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**Portfolio for Professional Doctorate in Counselling  
Psychology (DPsych)**

***'It's not just about lock and key, it's about you as a  
human being'***

**Treating the Person before the Personality Disorder  
in Prison**

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**October 2015**

**VOLUME ONE**



## THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR COPYRIGHT REASONS:

**Vol. 2:**

**pp 18-65:**     **Part 2. The Article.** 'I feel bad for my victim'; forensic Dialectical Behavioural therapy and the potential impact on recidivism.  
                  **Appendix A.** Submission guidelines for The Journal of Forensic Psychiatry and Psychology.  
                  **Appendix B.** Formatted article.

## THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR DATA PROTECTION/CONFIDENTIALITY REASONS:

**Vol. 2:**

**pp 66-110:**   **Part 3. Professional practice: advanced case study.** Square pegs and round holes: Dialectical Behavioural Therapy within a forensic setting.  
                  **Appendix A.** Assessment schedule.  
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## **Terminology**

ACCT - Assessment, Care in Custody and Teamwork (this is a prison safeguarding procedure whereby prisoners at risk of self-harm or suicide are closely monitored through the framework provided by this document, such as increased observations and the recording of known triggers)

BPD - Borderline Personality Disorder

BPS - British Psychological Society

CAT - Cognitive Analytic Therapy

DBT - Dialectical Behavioural Therapy

DSH - Deliberate Self-harm

HoST - Holloway Skills Therapy Programme

IEP's - Incentives and Earned Privilege Scheme (Markers given for positive or negative behaviour, as assessed by prison officers and allocated prison civilian staff)

IPA - Interpretive Phenomenological Analysis

IRAS - Integrated Research Application System

MBT - Mentalisation Based Therapy

NHS- National Health Service

NHS R&D - National Health Service Research and Development

NICE- National Institute for Clinical Excellence

NRES - National Research Ethics Service

NOMS - National Offender Management Service

RCT - Randomised Controlled Trial

SCID II - Structured Clinical Interview for DSM-IV Axis II personality disorders

SFT - Schema Focused Therapy

TAU - Treatment as usual

TFP - Transference Focused Psychotherapy

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This thesis is dedicated to the memory of Dr. Wayne W. Dyer, who taught me how to live the power of intention and to think from the end. I will hold onto your advice '*don't die with the music still inside you*'. Rest In Peace and see you on the other-side.

## **City University Declaration**

I grant powers of discretion to the University Librarian to allow this Doctoral thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

## **Preface**

This is a body of work that explores Dialectical Behavioural Therapy (DBT) within a forensic prison context. In representing the facets of counselling psychology this portfolio encompasses both research and clinical practice. Part one presents an interpretive phenomenological analysis (IPA) research study of seven participants who completed a DBT programme adapted for a UK prison. Part two provides an academic article for the Journal of Forensic Psychiatry and Psychology, which explores the potential impact DBT may have on recidivism. Part three is an extended case study to show forensic DBT in action, a theoretical overview, and the challenges that engaging with DBT in a prison context brings. A particular emphasis is placed on the clinical insights, learning and self-awareness I experienced in relation to the therapeutic alliance and process.

In the interests of remaining transparent I have chosen to append the documents relating to the variety of ethical approvals needed for the completion of this research. I hope to help other researchers to understand the logistics involved in liaising between these agencies. As a result this portfolio spans two consecutive volumes of work. Therefore volume one consists of part one, the research. Volume two consists of part two, the academic journal article and part three, the extended client case study. Italics are employed throughout the portfolio to indicate a direct quote from the participants engaged in this research.

I have been working with people in receipt of a personality disorder diagnosis for seven years and in this short time I have experienced first hand a breadth approach to personality disorders, ranging from a reputation of being untreatable, to a reputation of not existing in terms of diagnostic categorisation. What has struck me

throughout my experiences of inpatient secure settings, outpatient community based services and the forensic prison environment is the lack of value placed on an individual's subjective experience and their opinion on what therapy they would like to engage with as an endeavour to manage their psychological health.

In searching for a route to help people who were vulnerable and marginalised by society I found counselling psychology. The underlying philosophy of counselling psychology to respond empathically and with respect to the client's individuality (BPS, n.d) married well with my own personal values of equality and my belief system towards humanity as being inherently and essentially good. Counselling psychology facilitated my endeavour to enact change from within healthcare services, by contributing to the development of interventions aimed at improving psychological wellbeing.

During my career and in conducting this research I have been challenged by the conflict between my humanistic values as a counselling psychologist, and the pathologising of peoples experiences within the medical model. My personal epistemological position is in the centre of the realist-relativist continuum, I adopt a constructivist paradigm in my understanding experience as being socially and culturally constructed and temporally bound. In my experience the positivist framing of human experience into a reduction of symptoms fails to account for the subjectivity inherent in that experience. In working with people who are in receipt of a borderline personality disorder (BPD) diagnosis I have yet to meet two people who experience their 'symptoms' in the same way. I honour that there can be a commonality in experience and a resulting relatedness between individuals; indeed this research has shown as much. However in the endeavour of well-being and psychological health I believe there is value for the individual in understanding the unique features of their

experience, as opposed to blanketing experience across individuals to satisfy the convergence needed in diagnosing and in providing empirically defined evidence-based treatments. In qualitatively illuminating the subjective experience of the participants within this research I hope to show that understanding this subjectivity holds value in contributing to evidence based practice. I intend to present the participants views of how their therapeutic experience impacted upon their view of self and way of being in the world. Further to this I intend to demonstrate the potential of the participants views to inform the development and delivery of forensic therapies.

Managing the potential conflicts inherent within my role as both a researcher and a practitioner for this research thesis has required a committed, diligent approach throughout all stages of the research process. I have an acute awareness and understanding of the ethical, professional and academic considerations that have needed to be addressed and adhered to in crossing this boundary. I am proud that the counselling psychology model, of being both researcher and practitioner, educates psychologists like myself to be able to manage and overcome this potential conflict of interest. It is my hope that this research promotes the awareness that, with careful consideration, the potential conflicts of a dual role can be managed thus providing access to often difficult to reach contexts and client groups.

### **Part one, 'Life Changing' Prisoners Experiences of DBT**

My role as a DBT therapist in prison gave me insight into the challenges faced in maintaining funding for a service which lacked published research evidence to support it's effectiveness. I was able to experience first hand the challenges involved in working therapeutically within a forensic context. These challenges are exacerbated by a lack of awareness of 'what works' for people diagnosed with a



personality disorder (McGuire & Priestley, 1995), and a lack of consistency in approach. I felt passionately that the client's opinions and experiences of the therapeutic interventions they are engaged in could, and should, contribute to the development and improvement of these service provisions. Completing a research thesis within my DPsych Counselling Psychology training gave me the opportunity to provide a voice for these clients.

My commitment to illuminating the clients experiences provided the motivation to overcome the challenges faced in gaining ethical approval from four separate governing bodies. An organised, tenacious, patient and determined approach is needed in orchestrating the dance between these bodies in gaining ethical approval to proceed. However the choreography can be achieved and there is no doubt that the scrutiny this research was subjected to subsequently improved the academic rigour of the methodological approach.

The research highlights the views of the participants and conveys the impact they experienced in their view of self and their way of being in the world. The themes presented are grounded within the existing literature base and provide further insight to the limited qualitative research currently available. Clinical implications derived from the data are defined and contribute to recommendations for future practice and research in developing forensic DBT.

The thesis write up follows the organic process of discovery that I experienced as the researcher in order to convey my journey to the reader. Traditionally newly emerging information may be integrated retrospectively to the literature review in order to remain consistent. However due to my dual role as researcher-practitioner it was important for me to bracket my prior knowledge and assumptions of the therapeutic approach and context. Remaining transparent throughout the research process contributed to reducing the likelihood of a conflict of interest, and/or impacting upon the data and affecting the quality of the analysis and

interpretations. Therefore I wrote the thesis as a reflection of my linear progression. Additionally I use the reflexivity sections to further detail to the reader the personal process I experienced throughout.

