explored based on Interview Prompt Questions (see Appendix 3).
6. Following the reading of the texts and all meaning units were considered, the themes were then finalised. With the identified meaning units, each was considered independently and initially assigned into the Aspect categories; then into Themes categories. Each meaning unit was again considered to identify potential Sub-Theme categories. The Sub-Themes were identified and the second version of the Coding Analysis Sheet (see Appendix 7) was finalised.
7. Throughout the development of the Coding Analysis Sheet, a glossary (see Appendix 8) was also developed by the researcher to provide meaning to the concepts contained within the research study. Coding categories and glossary meanings were discussed with DBT colleagues and amended with the researcher's agreement.
8. The management of the text data involved using a word processing program to automate some of stages of categorising the data into aspects, themes and sub-themes, as described by Burnard (1994). This method allowed for less time to be spent on the clerical aspects of assigning each meaning unit as well as being able to view the data for occurrences and variations and in various comparisons.
9. The data analysis involved assigning each meaning unit of each participant's text into one complete document, using the Coding Analysis Sheet, Version 2, (see Appendix 8).

The qualitative aspect of the research design allows the researcher to develop the final categories for analysis as the study design progressed. In this way, the method chosen allowed the researcher to obtain data that was initially allotted to those semi-structured interview prompts (see Appendix 3); namely aspects around pre-intervention, the intervention, and post-intervention. This method of semi-structured prompts also allowed the participant to describe their own points of view that are not readily moulded into the established analysis categories at the outset of the study design. In this way, the researcher is able to phenomenologically analyse the data and develop the themes and sub-themes as the study progressed.

The analysis of the data was based on that of discourse analysis, as advocated by Potter and Wetherell (1987); Hardy et al. (2009); Liamputtong (2009); Potter and Wetherell (1987), who believe that any interpretation of a narrative is not simply a matter of categorising pieces of speech. They argue that the function of a narrative will vary according to the purpose of the speech and the variations can be used as evidence of how a person has constructed meaning. Analysing narratives

can involve searching for patterns, then clustering these patterns based on the theoretical underpinning of the relevant literature, such as the fundamental theoretical concepts of DBT. These clusters can then be considered in relation to the original research questions and used to form the findings. In this way, the categorisation process of discourse analysis is useful to exploring and improving healthcare practices rather than developing new theory.

Ethics

In May 2010, a National Ethics Application Form was submitted on the NSW Health Ethics online site; with its review being conducted by the Hunter New England Health Human Research Ethics Committee (HNEHREC). Further clarification was sought by the Committee, in relation to the conducting of the Mental State Examination and the strategies to deal with any emotional vulnerability of the Research Study Participants. The researcher also amended the Letter of Invitation to ensure participation was freely given and no coercion occurred. The clarifications and amendment were re-submitted and approval to conduct the research was granted in August 2010.

NSW HREC Reference No.: HREC/10/HNE/90.

HNEHREC Reference No.: 10/05/19/4.01.

Findings and Discussion

The findings of the research study are categorised into the identified aspects of pre-intervention, during the intervention and after the intervention. Following each aspect, the relevance of the findings is discussed in relation to the cited literature and knowledge.

Pre-Intervention

The research study participants were asked to describe what their lives were like prior to undertaking Dialectical Behaviour Therapy (DBT). Across the participants' comments, recurring themes emerged of their lives prior to DBT which included: backgrounds and histories of instability and invalidation; the participants' level of distress, poor coping skills and low levels of resilience; episodes of chaos, impulsivity and dissociation; as well as their efforts to obtain professional help and the stigma they encountered. One comment describes the difficulties:

"It was so frustrating; anxiety would freeze me [then] I'd get in a panic and harm myself" RSP02:10.

These form pictures of lives which may be very foreign to other people. To better understand these themes, each is examined in more detail.

While one study participant made no comment in relation to her early childhood and immediate family members; the other participants' were able to describe events in their childhood development that they viewed as being invalidating, abusive or neglectful. Three participants offered the information that they had been sexually abused as a child. One participant also described a high level of physical abuse and violence being part of her childhood history. While the participants did not necessarily describe coming from poor or disadvantaged families, they were able to expand on episodes that they described as neglectful; lacking protection; or had a high level of invalidation or a lack of validating environments.

Three participants made comments regarding their relationship with their mother and childhood, which involved: a lack of trusting their mother, being neglected, being left unprotected, being dominated by, being ridiculed or put down by their mother. For one participant, part of her description of childhood, is as follows:

“My mother couldn't even cope with the fact that I had been sexually abused – she put it all back on to me. So who could I trust? I trusted the people who I thought loved me and cared about me and what they did to me – that was not love – that was not caring – that was extremely abusive” RSP03:9-10.