## **Part two: 'I feel bad for my victim': Forensic DBT and the Potential Impact on Recidivism**

The article written for the Journal of Forensic Psychiatry and Psychology focuses on the specific themes generated from the research data that have the potential to impact upon reducing the risk of reoffending. The Policy Guidance for Services for People with a Personality Disorder (Department of Health, 2003) and the Offender Personality Disorder strategy (OPD) (Department of Health and Ministry of Justice, 2011a,b) present a model for treating and rehabilitating personality disordered offenders which states that three areas of functioning should be addressed; mental health need, offending behaviour (and risk), and social functioning. This paper shows how the prisoners experiences of completing the DBT programme illuminates the potential of forensic DBT to address these areas of functioning. The breadth of the impact the participants experienced and how this relates to multiple areas associated to recidivism is explored. The paper considers the post-DBT opinions and views of the participants, and highlights the resulting impact on their view of their index offence, and of the victim(s) of the crime for which they are in prison. The paper considers the challenges inherent within the OPD strategy and the limitations of DBT in addressing all areas related to criminogenic risk. The paper concludes with recommendations derived from the participant's experiences for improvements to clinical practice. Future research needs are identified in order to develop forensic DBT in the targeting of mental health need and recidivism.

In content the article adheres to the stipulations set out by The Journal of Forensic Psychiatry and Psychology (see appendix A). In line with the previously

published qualitative articles the body of analysis is presented as both thematic and phenomenologically interpretive. For inclusion in this portfolio, and in order to remain consistent, the article has been written to adhere to the current presentational format. The article formatted to adhere to The Journal of Forensic Psychiatry and Psychology, as will be required for submission, is appended (see appendix B).

### **Part three: Square Pegs and Round Holes, DBT in a Forensic Setting, a Client Case Study**

This case study presents the therapeutic process of DBT modified to a 9-week intervention. It highlights the challenges faced in considering the conflicting aims of the behavioural principles and skills use in DBT and the punitive prison objectives. The difficulties in modifying the DBT programme to 9-weeks are discussed and understood within the needs of the client base. This case study illuminates the personal learning and development I experienced in relation to the DBT approach including the inherent limitations and strengths to the theory and practice as applied to a forensic context. My reflections, challenges and self-development in working with people convicted of serious offences are discussed in relation to the framework provided by DBT.

### **Summary**

Together the IPA research study, the academic journal article and the extended client case study present a multifaceted and holistic insight into DBT conducted within a forensic context. This portfolio of work incorporates the experience of the clients, the view of the therapist, and the insight of the researcher. Insights are gained into the challenges confronted due to the conflicting aims of healthcare services and the prison regime. The political factors to consider when targeting treatment of people in receipt of a personality disorder diagnosis within

prison are understood and conveyed to the reader. Finally this portfolio provides clinical implications and future research needs pertaining to the development of DBT within a forensic context as generated by each unique section.

## **Part 1 The Research**

### ***'Life Changing': Prisoners Experiences of Dialectical Behavioural Therapy***

## Abstract

There continues to be an over-representation of female offenders diagnosed with borderline personality disorder (BPD) within UK prisons (Sansone & Sansone, 2009). Dialectical Behavioural Therapy (DBT) has shown effectiveness in managing the symptomatology of BPD and has been adapted for a forensic context (Nee & Farman, 2005, Gee & Reed, 2013). There is limited qualitative data available pertaining to the experiences of clients within DBT programmes and none for a forensic context.

Seven female prisoners completed semi-structured interviews regarding their experience of completing a 16-week DBT programme.

Interpretive phenomenological analysis (IPA) illuminated six superordinate themes and 19 subordinate themes, which can be understood as features of personality and behavioural change. Superordinate themes were **prison life**, which highlighted an impact to life in prison through a reduction of prison disciplinary and risk procedures, and an increase in privilege levels. **'It's a struggle'** represented the challenges participants faced and overcame. **Increased connection to others** illuminates the change in personal relationships participants experienced. **Emotional awareness** represents the participant's gain in understanding and managing emotions. **Who am I?** Depicts the increased understanding, acceptance and value participants experienced for themselves. **The bigger picture** represents the participant's ability to reflect upon and re-evaluate a situation, the increased awareness of another person's perspective, their increased understanding of consequences of their actions, and their future outlook on life.

Themes are discussed in relation to the potential impact the DBT programme may have for people experiencing emotional and behavioural instability within the

prison environment, suggesting engagement with DBT should be based upon individual case formulation rather than BPD diagnosis. The potential of DBT in addressing the government initiative the Offender Personality Disorder (OPD) strategy and recidivism is explored. Finally, the limitations to this study, recommendations for clinical practice, and future research needs are defined.

## **1.0 Background and Research Rationale**

### **1.1 Chapter Overview**

This chapter introduces the main concepts under investigation within this research, borderline personality disorder (BPD), dialectical behavioural therapy (DBT) and the treatment of BPD within a forensic setting. This chapter will also provide a rationale for this research and present the research aims.

This research adheres to a social constructivist epistemology that these concepts are socially and culturally constructed, and are temporally dependent upon that culture and context. It is within the researcher's awareness that the medicalised model of diagnosis and BPD is in contrast to the phenomenological methodology of this research, which holds a relativist ontological position. The diagnosis of BPD, as categorised by the Diagnostic and Statistical Manual of Mental Disorders (5<sup>th</sup> ed., DSM-5; American Psychiatric Association, 2013), is grounded within a positivist framework, which is supported by an empiricist evidence base. Subsequently the medical model provides the foundations for both diagnoses and the resulting mental health interventions within the cultures and contexts presented here. This research utilises a pragmatic approach, therefore the assumptions provided by these frameworks, and the resulting implications, should be held in mind by the reader. A full discussion of these implications and the epistemological position and philosophical assumptions of this research can be found within the methodology section.



## **1.2 Borderline Personality Disorder Aetiology**

Personality disorders are defined by the American Psychiatric Association (DSM 5-R, 2011) as 'impairments in personality (self and interpersonal) and the presence of pathological personality traits'. Within the symptomatology of BPD, impairment in self-functioning is defined within the framework of identity disturbance and self-direction, and impairments in interpersonal functioning are defined within the domains of empathy and intimacy. Pathological personality traits are defined within the domains of negative affectivity, disinhibition and antagonism. These impairments must be stable across time and context, and not understood as normative for the individual in terms of developmental stage or socio-cultural environment, or due to the direct psychological effects of a substance or general medical condition. In developing the International Personality Disorder Examination (IPDE) for the World Health Organisation (WHO), Loranger et al. (1994) estimated that 30% of all inpatients worldwide, who are treated for personality disorders, meet the criteria for a BPD diagnosis, meaning that BPD is the most prevalent of all personality disorders.

While there is no definitive consensus on the basis of BPD, research appears to suggest either a biological basis or a biological basis coupled with adverse environmental experiences. Research conducted by Donegan et al. (2003) assessed amygdala reactivity in BPD patients compared to people without a BPD diagnosis. These researchers found that BPD patients had a significantly greater activation in the left amygdala than the control subjects in reaction to facial expressions of sadness, happiness, fear and a neutral

expression. Researchers concluded that this difference in activation level contributes to the emotional dysregulation and unstable interpersonal relationships experienced by people diagnosed with BPD. Several research studies presented by Depue and Lenzenweger (2001, 2005) suggested that a complex interplay between neurotransmitters, neurobehavioural and neurobiological systems has a significant relationship to the traits of emotional instability displayed by those diagnosed with BPD. Ochsner, Bunge, Gross and Gabrieli (2002), showed that healthy subjects had a greater activation in the amygdala when reappraising stimuli rather than just attending to stimuli when compared to individuals with BPD; the research completed by Ochsner et al. (2002) contributes to the hypothesis that it is the cognitive processing of events that results in the heightened response from the amygdala. This research, among other research into the neurobiological factors associated with BPD, remains promising in gaining insight but is, as yet, inconclusive (Silk, 2000).

It is suggested within the literature that in working towards a developmental theory of BPD any biological predisposition must also have an environmental interaction that relates to factors such as cognitive appraisal, relationships with care givers, childhood neglect, and traumatic experiences (Paris, 1999; Rutter, 2002). In a review of the literature, Feigenbaum (2007) suggested that a heightened emotional state impacts upon the affective ability of cognitive processes, such as developing effective and adaptive coping skills for both environmental and emotional stressors. Feigenbaum suggested that adaptive skills, when employed, are not retained by memory in this heightened state which results in maladaptive coping skills.

Zanarini et al. (2000) found that 84% of BPD subjects had experienced parental abuse or neglect prior to the age of 18. This was significantly higher

than the Axis II control group. Data from semi-structured interviews also found that participants with BPD experienced a lack of validation of their thoughts and emotions from care givers and an inconsistency of care within this relationship. Putnam and Silk (2005) point to the subjective, individual nature of each person's environmental experience and potential interaction with biological factors, which inevitably makes a consistent and proven developmental theory unlikely. However, the evidence presented here and throughout the wider research arena conveys the importance of treatments for BPD to be holistic in their approach to consider both biological and environmental factors.