All four participants described events and episodes in their lives prior to DBT, that can be viewed as chaotic, impulsive and very often, unsafe. These events often involved actions of self-harm and putting self in unsafe positions and of attempted suicide. Participants' descriptions of self-harm, included: deliberate binge drinking of alcohol; deliberately cutting self with knife or instrument with sharp or pointed edge (e.g. screwdriver); hitting self by punching self in head, hitting brick walls with closed fists, hitting head on wall; and, burning or branding self with heated instrument. One participant described episodes in the following way:

“I would brand myself with a sharp knife – cutting my forearms or branding myself by heating up a spoon and putting it on my skin – just to feel something, anything”, RSP02:7-8.

All four participants also described dealing with their emotions and stress by considering suicide. Collectively, ideas and plans included: considered electrocution; deliberately smash car into a stationary object or large truck; overdose of medications; deliberate drink driving; considered and attempted hanging; overdose of alcohol; overdose and considered drowning; considered jumping in front of moving bus, train or truck; and, living with venomous creatures.

What is not often described in the literature, but is evident in the participants' comments are the emotions and thoughts they are having around these times of emotional crisis and not coping. Such emotions included being frustrated, anxious, impulsive, guilty and shameful, angry, insecure, lacking trust, not coping to the point of dissociation, feeling confused, fearful, miserable, erratic, or overwhelmed. Throughout these times, all four participants described seeking healthcare assistance by way of the emergency services or by going to the Emergency Department of the nearest hospital.

The participants were able to give accounts where they reported being had treated with 'less-than-professional' healthcare, involving being treated badly or being treated like 'nothing'. One participant described feeling very suicidal while driving her car, so she went to the nearest Emergency Department for help.

“An awful Registrar treated me like dirt, yelled at me, threatened to ring DOCS about my baby”, RSP01:8.

Participants' comments relating to such treatment in the healthcare system highlight the ongoing invalidation, rejection and the stigma that people with a BPD diagnosis encounter when seeking assistance.

Overall, the findings within the pre-intervention aspects concurred with the research literature. Certainly the comments of the study participants; describing the chaos, the impulsivity and their means of coping echo the criteria for a BPD diagnosis as set out by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000) and as described by Gunderson (2006, 2009), Oldham (2006, 2009), Kernberg and Michels (2009), Linehan (1993, 2000) and other acknowledged health professionals. All of the research study participants were able to describe

instances of stigma and discrimination, similarly described by Hoffman (2007), Fallon (2003) and Nehls (2000). What is also evident is that the qualitative nature of the study helps to impart the need for health professionals, when dealing with BPD, to consider the personal and individual aspects of every person - rather than labelling.

During the Intervention

The research study participants were asked to describe what were the 'helpful' and 'unhelpful' aspects of undertaking the DBT program. Findings note that there were more comments made about helpful than unhelpful aspects in relation to the intervention. The study analysis highlights that the *most* helpful aspect all the participants made comment on was the insights and awareness that they felt they gained by participating in the learning aspects of the whole program.

Comments on the insightful nature of the intervention included insights into oneself, into the disorder, and in relation to their environment. These comments included:

"Without DBT, I wouldn't have been able to identify what was happening for me", RSP02:25;

"It keeps you thinking and feeling that you are a human being, you are not this big monster", RSP03:19.

While comments on the awareness obtained, included:

"Until I came to DBT I didn't know I had an underlying emotional disorder", RSP03:10;

"I was getting a lot from it, a lot of support and validation and learning", RSP01:5.

This aspect was then followed by the helpful aspects of the program's level of support and assistance by the staff – via the support and validation from the DBT Group Facilitators, the trust and support with the individual therapists as well as the benefit of the DBT Phone Coaching service.

In relation to the attainment of DBT skills to use in their lives, comments included:

"Having the modules repeated twice, in case you don't get it the first time you had a chance to pick it up", RSP04:2;

"Using the diary cards to be aware of your emotions, to acknowledge them and to use the skills to deal with them", RSP03:11-12.

Other comments related to the positive benefits of mindfulness (the most nominated skill used by all participants) and to learning about 'emotions'. Finally, all four participants commented on the helpfulness of belonging to a group. These included:

"It was nice to hear that you weren't the only one and you could talk to the others about things.

It was good", RSP04:2;

"Just coming somewhere where they understood what was happening in your head", RSP01:2.