### **1.3 BPD and criminality**

A review of research conducted into BPD and criminality shows that BPD is over-represented within prison populations both worldwide and within the UK (Sansone & Sansone, 2009). The rates of a BPD diagnosis are shown to be higher for females than males, Swartz, Blazer, George, & Winfield, (1990) estimate that two thirds of those diagnosed with BPD are females. This trend continues when considered within a prison context, it has been estimated that there is a significant over-representation of females with BPD within the prison population of England and Wales. Singleton, Meltzer, Gatward, Coid and Deasy (1998) estimate this figure at 20% in comparison to 2% of the general population. This pattern is also found cross-culturally: von Schonfeld, Schneider and Schroder (2006) found that the rates of BPD within a German prison context were comparable to the general population for males (at 5.3%), yet significantly higher for females (at 42.9%). Black et al. (2007) found that within male and female offenders newly committed to the Iowa Department of Corrections, USA,

the percentage of women meeting criteria for BPD was more than twice that for men.

The over-representation of females with a BPD diagnosis within the prison population, can be understood by common features of BPD being related to criminogenic risk (Nee & Farman, 2005). Factors such as impulsivity, parental neglect, and a history of mental health issues, have been shown to increase the likelihood of engaging in criminal activity (Andrews & Bonta, 1998; Farrington, 2002). Warren et al. (2002) investigated the relationship between personality disorders and violence in female prisoners and found a high degree of comorbidity between Cluster B diagnoses and a significant association with various types of violent and non-violent criminality. Raine (1993) found that within a prison population borderline traits such as unstable intense relationships and affective instability were associated with extreme violence. The Bureau of Justice Statistics Special Report (2006) into the mental health problems of prison inmates found that prisoners with mental health problems are substantially more likely to be charged with an assault during their prison term. Prisoners with mental health problems are also more likely to have a longer sentence (BJS, 2006). The unstable nature of BPD, including aggressive and violent acts to others, and deliberate self-harm (DSH), means that these prisoners present a considerable management problem within a prison setting.

## **1.4 Treatments for BPD**

BPD has had a longstanding reputation in both psychology and the wider medical setting as being notoriously difficult to treat (Silk, 2008). This reputation is also apparent within the prison context (Warren et al., 2002). However, the Department of Health (DoH) publication, *Personality Disorder: No Longer a*

*Diagnosis of Exclusion* (2003), marked a change in attitude and approach to BPD and other personality disorders.

Recent years have seen substantial developments in treatment strategies for BPD. Fonagy and Batemen (2006a) described this progress as 'radical' (p. 1). Treatments such as Mentalisation-Based Therapy (MBT) (Bateman & Fonagy, 2004), Cognitive Analytic Therapy (CAT) (Ryle & Golyunkina, 2000), DBT (Linehan, 1993a), Transference Focused Psychotherapy (TFP) (Clarkin, Yeoman & Kernberg, 2006), and Schema Focused Therapy (SFT) (Young, 2003), have all contributed significantly and uniquely to our understanding of BPD and how the disorder can be effectively treated. These therapies have begun to be empirically validated through the published findings of both outcome measures and randomised control trials (RCT).

When considering the psychological treatment of BPD, the National Institute for Health and Clinical Excellence (NICE) guidelines (2009) recommends that the choice and preference of the service user be taken into account, 'The degree of impairment and severity of the disorder' should also be assessed, along with the 'person's willingness to engage with therapy', 'their motivation to change', 'their ability to remain within the boundaries of a therapeutic relationship' and 'the availability of personal and professional support' (NICE, 2009). DBT is stated as the preferred treatment for women for whom 'reducing recurrent self-harm is a priority' (NICE, 2009).

## **1.5 Treatments for BPD in prison**

When adding a prison context to the difficulties involved in treatment therapies for BPD, the literature becomes significantly less substantial in

understanding what is effective and how these therapies can be implemented in this setting. One pilot study was found for Systems Training for Emotional Predictability and Problem Solving (STEPPS), a group treatment programme used for women offenders with BPD in the USA (Black et al. 2008). Other published pilot studies for BPD in a prison context utilized DBT as the psychological treatment intervention (Nee & Farman, 2005; Shelton, Sampl, Kesten, Zhang, & Trestman, 2009). DBT is a comprehensive cognitive-behavioural treatment for complex, difficult to treat, mental disorders (Linehan, 1993a). DBT is evidenced to be especially effective in managing suicidal and parasuicidal behaviours, as well as impulsivity, aggression and interpersonal effectiveness (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Tutek, Heard & Armstrong, 1994); all of which are of particular relevance when considering BPD in a forensic setting. Research conducted by Black, Blum, Pfohl & Hale (2004) found that at least three quarters of those diagnosed with BPD attempt suicide, with 10% of these resulting in death. Risk factors for attempts at suicide included both comorbidity with a major depressive disorder, and/or a substance misuse disorder. Studies reviewing evidence for the prevalence of major depressive disorders in prison show figures approximating 31% of female inmates adhere to this diagnosis (Steadman, Osher, Robbins, Case & Samuels, 2009). Studies reviewing the evidence of prevalence of alcohol abuse and dependence in female prisoners provide estimates of between 10-24% for drug abuse and of 30-60% for alcohol dependence (Fazel, Bains & Doll, 2006). Data to show the percentage of female prisoners attempting suicide are notoriously difficult to gain, largely due to under-reporting by the establishments (Leibling, 1995). However, the figures presented here indicate that the risk of female prisoners attempting suicide is notoriously high and in need of a specific therapeutic intervention in order to target such behaviours. The focus of DBT on

suicidal and parasuicidal behaviours is unique to DBT and provides a rationale for its use within the female prison estate.

Warren et al.'s (2003) research supports the suggestion that DBT may be the most appropriate intervention for a forensic population due to its reliance upon cognitive behavioural approaches, which have a substantial evidence base in targeting offender behaviour (Losel, 1995). DBT can be viewed as an emerging approach to BPD clients within a prison context. The particular mechanisms of change within DBT have only been speculated upon and are, as yet, not empirically validated. It is not known which components of the therapy are necessary and which are superfluous (Robins & Chapman, 2004). A review of the literature pertaining to the factors affecting change within DBT will be discussed, however, as with any new psychosocial treatment the particulars of what is effective usually follow the evidence that the treatment is effective, rather than preceding it.

## **1.6A qualitative approach and the value of clients' perspectives**

The literature review chapter presented here will provide an overview and critique of the current quantitative and qualitative research relevant to this research. What this review will show is a lack of research that provides service users perspectives on their therapeutic experience. This lack of service user involvement in research can be understood with the historical development of psychological theory. Freud (1917) suggested that issues of mental health tend to be largely unconscious to the patient; this promoted a lack of consideration for clients' perspectives in the development of effective interventions. This was further supported by the behavioural approach (Hull, 1939), which failed to

recognise the interplay and importance of clients' thoughts, motivations, and values in their resulting conditions. As psychological theory and knowledge have developed, perspectives and interventions have emerged to be integrative across these historic paradigms (albeit with differing emphasis). Along with this development researchers have argued for the importance of clients' perspectives in psychotherapeutic research. This is seen as being essential to improve the reliability and validity of the data produced, and the potentially resulting therapeutic interventions developed from the research. Macran, Ross, Hardy & Shapiro (1999) highlight the importance of working collaboratively with service users, without the clients' experiences being obscured by the researchers own beliefs and values. These researchers point to the historical dominance of the medical model over psychotherapeutic research, whereby the client is seen as a passive recipient of therapy. However there is much research available that highlights the interpersonal and subjective nature of the clients experience facilitating therapeutic change (Butler & Strupp, 1986; Greenberg, 1986), thus suggesting that as researchers we cannot begin to understand if, how, or why psychological interventions are effective without involving service users within the research process (Hodgetts & Wright, 2007). The Department of Health (2011) supports the inclusion of service user perspectives in the development of treatment strategies. Macran et al. (1999) suggest that in order to improve validity this involvement needs to be as part of the research design, rather than just as participants.

A comprehensive approach to research is advocated in addressing the holistic endeavour of involving all those affected by results within the process. To this end Connally, Conlan, & Deutsch (1980) presented the constituency approach. Within mental health services this approach denotes that stakeholders are defined as patients, clinicians, carers, policy makers, health authorities and



non-service users from the general public, each of whom should be involved in all stages of research from the research agenda, design, implementation, data collection, analysis, through to dissemination. Despite a consensus that service users and/or stakeholders perspectives are essential for the development of effective services, there remains to be a lack of service user involvement.

Telford & Faulkner (2004) point to a lack of understanding from researchers, practitioners and service users of how to operationalize this endeavour. They also highlight a lack of resources and an inherent resistance. Kara, (2013) discusses the difficulties and lack of understanding in managing an overlap of roles, in terms of how to manage this both practically and ethically. However some institutions are leading the way by having research departments entirely consisting of service users, such as the Service User Research Enterprise (SURE) at the Institute of Psychiatry, London has conducted and published peer-reviewed research (Rose, 2003; Rose, Fleischmann, Wykes, Leese & Bindman, 2003). It is now becoming more common for public funding streams to have a requirement which denotes that researchers must demonstrate how service users opinions and involvement has been incorporated into research projects (INVOLVE, 2003). This includes research aimed towards a forensic setting (NHS National Programme on Forensic Mental Health Research and Development, 2004).

Telford & Faulkner (2004) highlight the difference between user-led, user-controlled and user involvement in research, and state that a consensus in research motivation between researchers and service users needs to be agreed upon in order for a collaboration to work successfully. Barriers to service user involvement include conceptually incompatible ideologies, the representativeness of the chosen service user and the inherent conflicts involved in who does the choosing, and why that service user was indeed chosen.

Patterson, Trite & Weaver, (2014) highlight challenges with service user involvement as being the subjective nature of service user opinions, and how to allow for this within the framework of validity and reliability in research findings, and the imbalance of value placed upon differing areas of expertise, i.e. academia versus lived experience. Patterson et al. (2014) also comment on the challenges faced in maintaining an objective research agenda within a culture of pharmaceutical and biotechnological industries inherently led by political agendas.

When surveying the activity and views of service users involved in mental health research in the UK, Patterson et al. (2014) found that the majority of those surveyed reported that their involvement had been a positive experience that had improved their awareness of how the mental health system worked together as a whole, and that their involvement had also had a positive impact upon their mental health, identity and self-efficacy. The majority of those surveyed also agreed that their participation improved the overall quality of mental health research. These authors also conclude that in order to overcome the previously stated barriers a cultural change is needed for service user engagement to be utilized to its highest potential. Boaz & Ashby (2003) state that in gaining the will of professionals it should be seen that service user participation in research contributes to evidence based practice in that it ensures research is fit for purpose and increases the credibility of its outcomes. Therefore it can help to increase practitioners' confidence in providing therapeutic services.

Further complicating the previously stated barriers to service user involvement, and relevant to the research presented here, is involving service users at all levels of research within restrictive settings, such as a prison. In a review of service user involvement in prison mental health research, conducted by the Sainsbury Centre for Mental Health (2008), several challenges were

highlighted including, the time it takes to produce robust research, the representativeness of participating prisoners, the process of overcoming inherent power imbalances to engage prisoners, supporting prisoners throughout their involvement, confidentiality and issues relating to the boundaries of this, ethical approval from all bodies involved in the research process, including the National Health Service (NHS) Research and Development (R&D) National Research Ethics Service (NRES), the National Offender Management Service (NOMS) and further ethical procedures governing individual research institutions which may not have experience in this context, issues of prison security including both personal security and Her Majesty's Prison Service (HMPS) security procedures and Criminal Records Bureau (CRB) clearance, the staff culture and their agreement, participation and willingness to the process, and the ethical and political issue of payment for prisoners time. It is my experience that with careful consideration, detailed planning, a good working relationship with the prison establishment where the research takes place, a commitment to adhere to the stipulations set out by HMPS, NOMS, NHS R&D and NRES, and the individual research institution to which the researcher is affiliated, it is indeed possible to overcome these barriers and complete research which is reliable, valid and meets the research aims. What I have found is that research in this area is in its infancy and as such involving prisoners at all levels of the research design can prove problematic when taking into account the motivations of the researcher, the research and the ethical considerations. A further exploration of these issues can be found within the methodology chapter and reflexivity section.

Notwithstanding the considerations presented here the literature provides a sound rationale for completing research on this topic, within this domain, and with service user involvement.

## **1.7 Research rationale**

The limited qualitative research evidence describing the experience of undertaking DBT for BPD within a prison setting is prohibiting the development of successful and replicable treatment strategies. The research presented here is concerned with understanding the experience of BPD prisoners undertaking a DBT treatment strategy that has been modified for a prison context. For a treatment to be considered effective, as applied to BPD in a prison context, it needs not only to be proven successful in reducing symptomology of BPD, but also in reducing criminogenic risk (DoH, 2003). This holistic approach to treating BPD within a prison context thus addresses a range of psychosocial needs. The research presented here provides a qualitative interpretative phenomenological analysis (IPA) of female prisoners' experiences of completing a modified forensic DBT programme at a prison in the UK. This research aims to add to the limited literature currently available, and provide a voice to the service users of DBT within a forensic context. Clinical implications derived from the research analysis that have the potential to inform further practice are discussed.

## **1.8 Research Aims**

To understand the experience of completing a forensic DBT programme at for females diagnosed with BPD.

To understand what aspects of the forensic DBT programme the women found most and least useful and why.

To explore the nature of any effect of completing a forensic DBT programme on the women's experience of their emotions.

To explore the nature of any effect of completing the forensic DBT programme on the women's experience of their interpersonal relationships.

To explore the nature of any effect of completing the forensic DBT programme on the women's experience of tolerating distress.

To explore the women's experience of mindfulness within the forensic DBT programme.

To explore the women's experience of individual therapy within the forensic DBT programme.

To explore the nature of any effect of completing the forensic DBT programme on the women's view of their index offence.

## **2.0 Literature Review**

### **2.1 BPD Treatment Approaches**

Historically, BPD has been seen to be notoriously difficult to treat, due in part to factors such as emotional instability, engagement in self-harming behaviours, suicidal ideation and high treatment drop-out rates, with some studies showing treatment completion rates as low as 33% (Kelly et al., 1992). However, a closer look at the treatments involved in producing these figures shows not that BPD is untreatable, but that the methods previously being employed were ineffective (Barnicot, Katsakou, Marougka, & Priebe, 2011).

Research shows that patients with BPD utilise treatment of a greater length of time and breadth of nature, than other personality disorders and patients with a major depressive disorder (Bender et al., 2001). A lack of direction and mapping of symptom to therapeutic approach results in a considerable economic cost to healthcare providers, and contributes to patients' engaging in a variety of therapies before experiencing any reduction in symptoms or therapeutic benefit.

The emergence of the aforementioned therapies MBT, CAT, DBT, TFP, SFT, and their growing evidence base, support the effective treatment of BPD. A review of psychotherapeutic effectiveness evidence for the treatment of personality disorders completed by Perry, Banon and Ianni (1999) found that 52% of patients who remained in therapy for a mean of 1.3 years no longer met full diagnostic criteria for a personality disorder. However this review can be criticised due to the small number of studies included (15) and the variation of those studies in diagnosis, treatment modality and assessment methods.

Zanarini, Frankenburg, Hennen and Silk (2003) tracked the syndromal and subsyndromal phenomenology of BPD over six and 10 years (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2010), with their first set of results published in 2003. They showed that 73.5% of BPD patients who require in-patient care achieve diagnostic remission after six years. The follow up study published in 2010 produced a further holistic breakdown and showed that 50% of all participants achieved diagnostic remission over a 10 year period. Of these, 86% of participants achieved diagnostic remission lasting at least four years, and that just 15% of these experienced recurrences. These authors concluded that their results indicate that recovery, when defined as both symptomatic remission and an improved psychosocial functioning, is challenging to gain; however once achieved it can be judged as stable over time. These results are promising for those diagnosed with BPD, and for practitioners, these results have also contributed to the changing landscape in the reputation attached to treating BPD. However, the psychological treatments that participants within this study received were varied across discipline, approach and context which negates the possibility of determining the effectiveness of particular psychotherapeutic approaches and interventions aimed to treat BPD.

Bateman and Tyrer (2004) stated that the research for personality disorders lacks in its ability to decipher the effective components due in part to small sample sizes, and multifaceted treatments. This was supported by a review of psychological therapies for people with BPD conducted by Binks et al. (2009). These researchers concluded that symptoms of BPD are amenable to talking therapies but that due to the lack of research and small sample sizes, conclusions on the effectiveness of one particular treatment approach over another is not possible. Researchers were encouraged to focus on individual approaches. Giesen-Bloo et al. (2006) compared three years of TFP to SFT and found that both approaches reduced PD symptomatology but that SFT was significantly more effective than TFP.