Unhelpful aspects were few. Comments related to participants feeling unsupported and times when the participants' commitment wavered. These comments included:

"Therapists who didn't want you to use medication", RSP04:5;

"Facilitator relaying negative stories about other clients", RSP03:6.

Comments regarding commitment, included:

"I had major issues with Radical Acceptance – of the diagnosis, of the appropriate treatment", RSP001:7;

"Just the physical effort of getting to the Group was all I had to offer at the time", RSP01:7.

One participant commented that they had had a suicide attempt during the program, identifying a large amount of "external-to-the Group" stress; that they felt impacted on their ability to commit in the program.

Participants' comments also identified that the program, while being mostly 'helpful', was not instantaneous or easy. Comments included:

"Not everything worked straight away, it took a long time", RSP04:6.

"I will be honest, it was tough", RSP03:5.

While this research study did not seek to explore an in-depth interview with the participants' solely based on aspects of undertaking the DBT program; the findings show the majority of comments in this section related to the program being more 'helpful' than 'unhelpful'; that the 'helpful' comments centre on 'group' aspects rather than on individual therapy sessions; and, that 'unhelpful' aspects were more about the level of program commitment. All of the participants' comments are reflected in Araminta's comprehensive study (2000:251-297) of client and therapists views on DBT. Similar to Araminta's client participants, there was agreement that increased awareness was a 'salient' aspect of the therapy; as well as the support and assistance received, the skill attainment and the acceptance of the Group environment.

Unlike those participants' in Hodgetts' (et al., 2007) study, where a number of participants' had not enjoyed the DBT Group program at all; findings for this study showed that there were no totally negative comments about the Manning 'Moving Forward' DBT program (Boaden & Macauslane, 2004). Hodgetts' participants similarly identified the support and sharing of the Group as significant and that 'commitment' was a common difficulty. The study findings of participants' comments were similar to those iterated by Persius' (et al., 2003) study, with agreement about the awareness gained, the benefit of the skills and the difficulty of the whole program.

Post Intervention

The findings, within the post-intervention aspects, include the attainment and use of DBT skills; notable outcomes; and, those indicating elements of recovery and social inclusion. While the research study did not aim to directly attribute DBT to the participants' skill attainment and use; the analysis does show that the participants' described various DBT skills in use, two to five years after the intervention. Participant comments that directly identify the attainment and use of skills, include:

"I can get myself in a real state but then be able to use skills to cope with distress", RSP01:29.

While awareness and knowledge of the individual DBT modules – Mindfulness, Emotion Regulation, Distress Tolerance and Interpersonal Effectiveness, including Radical Acceptance – are evident; the degree of ongoing skill use varied, ranging from minimal to everyday use.

"[I] go on to use other strategies to help myself even if I need to refer back to my DBT notes", RSP02:27;

"Afterwards I just put everything away and I went back to living my life how I had always lived it", RSP01:3;

The skill of 'Mindfulness' was nominated by all the participants' as the most helpful skill attained in the DBT program and for ongoing use; with two participants detailing their assisting others to learn Mindfulness skills. The ability to use skills to better tolerate distress was present; with comments including:

"I can distance myself from distressing things", RSP04:20.

It is also evident that participants' are able to care for themselves as needed.

Participants' comments also pointed to an improved ability to regulate their emotions and to take control in different situations. The ability to cope 'better' was commented on by three participants; that life and emotions were more 'stable'; including the ability to take control [of themselves] and their environment. One comment summarises the general view:

"I've got choices and I don't have to allow the emotional roller coaster [to] take me wherever it wants to go", RSP03:20.

In relation to aspects of Interpersonal Effectiveness in their lives; participants' commented on their relationships with others with three making comments about their mothers. These comments described having ongoing difficulties in their adult relationship with their mother, such as: 'never ever' trusting their mother, continuing to be manipulated by their mother, having to limit the contact with their mother, mothers that were still unsupportive, and, dealing with an elderly mother who 'throws tantrums like a child'. One participant's comment was positive in relation to her mother, stating:

"My relationship with my mother has improved over time. I think she is more trusting and less afraid" RSP04:20.

In relation to others, such as other family, friends or associates; two participants' described their partners as having a good understanding of the participant's mental health issues. One participant described having an improved and improving relationship with a child. One comment included:

"I try to validate their feelings about the past, I can accept it – it has helped the relationship greatly", RSP03:19.

All the participants commented on 'friends' in their lives, with descriptions of positive regard and others on the limitations of friendships. Another two comments show the use of skills when interacting with others:

"If I get angry, I excuse myself and go and use my skills – I don't have to chew people's heads off", RSP02:30;

"I know now that assertiveness is a better way to go – anger is not assertiveness", RSP03:18.