Clarkin and Levy (2003) found that TFP had comparable outcomes to DBT and psychodynamic day treatment in a reduction of hospital inpatient stays, emergency room visits and an increase in global functioning. However this comparison between treatment modalities did not take into consideration the differences in the participants for each study in terms of severity of symptoms, history and frequency of deliberate self-harming behaviours, and current substance misuse status. Although this lack of homogeneity across the studies limits the ability to compare results, it does not negate the positive outcomes individually reported.

Further research completed by Clarkin, Levy, Lenzenweger and Kernberg (2007) compared various approaches of one year of outpatient treatments. BPD patients were assigned to TFP, DBT or dynamic supportive therapy. Upon treatment completion results showed that each group displayed a positive change in depression, anxiety, global functioning and social adjustment. Both DBT and TFP were significantly associated with an improvement in suicidality; TFP and dynamic supportive therapy both had an association with improvements in anger and facets of impulsivity. This research is robust in that it is comparing like for like in terms of manualised treatments which begin to specify components of change. The strengths of this research are that the therapists within each treatment approach were all matched in terms of expertise, experience and supervision, participants were randomly assigned and outcome measures were delivered by blind assessors. The homogeneity of the sample was controlled for as much as possible within the constraints of ethical considerations, although published data does not provide the particulars regarding the history and frequency of suicidal acts and deliberate self harming behaviours to support the finding of a significant improvement. Statistical power could have been improved with a total of 90 participants across the three treatment approaches. However with the limited RCT data available, the study



contributed to the evidence base in beginning to show potential for how each therapy has success in varying areas of symptomatology.

Weinberg, Ronningstam, Goldblatt, Schechter and Maltzberger (2010) compared the treatment strategies of DBT, MBT, TFP, SFT, STEPPS and general psychiatric management for BPD. They found similarities in a clear treatment framework, attention to affect, focus on treatment relationship, active therapist, exploratory interventions, and change oriented interventions. Differences were outlined as multimodal and team collaborative treatments, explicit treatment targets, the use of interpretation, supportive interventions, support for the therapist and attention to functioning. These researchers linked these commonalities and differences to corresponding overlaps between treatments in the reduction of particular BPD symptomatology such as emotional, behavioural and interpersonal dysregulation. This research began the process of matching the subjective nature of an individual with BPD to an appropriate treatment intervention. This research is limited to comparisons and does not have the scope for evaluating the effectiveness of the treatments; there is also the potential for researcher bias as the researchers both developed and applied the Treatment Intervention Rating Scale (TIRS), which was used to measure the comparisons. However these limitations again do not limit the potential value of the data produced in contributing to an understanding of the mechanisms of change within therapies aimed at particular and specific BPD symptomatology.

It is within this evolution that recent research has also begun to focus on contextualising the effectiveness of treatments. For example, MBT has been shown to be effective as applied to a family context (Fonagy & Bateman, 2006b), and CAT is considered when restricted by the length of time treatment can be given (Ryle & Golyukina, 2000). Relevant to the research presented here, evidence for DBT has

shown the effectiveness of DBT for BPD when considered in the context of serious offending behaviour (Warren et al., 2003).

## **2.2 BPD and Criminality**

It is well documented that the percentage of prisoners who fit the criteria for various personality disorders is far higher than expected when considering the national average (Sansone, & Sansone, 2009). A survey of prisoners in England and Wales conducted by Singleton, Meltzer, Gatward, Coid and Deasy (1998) estimated that 20% of the prison population falls within the diagnostic criteria for a personality disorder diagnosis - this is in comparison to 2% of the general population. In a survey of two UK male prisons, Davison, Leese and Taylor (2001) found rates of BPD to be between 45.7-47.4%. This trend continues cross-culturally. Random sampling of male prisoners in North America has shown rates of anti-social personality disorder (ASPD) to be anywhere between 39%-62% (Moran, 1999). In contrast to the concurrently high rates of BPD in prison for both males and females, von Schonfled, Schneider and Schroder (2006) found that within German prisons, male rates of BPD were comparable to the general population at 5.9% but that female rates of BPD far exceeded the national average at 42.9% in comparison to 5.3%. These shocking figures become even more concerning when considering particularly violent offenders. Coid (1998) screened high risk offenders in the USA for personality disorders and concluded that 98% of those assessed met the criteria for at least one personality disorder; rates of over 50% were found for paranoid, narcissistic, borderline and passive-aggressive personality disorders. In a review of the literature, Sansone and Sansone (2009) stated the prevalence of BPD within a prison context to be anywhere between 25%-50%.

The validity of these high rates of personality disorders have been questioned by some researchers. Rotter, Way, Steinbacher, Sawyer and Smith (2002) suggested that contextual influences of the prison environment promote Axis I and Axis II disorder diagnosis. These researchers stated that symptoms associated with personality disorders overlap with behaviours that are adaptive within a prison context. Pollack (2005) stated that there was a current trend of pathologising reactions and behaviours associated with a prison context. However, when considering a high security forensic hospital population, Jamieson and Taylor (2004), completed a logistic regression analysis of data from the UK national annual high security hospital discharge cohort. These authors found that people with a personality disorder diagnosis were seven times more likely than people with an Axis I disorder diagnosis, to be convicted of a serious crime following discharge. These figures, at least, support a link between a personality disorder diagnosis and an increased risk of criminality. The various features of personality disorders such as impulsivity, hostility, anger and violence means that these prisoners present a considerable management problem within prisons. However, there is no national, local policy, or psychological intervention aimed specifically at managing or treating this group of people within a prison context.

When considering treatment for personality disorders it may be important to distinguish between high security forensic hospital populations and prison environments. Research has shown that there are effective therapeutic interventions for personality disorders within a clinical setting (Fonagy & Bateman, 2006; Clarkin, Yeoman & Kernberg, 2006; Ryle & Golyukina, 2000). However, when considering interventions such as MBT, TFP and CAT, within a prison context, there are additional factors that need to be understood and prepared for.

In order for a psychological treatment to be considered and evaluated as effective within a prison environment the intervention needs to evidence itself as

addressing both clinical and criminogenic outcomes. This can result in conflicts between the aims and objectives of prison authorities and the aims and objectives of healthcare staff. Practical issues of funding, risk assessment, and working therapeutically within a prison regime can all affect the delivery and measures of success of psychological therapies.

There is a shortage of research and literature pertaining to 'what-works' (McGuire & Priestley, 1995) for personality disordered offenders within a prison context. Blackburn (1993) highlighted that no one particular psychological approach can claim dominance in treating personality disorders and this is still the case. However, methods such as a therapeutic community, social skills training, and cognitive restructuring have all been shown to be effective. Existing therapies that have been shown to be effective in treating personality disorders are being adapted to a prison context, namely DBT (Nee & Farman, 2005; Gee & Reed, 2013), and Thinking Skills, which is a cognitively based intervention (Vennard, Hedderman & Sugg, 1997). Trestman (2000) suggested that DBT is appropriate for a prison setting due to its roots in cognitive behavioural therapy and structured format, particularly when considering the psycho-educational nature of the DBT skills component within the therapy.

### **2.3 What is DBT?**

In its original form, DBT is a comprehensive cognitive-behavioural treatment for complex, difficult to treat, mental disorders developed by Linehan (1993a, 1993b). DBT has a particular focus on treating suicidal and parasuicidal behaviours often associated with BPD. DBT is based on a bio-social model of BPD, which understands BPD as being the result of a dysfunction of the emotion regulation system, coupled with an invalidating environment, often incorporating childhood

trauma. DBT combines reinforcement strategies of behavioural therapies with eastern mindfulness practice, whilst consistently emphasising a dialectical worldview that synthesises the idea of opposing views such as acceptance and change. This is to highlight the tensions present in suicidal clients with BPD; DBT promotes an understanding of validation and acceptance whilst simultaneously enabling change.

DBT has been particularly successful in its addressing of therapy interfering behaviours on the part of the client and on the part of the therapist. Clients regularly address their therapy interfering behaviours in individual therapy and therapists do the same in weekly consultation meetings. It is this regular examination, reflection, and action, which enables both clients and therapists to be motivated and committed to the therapeutic process (Shearin & Linehan, 1994).