Two participants' identified the area of Interpersonal Effectiveness skills as the module they felt they needed to work on more.

Within the findings, it is evident that the participants' have attained and used those skills from the DBT program. There is also evidence of improved outcomes in the participants' lives; relating to health, mental health, recovery and social inclusion. Within the comments, two participants' described having less frequent episodes of 'dissociation' and that those episodes were less intense and of less duration. Two participants' described having less anxiety; with one participant further describing having had no severe panic attacks since starting in the local DBT program. All four participants described having 'better' mental health than before the DBT program.

All participants were invited to comment on any therapy they may have done following completion of the Stage 1 of the Manning 'Moving Forward' DBT program. Three participants had continued on to undertake Stage 2 DBT; which involves the client and individual therapist continuing to work on the acquisition and generalisation of DBT skills into everyday use. The support and assistance of the therapist may be for an unspecified time, depending on the level of need. Two participants described undertaking other therapeutic programs since completion of the DBT program. One participant described not having done any further therapy, while another described working with a private counsellor at the time of interview. Three participants' described

no longer seeing a Psychiatrist on a regular basis and had less contact with the local Mental Health Service. Three participants also felt that their overall general health had improved since undertaking the DBT program.

Within the aspects of recovery and social inclusion; one participant described undertaking a course of study; two participants had gained or maintained employment and a further participant described undertaking a pre-employment program. One participant described her employment situation as:

“My highlights have been working for [company name] and being part of a team”, RSP04:23.

Certainly within the findings evidence exists of the participants' levels of social inclusion, be it through work, community or social outlets. While comments on friendships have been fore-mentioned, the increased level of participation in social situations and to obtain enjoyment is noted as well. One comment is evident of the enjoyment in having or interacting in social gatherings, namely:

“I had a party [at my place] on a freezing night but all my friends turned up and then stuck around. Everyone loved it. It was awesome”, RSP04:24.

Only one participant felt that their level of social interaction had not improved.

Within the participants' comments, there is evidence that undertaking the Stage 1 of the Manning 'Moving Forward' DBT program has been beneficial. However, all four participants made comment in relation to their own recovery, either as being 'a work in progress' or 'still having work to do'. One participant commented:

“I am not a star pupil but I'm learning all the time”, RSP003:17.

Participants described being able to forward with their lives. While the research study did not aim to directly attribute 'recovery' to the DBT program; the participants' comments are evidence that they have been able to develop improved skills in distress tolerance, emotion regulation and interpersonal effectiveness to make improvements in their quality of life; with increased opportunities for employment, social activity and significant relationships.

Limitations

The author acknowledges a number of limitations to this research study. This was the researcher's first research study project. The qualitative study used a discourse analytical approach where the researcher is the primary instrument. As such, the researcher is required to 'indwell' in the data and to be aware of their own biases and preconceptions that may be of influence. Certainly, the author's professional stance is positive towards the benefits of DBT.

Another limitation is the small number of potential participants for a research study. However, the issue of smaller numbers of potential participants is well documented for many research studies, both quantitative and qualitative, into BPD and the various psychotherapies for the disorder, such as DBT. Part of the difficulty in obtaining potential participants is partly attributed to the known difficulty in engaging this health population into psychotherapeutic treatment. Smaller numbers of research participants does not lessen the value of the research, rather it provides a rich source of healthcare data from the 'patient's' point of view (Elliott, 2008 a, b; Nehls 2000).

Conclusion and Recommendations

This research study aimed to explore our understanding of the participants' experiences of their lives prior to undertaking Dialectical Behaviour Therapy; of the participants' experiences of the helpful and hindering aspects of participation in and completion of Stage 1 of the Manning DBT "Moving Forward" program; and, of the participants' experiences of the impact of DBT on their current levels of recovery and social inclusion, within a two–five year framework post-intervention.

The research literature review located minimal literature on qualitative studies focussing on the outcomes for participants at the medium-term post-intervention phase. The findings have enabled the 'voices' of the participants to be heard – to have their experiences of Borderline Personality Disorder contribute to the body of knowledge that aims for 'recovery'. Also, their voices do speak of more positive outlooks on life and of improved health outcomes. As helping professionals, it is important for clinicians to be able to reflect not only on those 'helpful' aspects but also the identified unhelpful aspects, so that they can be improved on or discussed with future participants.

The Manning 'Moving Forward' DBT program (Boaden & Macauslane, 2004) has also provided HealthCare providers with a pathway of care for those clients with Borderline Personality Disorder.