DBT was originally developed as an out-patient treatment programme delivered over a period of one-year. Clients are strictly required to commit to a full year of treatment before treatment can begin. Clients have individual weekly therapy sessions (50 mins) whereby the past week is reviewed using 'diary cards' that the patient has filled in throughout the week. Individual sessions are highly structured and follow a hierarchy of topics: life threatening behaviours, therapy interfering behaviours, quality of life interfering behaviours and finally a review of skills use. It is important to note here that the focus of these topics in therapy is determined by the presentation of the client, for example if a client is not exhibiting parasuicidal behaviours then their focus may primarily fall to quality of life interfering behaviours instead of life threatening behaviours. The therapist is encouraged to provide a validating environment for the client, whilst employing a method of 'behavioural chain analysis' to facilitate the client's understanding of the origin of their behaviour, and gain insight and awareness, whilst developing alternative solutions.

Clients also attend a weekly skills group for two and a half hours. This takes the form of a classroom environment and includes other clients on the DBT

programme. Two skills trainers (who may also be some of the clients' individual therapists) teach the skills relevant to the current module; clients are expected to practice these skills throughout the following week and beyond. Modules consist of mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. Each module is broken down into specific weeks and follows a structured plan as stipulated by Linehan (1993b). It is directed to take 24 weeks to complete the full skills curriculum; clients are then taken through the whole programme twice, within the original one-year therapy programme.

There are two further components of DBT in its original form: out-of-hours telephone contact and the consultation group. Clients are given telephone contact with their individual therapist; this is again structured whereby telephone calls are restricted to skills coaching a client through a particular situation. Telephone calls are limited to ten minutes and are promoted not to be used as an extra therapy session. The weekly consultation group does not involve clients; it is essentially a peer supervision group, whereby skills trainers and individual therapists meet to review the programme, their practice and the clients. This consultation meeting is structured in content with each person having a particular role to fulfil. It is within this arena that the clinical work and the language and ethos of DBT are promoted and supervised.

## **2.4 Quantitative Research Evidence for DBT**

Early randomised control trials (RCT) compared DBT to treatment as usual (TAU). Linehan et al. (1991) compared outpatient DBT to TAU; 44 chronically parasuicidal women were randomly assigned to each group. The TAU group consisted of community-based treatments. Treatment adhered to the standard model of DBT and both groups participated in therapy for a one year period, assessments were every four months. At each assessment, the DBT group showed a greater

reduction than TAU in the frequency and medical severity of parasuicidal acts; DBT also showed a greater reduction than TAU in the frequency and length of inpatient hospitalisation. DBT retention to treatment was also greater than that of TAU. Interestingly, treatment gains were also maintained for the DBT group at six, and 12 month follow up assessments (Linehan, Heard, & Armstrong, 1993). However, Linehan et al. (1991) found that both groups improved in depression, hopelessness, and reasons for living: there was no statistical significance between the groups on these variables. Koons et al. (2001) offered a possible explanation for this through the findings of a second study.

Koons et al. (2001) completed the first replication of this RCT, comparing six months of DBT to TAU, 20 women veterans were randomly assigned to each group. Participants in the DBT group reported significantly greater decreases in suicidal ideation, hopelessness, depression, and anger expression. Koons et al. (2001) showed that DBT treatment was effective after six months; this study also highlighted the potential effective components and the impact of inclusion criteria to the studies as although the DBT group demonstrated a significant decrease in the number of parasuicidal acts, this was not significantly different from the TAU group. This was explained by the inclusion criteria for the study; in comparison to the Linehan et al. (1991) study, this study did not require that participants had engaged in parasuicidal acts in the prior eight weeks to beginning the therapy, which limits the change of this variable. These findings, and those provided by Linehan et al. (1991), can be understood by the hierarchy of treatment strategy within individual DBT sessions, whereby the focus would be on life threatening behaviours for those patients actively engaging in parasuicidal behaviours, and the focus would be on quality of life issues for those who are not, thus affecting the likelihood of change within these variables.

A third RCT was completed by Bohus et al. (2004) who compared a three month inpatient DBT programme to TAU in the community. Pre and post test

comparisons showed a significant improvement for the DBT group on 10 of 11 psychopathological variables including a significant reduction in self-harming behaviours. There were no significant changes recorded during the same time period for the TAU group.

These early RCTs can be criticised for using TAU to compare to DBT. DBT is considered to be specialised treatment involving skilled psychologists who are specifically trained within cognitive and behavioural approaches as well as DBT, whereas TAU consisted of a variation of community based treatments lacking in a particular discipline, with training, among other variables, not controlled for. In response to this, Linehan et al. (1998) developed a RCT comparing DBT to community treatment by experts (TBE). Experts consisted of highly skilled clinicians who were matched to the DBT therapists in terms of experience, qualification, salary, and supervision to the therapists' was also controlled for. Linehan et al.'s (1998) results from this RCT showed that individuals in the DBT group had a greater reduction in suicidal behaviours and the use of inpatient psychiatric care, than individuals in the TBE group. The DBT group also had greater treatment retention than the TBE group. The focus of DBT on therapy interfering behaviours could be an explanation for this difference.

Existing DBT research can be criticised for a lack of heterogeneity within inclusion criteria, and a lack of transparency of the inclusion criteria within the published studies. Blennerhassett and O'Raghallaigh (2005) highlighted the subjective experience of BPD symptomatology, and the potential for, and consistent overlap of, features also associated with other AXIS I and II disorders, thus limiting the assumptions that can be made from research stated as treating BPD.

Research has shown DBT to be particularly efficacious in the treatment of parasuicidal behaviours (Koons et al., 2001; Linehan et al., 1998; Linehan et al., 1993; Linehan et al., 1991). Some researchers are therefore suggesting that DBT



may be emerging as a treatment specifically for deliberate self-harm rather than BPD symptomatology in its entirety (Blennerhassett and O'Raghallaigh, 2000; Verheul et al., 2003). Linehan and Heard (1999) stated that between 60-80% of people diagnosed with BPD engage in parasuicidal behaviours showing a clinical need to prioritise this particular symptom of the disorder. Second to this is the research that supports the effective treatment of other BPD symptoms and traits through DBT. In line with the treatment hierarchy, if clients are not engaging in life threatening behaviours, the therapy targets quality of life interfering behaviours. As previously stated when comparing a DBT group to TAU, Koons et al. (2001) reported significantly greater decreases for the DBT group in suicidal ideation, hopelessness, depression, and anger expression. Neacsiu, Lungu, Harned, Rizvi and Linehan (2014) found that DBT decreased participant's experiential avoidance and expressed anger significantly more than community treatment by experts (CTBE).

Scheel (2000) criticised the finding that DBT also showed a greater reduction than TAU in their frequency and length of inpatient hospitalisation (Linehan et al., 1991). Scheel (2000) states that the reporting of this finding can be interpreted as suggesting that the DBT clients are higher functioning than the TAU usual clients. Scheel (2000) also highlights that DBT has a strategy of keeping clients out of inpatient psychiatric care which involves the DBT therapist liaising closely with the hospital and clients clinician, whilst also taking a higher level of responsibility for that client than a TAU therapist would usually do so, this ensures that the client is able to either be released or stay out of inpatient services. Linehan (2000) agrees that it is DBT strategy to do so as this is in line with the overall goal of building a life worth living which involves staying out of inpatient hospital and taking responsibility for ones own care and safety. The argument presented by Scheel (2000) raises the debate as to whether a researcher should state the efficacy of an outcome that has been specifically targeted within the treatment. Linehan (2000) showed that this type

of strategy is exactly what makes DBT unique and effective, as seen in the outcome measure of a greater reduction of frequency and length of inpatient stays for DBT client than clients in TAU (Linehan et al., 1991).

## **2.5 Treatment Retention**

The finding that DBT has a higher treatment retention than TAU or TBE (Linehan et al., 1991; Linehan et al., 1998) has been criticised by Scheel (2000) due to the DBT participants receiving their therapy free of any personal cost to themselves, whereas the TAU participants were personally liable for payment. Scheel (2000) also cited the awareness that the participants had of being involved in a research study for a new therapy as a confounding variable. Scheel (2000) further stated that she believed there may have been a positive association with this, which may have increased client retention. In addition, Scheel (2000) stated the knowledge that participants had been assigned to TAU may have increased drop out rates due to a negative association with this condition. In conflict with this is a review of research conducted by Perry, Banon and Ianni (1999) into the effectiveness of psychotherapy for personality disorders. These researchers found that patients included within an RCT had a higher rate of dropout from treatment than those not included in an RCT regardless of allocation to treatment condition. In absence of reasons pertaining to one condition or another Perry et al. (1999) stated an overall lack of treatment choice as a potential reason for this. Notwithstanding the points raised by Scheel (2000), this critique focuses on methodological issues and fails to consider the interaction of the aetiology of BPD in treatment dropout.