Further Research

Further research into Borderline Personality Disorder and Dialectical Behaviour Therapy is needed and is occurring. Each piece of research information can then potentially be used to improve the outcomes for clients with a diagnosis of BPD.

Part of the value in a range of research studies into BPD and the various psychotherapies is the ability to compare those therapies to each other and to compare them to those clients who do not undertake the DBT program but are allocated to the 'Treatment As Usual' (TAU) process. The author may seek to undertake a further research study into the latter groups, namely; DBT versus TAU.



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Appendices



Client Name
Address
Town/Postcode

12 August 2010

Dear

I would like to invite you to consider participating in a research study that seeks to explore the experiences of people who have completed and graduated from Stage 1 of the Manning Dialectical Behaviour Therapy (DBT) 'Moving Forward' program. In order to help you decide if you are interested, I have enclosed an information sheet that gives an outline of the study and explains what your participation would involve.

The research study is being funded by the NSW Institute of Rural Clinical Services and Teaching and is being conducted by **Jullie Williams**; Registered Nurse, DBT therapist and researcher, working in the Manning Mental Health Services of the Hunter New England Area Health Service.

Participation in this study is entirely voluntary and I do not want you feel that you are under any obligation to participate in this study. If you do choose to participate; please fill in the section below and post it in the reply-paid envelope to our service in the next two weeks; or you may phone Jullie Williams (on 6592 9315) and inform her of your willingness to participate in the study.

If you choose not to participate in the research study, you do not have to do anything.

If we have not heard from you, Jullie Williams will be contacting you by phone to answer any questions you may have and to enquire if you would be interested in participating in this study.

Yours Sincerely

Gail Stevens

Manager
Manning Mental Health Services
Taree
Phone: 6592 9525

✂-----

I wish to participate in the research study.

Name: _____

Address: _____

Phone Contact: _____

Jullie (JP) Williams

HNEHREC No.:10/05/19/4.01



RESEARCH STUDY: EXPLORING CLIENTS' EXPERIENCES AFTER DIALECTICAL BEHAVIOUR THERAPY

INFORMATION FOR PARTICIPANTS

You are invited to participate in a study looking at the experiences of people who have completed Stage 1 of the Manning 'Moving Forward' Dialectical Behaviour Therapy (DBT) Program. As a Graduate of the Manning DBT Program and with the passing of time, you have unique experiences that the researcher is interested in exploring with you.

The study is being undertaken by **Jullie Williams**; Registered Nurse, DBT Therapist and researcher, working in the Manning Mental Health Services of the Hunter New England Area Health Service.

Before you decide whether or not to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information to assist you in your decision.

What is the purpose of this study?

Within the field of DBT, various research has been conducted that has concentrated on the 'science' of DBT. While scientific research is very important, it is equally important to undertake research that explores and documents peoples' experiences. To date, the researcher has located only 4 research publications (around the world) that involve peoples' experiences of DBT in the immediate period after therapy has occurred.

It is the purpose of this study to explore peoples' personal experiences of DBT and the impact it has had on their lives within 2-5 years after the Therapy was completed.

What will participation in the study involve?

If you agree to participate in the study, you will be invited to take part in an interview with Jullie Williams. The interview can take place in a location of your choice (your residence or at the nearest Community Health Centre) on a day and time that best suits you. The interviews are expected to last 1-2 hours. Your permission will be sought to digitally record the interview for later analysis. At any time during the interview you may ask for the tape to be stopped and edited; and you may ask for a copy of the transcript to review. The researcher may also need to access your medical records and your permission will also be sought for this to happen.

What if I don't want to participate in this study, or I decide to withdraw from the study later?

Participation in this study is entirely voluntary; you are in no way obliged to participate. If you decide not to participate, you are encouraged to return the tear-off section on the Letter of Invitation and return it in the reply-paid envelope or you can phone and tell the researcher of your decision. If you decide to participate, and then choose to withdraw at a later stage, you do not have to provide a reason. If you decide to withdraw from the study you may request that all the information, in relation to you, be destroyed.

Your decision not to participate in this study will not affect the service you receive from Manning Mental Health Services now or in the future.

What are the benefits or potential risks to me participating in this study?

If you do agree to participate in this study; there are no likely immediate benefits and no known or likelihood of risks to you. However, if you suffer any stress as a result from participating in this study you should contact the researcher as soon as possible. Assistance in obtaining appropriate care and/or counselling will be provided.

How will issues of privacy and confidentiality be addressed?

Any information collected from you will be de-identified (your name and any identifying details will be removed) and the remaining information will be sorted (or given codes) into a range of categories that allow the researcher to look for similarities and differences amongst all participants.

Only the researcher will have access to your details, the contents of the interviews and the whole research study; which will be held securely at Taree Community Health Centre. Following completion of the research study, the information will be kept for the minimum legally required period after the study has been completed (usually 5 years) and then destroyed.

What will happen with the results of the study?

The results of this study may be used for the following purposes:

- present the results in a final report to the Institute of Rural Clinical Services and Teaching
- present the results in a final report to the management of the Manning Mental Health Services and the Hunter New England Mental Health Service
- present the results in a final report to the local DBT Therapists
- present the results as a paper at a health conference or other professional forum
- publish the results as a journal article in a relevant health journal.

Results of the study will be provided to you upon request.

What should I do if I want to discuss this study further before I decide?

If you have any further questions, the researcher is available to discuss these with you. Please do not hesitate to contact Jullie.

Jullie Williams
Taree Community Health Centre
PO Box 35
Taree NSW 2430
Phone: 02 6592 9315

Who should I contact if I have concerns about the conduct of this study?

This research study has been approved by the Hunter New England Area Health Service (HNEAHS) through the Human Research Ethics Committee (HREC). If you have any concerns about the conduct of the study, please contact the committee through:

The Manager
Research Governance and Ethics Unit
Locked Bag 1
New Lambton NSW 2305
Phone: 02 4921 494950 or email: HNEHREC@hnehealth.nsw.gov.au

Thank you for your time in considering to participate in this study.

The information sheet is for you to keep.



MANNING MENTAL HEALTH SERVICES

RESEARCH STUDY: EXPLORING CLIENTS' EXPERIENCES AFTER DIALECTICAL BEHAVIOUR THERAPY

INTERVIEW PROMPT QUESTIONS

- Can you tell me how long was your individual DBT program (between 12 - 18 months)?
- Can you tell me why you chose to undertake DBT in the Manning 'Moving Forward' Program?
- What were the helpful aspects of DBT?
- Can you recall any of the Core Skills of DBT? Do you still use any of these skills?
- What were the not so helpful aspects of DBT?
- Could you describe what your life was like before DBT?
- Since undertaking DBT and with the passage of time, are you able to describe any current changes in your general functioning in relation to your:-
 - * overall health
 - * mental health
 - * ability to tolerate distress
 - * ability to regulate your emotions
 - * the effectiveness of your interpersonal relationships, and
 - * the level of social inclusion.
- Since completing DBT, have you attended any other psychological therapy or self-help courses?



RESEARCH STUDY: EXPLORING CLIENTS' EXPERIENCES AFTER DIALECTICAL BEHAVIOUR THERAPY

PARTICIPANT CONSENT FORM

I, (name in block letters) have read the participant information and any questions I have asked have been answered to my satisfaction.

I agree to participate in the research study, knowing that I may withdraw at any time. I agree that the research data gathered for the research study may be published, provided my name is not used.

I consent to:

- Having a Mental State Examination undertaken YES/NO
- Participation in the research study by undertaking an interview with the researcher YES/NO
- The digital recording of my interview by the researcher YES/NO
- A follow-up contact to check information, if required YES/NO

.....
(Signature of Participant)

.....
(Date)

.....
(Signature of Researcher)

.....
(Date)



INTERVIEW CHECKLIST

DATE:	INTERVIEW No.:	ID:
--------------	-----------------------	------------

- Arrangements for Interview:
 - Date _____
 - Time _____
 - Location _____
- Research study/information sheet discussed
- Mental State Examination conducted
- Informed consent given and form signed
- Assistance/MHAL information given
- Participant consent to check transcript, if needed.
- Participant requests copy of Final Report

What are the qualitative experiences of clients with a diagnosis of Borderline Personality Disorder; who have completed the Manning Dialectical Behaviour Therapy 'Moving Forward' Stage 1 Program in the last two-five years?

Analysis Coding Sheet – Aspects, Themes and Sub-Themes (Version 1)

ASPECTS	Pre DBT	DBT	Post DBT
	SUB-THEMES	SUB-THEMES	SUB-THEMES
THEMES	Distress Tolerance (DT) Emotional Dysregulation Interpersonal Effectiveness (IPE) Mental Health Services Past History	Core Skills Distress During Therapy Helpful Mental Health Self-Harm Unhelpful	Distress Tolerance Emotion Regulation InterPersonal Effectiveness Mindfulness Mental Health Other Treatments/Therapies Overall Health Radical Acceptance Recovery Skills Social Inclusion

Analysis Coding Sheet – Aspects, Themes and Sub-Themes (Version 2)