Treatments for BPD have a historically higher dropout rate than psychotherapeutic interventions targeting Axis I disorders (Yeomans et al., 1994). DBT was developed in consideration of this and consequently specifically targets

therapy interfering behaviours which could result in early termination of therapy within the treatment hierarchy. Linehan (1993a) stated that her intention in this was to increase treatment retention, as has been seen by subsequent research (Linehan et al., 1991; Linehan et al., 1998). Regardless of specifically targeting therapy-interfering behaviours, rates of dropout from DBT are found to be approximately 30-32% (Rusch et al., 2008; Kroger, Roepke, & Kliem, 2014). Rusch et al. (2008) found higher levels of experiential avoidance and trait anxiety at baseline in the non-completers of an inpatient DBT programme. Kroger et al. (2014) highlighted co-morbidity with antisocial personality disorder, and/or substance abuse as risk factors for dropout. However when framed in terms of behaviours these factors would be addressed therapeutically within the DBT target hierarchy, suggesting that as with other areas of DBT research, treatment retention and dropout is under investigation and in its infancy.

## **2.6 Treatment Components**

There is a lack of research pertaining to the efficacy of DBT as a whole and the particulars of which components of DBT are necessary for any significant change in symptomatology or BPD experience. Research utilising psycho-education groups based upon DBT principles alone have not yielded successful results and in some cases have been shown to be detrimental (Miller, Eisner, & Allport, 1994). Research completed by Soler et al. (2009) found that when comparing DBT skills group to standard group therapy, DBT skills groups had greater improvements in scores of depression, anxiety, irritability, anger and affect instability. The DBT skills group condition also had a lower drop out rate than the standard group therapy condition.

Research conducted by Neacsiu, Rizvi and Linehan (2010) examining DBT skills used found that utilising DBT skills fully mediated a decrease in suicide

attempts and increased the control of anger, and partially mediated the decrease of parasuicidal behaviours. Linehan (2000) criticised the group therapy featured in the research conducted by Miller et al. (1994) as not adhering closely enough to a DBT curriculum and advised that the skills groups alone are not sufficient and that the individual DBT therapy sessions are needed for skills acquisition and to complete the highly structured and comprehensive treatment DBT is prescribed as being. In an outcome measure review of 17 trials utilising DBT skills groups as a standalone treatment without other DBT features, Valentine, Bankoff, Poulin, Reidler and Pantalone (2014) summarised that there was preliminary evidence supporting the use of DBT skills groups alone but that a general lack of methodological rigour such as a lack of randomisation, no control groups, a lack of follow up data, and a wide variation in clinician training, prevented a reliable and valid conclusion regarding the components of DBT that are necessary or efficient to effect change.

Linehan (2000) summarised that the degree to which the efficacy of DBT is currently understood is limited, however she supported the research that has been published as robust when considering the context. Linehan (2000) also stated that the methodological critics should not deter further research on an approach and intervention that is in its infancy and that which showed promise for a client group that has previously been both ignored and deemed as untreatable.

## **2.7 DBT Adaptations**

This standardised model of DBT has been successfully adapted across various disorders, client groups and settings. DBT has been implemented and empirically evidenced for elderly depressed patients (Lynch, Morse, Mendelson, & Robins, 2003), eating disorders (Telch, Agras, & Linehan, 2001), substance abuse (Linehan et al., 1999) and attention deficit hyperactivity disorder (ADHD) (Hesslinger

et al., 2002). DBT has been applied across health care settings such as residential therapeutic communities (McFetridge & Coakes, 2010), inpatient units (Swenson, Sanderson, Dulit & Linehan, 2001), high security forensic hospitals (Low, Jones, Duggan, Power, & Macleod, 2001) and most importantly for the research presented here prisons (Nee & Farman, 2005). In a review of DBT adaptations, Robins and Chapman (2004) highlighted that predictors of outcomes and identifying components effecting change is not possible due to a lack of research and small samples sizes in existing research restricting statistical power.

## **2.8 Adaptations of DBT for a Secure Forensic Inpatient Context**

DBT is viewed as an appropriate intervention for both a forensic inpatient and prison population for a number of reasons. Firstly, Strick (1989) found that 70% of forensic inpatients are diagnosed with personality disorders; DBT has a growing evidence base showing the successful treatment of BPD (Robins & Chapman, 2004). Secondly, cognitive behavioural approaches have been shown to have a substantial evidence base in targeting offender behaviour (Losel, 1995); because DBT is based upon cognitive behavioural principles, it is seen to be an appropriate intervention to employ. Thirdly, the managing of aggressive and life threatening behaviours in a prison context is a consistent challenge and appropriate treatment strategies are essential to maintaining safety within this environment. This is addressed by DBT due in part to its emphasis on treating life threatening behaviours of patients and therapy interfering behaviours of both patients and staff.

Low, Jones, Duggan, Power and MacLeod (2001) engaged 10 female patients at a high security hospital in the UK in a one year DBT programme. This programme was not modified from the original Linehan (1993a, 1993b) model other than to be delivered within this secure setting. Results showed a significant reduction

in rates of self-harm. In line with the findings from Koons et al. (2001), this effect was only evident after six months of therapeutic engagement; a significant reduction was consistent six months post therapy completion. Low et al. (2001) reported a number of psychological variables that showed consistent and significant changes throughout therapy. These researchers also highlighted how these variables map onto the specific focus and rationale of DBT, for example, a reduction in rates of dissociation was linked to the focus on mindfulness, and an increase in survival and coping beliefs is linked to distress tolerance and building a life worth living. Reducing suicidal ideation, depression and impulsiveness are all central to the treatment hierarchy of reducing life threatening behaviours and quality of life interfering behaviours. In addition there was no change in levels of anxiety or irritability, both of which are less of a treatment focus. This difference in outcome variables can be interpreted as evidence that these results are not due to a response bias but are suggestive of the mechanisms effecting change. The small number of participants included in this study and the lack of a control group limit the generalizability of the findings and the assumptions based on DBT as an intervention that can be reliably proposed. However the recording of a consistent pretreatment baseline supports the changes being due to engagement in therapy rather than due to chance; also, the large effect sizes support the potential for significant results should an RCT be conducted.

Low et al. (2001) discussed the challenges of implementing a full DBT programme within a secure forensic setting. They highlighted the security measures in place as being in conflict with DBT strategies, such as impeding on the independence being promoted in the clients, and the promotion of clients taking responsibility for themselves whilst also under section. Low et al. (2001) highlighted the lack of a regular and private space for the therapy to take place, and the impact of the limit to confidentiality, essential and inherent to this context. However in the

spirit of DBT it is also important to consider how this context provides ample opportunities to utilise a dialectical philosophy and the skills taught to manage these conflicts in life within DBT. In a report of client case studies Low et al. (2001) stated that a feature of this offender client group is the severe symptomology, Low et al. (2001) suggested therefore that it may be that a one year programme is not sufficient to see a lasting change in all clients.

Evershed, Tennant, Boomer, Rees, Barkham and Watson (2003) compared DBT with TAU for male forensic patients in a high security hospital within the UK. These patients received 18 months of DBT adapted only to increase its relevance to a male population. Results showed that those patients in the DBT condition had a greater reduction in the severity of violence related incidents and in self report measures of hostility, cognitive anger, disposition to anger, outward expression of anger and anger experience. Researchers report these gains being maintained at a six month follow up data point. Interestingly of eight participants who began the DBT condition only one completed the full 18 months, however five of the participants who left set up their own self help group consisting of skills use and diary card completion. These researchers highlighted a lack of training and experience from the therapists delivering the DBT as a potential reason for this. The researchers also provide support from hospital staff in favour of DBT stating their observation of an improvement from the DBT participants in engaging in other therapeutic options available to them and the improvement in their resulting therapeutic relationships. Evershed et al. (2003) state that in reducing anger as a primary target of this setting DBT is considered by them to be more successful than TAU, however they refrain from promoting its further use without comprehensive training for the therapists tasked to deliver a DBT specific intervention.

McCann and Ball (2000), at the Colorado Mental Health Institute in Pueblo (CMHIP), have developed and published an adaptation of DBT for a forensic

inpatient population. McCann and Ball have adapted DBT to suit both the therapeutic and security needs of this challenging environment. These researchers highlighted the differences between an outpatient client group and a forensic client group in terms of violent histories and co-morbid diagnoses. As such forensic patients within this institution primarily include Axis I and Axis II diagnoses, and 75% of patients are charged with a violent crime.