ASPECTS	Pre DBT		DBT		Post DBT	
	SUB-THEMES		SUB-THEMES		SUB-THEMES	
THEMES	Distress Tolerance (DT)	Not coping Children Self-Harm Suicide	Core Skills	Mindfulness (M) Emotional Regulation (ER) DT IPE	DT	Dissociation Others Self care Use
	Emotional Dysregulation	Emotional State Boundary	Distress During Therapy	During Therapy	ER	Use
	Interpersonal Effectiveness (IPE)	Children Mother Others Self	Helpful	ER Group Identity Individual Therapist IPE M Process Skills Therapists Therapy Trust Validation	IPE	Children Mother Others Self Siblings
	Mental Health Services	Treatment	Mental Health	Other Treatments (Rx)	M/ Current History	Use
Past History	Background Mental Health (MH) Social	Self-Harm		MH	Status	

What are the qualitative experiences of clients with a diagnosis of Borderline Personality Disorder; who have completed the Manning Dialectical Behaviour Therapy 'Moving Forward' Stage 1 Program in the last two-five years?

ASPECTS	Pre DBT	DBT	Post DBT
		Unhelpful Group Process Self Therapy	Other Rx Psychiatrist Counsellors Courses/Therapies SUB-THEMES Overall Health Status Radical Acceptance Recovery Awareness Employment Hope Inclusion Ongoing Self Care Therapy Use Skills Awareness All Employment Use Social Employment Inclusion IPE Ongoing

ANALYSIS GLOSSARY

Abbreviation	Concept	Definition
	Aspects	Aspects of the research study relating to the participants comments in relation to their lives prior to; during; and, post-intervention, i.e. DBT.
	Awareness	Participants level of knowledge in relation to 'processes' and their capacity to be informed.
	Background	The social and historical circumstances and personal experience that lead up to or help to explain something (Macquarie Dictionary, 2010).
	Biosocial Theory	DBT is based on a biosocial theory of personality functioning; that BPD is primarily a dysfunction of emotion regulation systems resulting from biological irregularities combines with certain dysfunctional environments. Invalidating environments during childhood contribute to the development of emotion dysregulation (Linehan, 1993:42-43).
	Boundary	Something that indicates the farthest limit of an area, a border (Concise English Dictionary, 2003).
BPD	Borderline Personality Disorder	Borderline Personality Disorder is defined as a psychiatric disorder which includes 'a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked by impulsivity beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following: abandonment fears, unstable/intense relationships, identity disturbance, impulsivity, suicidal or self-injurious behaviours, affective instability, emptiness, anger, and/or dissociation' (DSM-IV-TR, 2000).
	Children	Participants' children.
	Core Skills	Skills training in DBT is designed to remediate behavioural skills deficits typical of individuals meeting the criteria for BPD; including emotion regulation skills, interpersonal effectiveness skills, distress tolerance skills and DBT 'core' mindfulness skills (Linehan, 1993:143-144).
	Counsellors	Current use of other health professionals; other than the DBT therapists working in the Manning ' <i>Moving Forward</i> ' DBT team (Boaden and Macauslane 2004).
	Courses/Therapies	Any course or therapy other than the Manning ' <i>Moving Forward</i> ' DBT program (Boaden and Macauslane 2004).
DBT	Dialectical Behaviour Therapy	<u>The Intervention</u> DBT is a structured multi-modal cognitive-behaviour psychotherapeutic program that is designed to treat emotional, cognitive, behavioural, self and interpersonal dysregulation. DBT sets out to establish a therapeutic relationship between the client and therapist that motivates the client to learn new skills and encourages and supports the application of these skills into everyday life (Linehan: 1993).
	Dissociation	The act of dissociating or state of being separated (Macquarie Dictionary, 2010).

DT	Distress Tolerance	DBT emphasises learning to bear pain [and distress] skilfully, using strategies to tolerate and survive crises and to accepting life as it is in the moment. Strategies include: distracting, self-soothing, improving the moment and thinking of the pros and cons, (Linehan, 1993:147-148).
	During Therapy	Events/incidents that occurred during the participants attendance in the DBT Group program.
	Emotion Dysregulation	The biosocial theory is that BPD is primarily a disorder of the emotion regulation system. Emotion dysregulation is due to high emotional vulnerability plus an inability to regulate emotions (Linehan, 1993:43).
ER	Emotion Regulation	DBT postulates that difficulties in regulating painful emotions are central to the difficulties of BPD. Skills and strategies are aimed at exposing the client to their own emotions and increasing their awareness and skills. Skills include: identifying and labelling emotions, identifying obstacles, reducing vulnerability, etc. (Linehan,1993:148-151).
	Employment	The act of employing or a state of being employed; the work or occupation in which a person is employed (Macquarie Dictionary, 2010).
	Group	Aspects relating to the attendance and participation in the Manning 'Moving Forward' DBT Group sessions (Boaden and Macauslane 2004), held every Wednesday from 12.00 md to 2.30 pm..
	Helpful	Those parts of DBT that participants' felt did help them.
	Hope	The expectation of something desired (Macquarie Dictionary, 2010).
	Identity	The condition of being oneself or itself, but not another (Macquarie Dictionary, 2010).
	Inclusion	The act of including; the state of being included (Macquarie Dictionary, 2010).
	Individual Therapist	DBT trained therapist who is allocated a client entering the DBT program process. Pre-treatment work is done with the individual therapist and then client and therapist have a weekly individual session during the DBT group program.
IPE	Interpersonal Effectiveness	Often, belief patterns and uncontrolled emotional responses are inhibiting the application of social skills. Skills are similar to assertiveness and interpersonal problem-solving skills and effectiveness is the obtainment of changes one wanted; keeping the relationship, and, keeping one's self-respect (Linehan,1993: 151-152).
	Invalidation	Invalidation or an invalidating environment is one in which communication of private experiences (e.g. thoughts, feelings, opinions) is met by erratic, inappropriate and extreme responses. The expression of these experiences are not validated; but trivialised, punished, disregarded, ridiculed, dismissed. Invalidation then tells the individual that they are wrong (in the expression of feelings, thoughts, actions) and that their experiences are socially unacceptable characteristics or personality traits (Linehan, 1993:49-50).
MH	Mental Health	A state of emotional and psychological wellbeing in which an individual is able to use their cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life (Macquarie Dictionary, 2010).

MHS	Mental Health Services	Those health care services that have mental health as the core business.
M	Mindfulness	Mindfulness skills are central to DBT; consisting of the “what” skills (observing, describing, participating) and “how” skills (nonjudgemental stance, focus on one thing in the moment, being effective). Mindfulness in its totality has to do with the quality of awareness that a person brings to activities (Linehan, 1993:144-147).
	Mother	Participant's mother
Other Rx	Other Treatment	Any other form of healthcare other than the DBT program.
	Others	Other people the participants' interact with.
	Overall Health	Participants' health in general
Past Hx	Past History	Those aspects of the participants' lives that impacted on their lives prior to DBT.
	Post DBT	Aspects relating to the participants' lives since completing the intervention.
	Pre DBT	Aspects relating to the participants' lives prior to completing the intervention.
	Psychiatrist	A medical officer who specialises in the practice or science of treating mental diseases (Macquarie Dictionary, 2010).
	Radical acceptance	DBT acceptance skills include radical acceptance (i.e. complete acceptance from deep within) (Linehan, 1993:148).
	Recovery	'A personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually-identified essential services and resources' (Commonwealth of Australia, 2008:31).
	Self	Those aspects that involve the internal emotional world of a human being
SC	Self care	Includes personal hygiene, maintaining accommodation, finances, lifestyle, identity.
	Self-Harm	The practice of cutting or otherwise wounding oneself, usually considered as indicating psychological disturbance, (Macquarie Dictionary, 2010).
	Siblings	Participants' brothers and sisters
	Social Inclusion	Social inclusion is about being able to participate in and contribute to social life – in economic, social, psychological, and political terms. To do this requires having personal capacity as well as access to employment and/or other social roles (Mental Health Coordinating Council, 2007).
	State	the condition of a person or thing, as with respect to circumstances or attributes: <i>a state of health</i> ; a particular condition of mind or feeling: <i>to be in an excited stat</i> , (Macquarie Dictionary, 2010).
	Sub-Themes	Meanings of Units
	Suicide	The act or an instance of killing oneself intentionally, (Macquarie Dictionary, 2010).

	Themes	A subject of discourse, discussion, meditation, or composition; a topic, (Macquarie Dictionary, 2010).
	Therapists	Inclusive of all DBT therapists working in the Manning 'Moving Forward' DBT team (Boaden and Macaulane 2004).
	Therapy	Aspects that related to the Manning 'Moving Forward' DBT program
	Trust	Reliance on and confidence in the truth, worth, reliability, etc., of a person or thing; a person or thing in which confidence or faith is placed (Macquarie Dictionary, 2010).
	Unhelpful	Those parts of DBT that participants' felt did not help them.
	Use	Participants' comments on use of the core skills
	Validation	Validation is, in essence, when the therapist communicates to the patient that their responses make sense and are understandable with their current life context or situation (Linehan, 1993:222-225).