The content of the module 'emotion regulation' has been adapted to facilitate an increase in emotional attachment, and empathy and consequences to others. An additional skill of 'Random acts of kindness' was also added to the skills acquisition teaching. Particular hand-outs from the skills programme were also revised to target anti-social personality disorder (ASPD) traits. In line with standard DBT protocol, the four-module programme is completed twice, in its entirety, after which patients are required to pass an exam in order to graduate. Following graduation patients move onto the most significant change to standard DBT: a fifth module entitled 'Crime Review'. Here patients review the crime that they have committed through the use of the DBT technique called a behavioural chain analysis (BCA). Whereby patients identify what led up to their crime(s), the vulnerability factors, precipitating events, and the problem behaviour. Patients take the perspective of their victim(s), complete a BCA and develop a relapse prevention plan that includes specific DBT skills. In addition to targeting life threatening and therapy interfering behaviours, this adapted DBT model also introduced targeting unit destructive behaviours in order to address the difficulties and challenges associated with an inpatient forensic environment. Unit destructive behaviours include lying, harassment, violation of others rights and rule breaking.

A forensic inpatient environment is commonly fraught with staffing difficulties, both being short-staffed and a high staff turnover. McCann and Ball (2000) found that this impacted upon the ability to offer consistent individual therapy sessions. In order



to address this, they developed a Chain Analysis Group (CAG) whereby patients review the weekly diary cards in a group setting and complete the relevant behavioural chain analyses. This is a significant adaptation to the original model proposed by Linehan (1993a).

McCann and Ball (2000) provided a coherent account of the modifications made to the DBT programme being implemented. They showed the importance of mapping the modifications to the individual needs of that particular client group and setting, and the importance of doing so whilst also taking into consideration the needs and impact of the staff providing both healthcare and institutional regime care.

Unpublished data from McCann, Ball and Ivanoff showed that in comparison to TAU, patients who completed the modified DBT programme over a 20-month period, had a significant decrease in depressed or hostile mood, paranoia, and psychotic symptoms. In comparison to TAU, DBT patients also had a significant decrease in maladaptive interpersonal coping styles, and a significant increase in adaptive coping styles; the patients in the TAU group did not reach significance in these changes. This research also monitored the effects of DBT for the therapists in comparison to therapists engaging with TAU. The results showed that DBT staff demonstrated a significant improvement in two of three burnout sub-scales and approached significance on the third sub-scale; the TAU staff did not show these improvements. McCann and Ball (2000) noted the importance of retaining, training and validating staff, and outline how integral these factors are in the delivery of a successful forensic inpatient DBT programme.

Within the literature there are reports of forensic inpatient and offender population DBT programmes globally (Berzins & Trestman, 2004). Research pertaining to the efficacy of these programmes is extremely limited presumably due to the obstacles outlined within the introduction such as the time commitment in implementing robust research, dual role of practitioner-researcher, internal politics,

obstacles to engaging clients, confidentiality and the boundaries to this, security measures and the impact of these on therapy, and ethical approval and security clearance procedures (Sainsbury Centre for Mental Health, 2008). This lack of research leads to a lack of consistency in approach, a lack of awareness and knowledge of 'what works', and due to this leaves healthcare staff at risk. An example of this is the review presented by Berzins and Trestman (2004). These researchers quoted their correspondence with the U.S Medical Centre for Federal Prisoners as not following a treatment manual, but modifying the skills group material ad hoc. This review showed a range of DBT programmes modified for a forensic context with no empirical data supporting or refuting their use.

## **2.9 Adaptations of DBT for a Prison Context**

Shelton, Kesten, Zhang, and Trestman (2011) investigated the impact of a DBT programme that was modified for a prison context with male adolescents within the USA, termed DBT-CM (corrections modified, Shelton et al., 2011). The DBT programme was modified to be accessible to make the vocabulary of DBT easier to understand and worksheets were adapted to include pictorials. Researchers also stated that the DBT skills were each adapted to be relevant to a correctional setting. Shelton et al. (2011) also made note of the prison safety measures that had to be adhered to in the usage of, and receiving of course materials by the prisoners. In addition to this, adaptations were made to the individual therapy sessions to ensure that the DBT skills learnt within prison were applicable within the community post release. Participants received a 16 week DBT-CM course.

Results showed that significant changes were found in a reduction of physical aggression, distancing coping methods and internal prison disciplinary methods. Impulsive aggression as measured by physical aggression, verbal aggression, anger

and hostility was also seen to significantly decrease. Although promising in nature and delivery, this study was subjected to the criticisms of a lack of control group and a small sample. However, this study does again contribute to the existing literature in supporting the use of DBT to reduce aggressive behaviours within a prison context. Challenges are noted as retaining staff, training implementation, funding and the ability to recruit a robust, homogeneous sample size. These authors suggested that DBT-CM may contribute to a decrease in problematic behaviours common within a prison context and therefore improve the quality of life for participants. The evidence produced by the outcome measures in a reduction of impulsive aggression and improved coping skills supports this claim. However it is without evidence that the authors also claim that DBT-CM may also have an impact on the wider context of these problematic behaviours in the prison and second to this, recidivism. However findings do report a positive experience from prison staff and participants in the management of impulsive aggression, thus providing some support to this claim.

DBT has also been implemented in UK prisons; in 2001, HMPS funded pilot programmes for DBT in three prisons. Two were closed training prisons (one high security), both of which ran standard one-year DBT programmes. The third prison was a locally allocated prison, which ran two modified DBT programmes; one of 16 weeks and two of 12 weeks. These ran three times each during the 20-month pilot. The DBT programme content was not changed but it was limited according to the time constraints of the shorter programmes. Nee and Farman (2005) completed research evaluations for these programmes and set up a waiting list control group. Evaluation measures consisted of psychometric tests, behavioural data, and interviews, with data taken at four different time points for the one year programme and three different time points for the modified brief programmes. Research was conducted to compare the effectiveness of the differing lengths of programme, the

impact of DBT on the characteristics of BPD (including incidents of self-harm), and the effects of DBT on criminogenic risk.

A total of 30 prisoners began the programmes across the three prisons, however due to transfer, release and voluntary drop out there were 16 prisoners who completed the full allocated programmes. Despite this seemingly low number of participants who completed the study, researchers found that in comparison to drop out rates from standard outpatient DBT programmes, there was no difference in the voluntary drop-out rate.

Evaluation results for the one-year DBT programmes found that there was significant improvement on a measure of the global syndrome characterising BPD, including measures of impulsivity, locus of control and emotion regulation, all of which are associated factors to criminogenic risk. Incidents of self-harm also reduced over the DBT period; at the final assessment point of six months post DBT there was a slight increase in the incidence of self-harm but this was lower than pre-DBT levels.

Nee and Farman (2005) stated that factors such as a lack of follow up support following the programme, and the suicide of a non-DBT participating prisoner should be considered in reviewing these results. In addition to incidents of self-harm decreasing throughout the programme; lethality of self-harm was also reduced, from death being highly probable, to death being a 50/50 chance, according to the Linehan (1993) scale. This finding supports the research conducted by Linehan et al. (1991) whereby DBT was seen to reduce the medical severity of parasuicidal acts. Nee and Farman (2005) reported potentially influential effect sizes, ranging from 0.40 to 0.61; this is substantially higher than the effect sizes reported for other recidivism interventions for non-BPD prisoners.

Interestingly, Nee and Farman (2005) noted improvements also in the data retrieved from the waiting list control group, although not statistically significantly. They attributed this to the control group being housed on the same wing as the DBT

group, and a generalisation of skills taking place. The researchers stated that this view was supported by the interview data obtained from both prisoners and prison staff. The programmes that were modified to be completed within either 12 or 16 weeks also yielded positive results. Statistically significant changes were recorded for measures of self-esteem, impulsivity and dissociation. Suicidal and parasuicidal behaviours also decreased significantly over the course of the programme.

Nee and Farman (2005) highlighted the tentative nature of the findings from all the programmes due to a small collective sample size (N=14). However, they also noted the importance of finding statistical significance in a sample this small, and suggested that this supports the notion that DBT within a prison context should be considered as a viable option for this client group. The researchers echoed the findings from McCann and Ball (2000) by highlighting the importance of staff training and retention. Nee and Farman (2005) stated that there was a 50% delivery team attrition rate for the DBT pilots; they gave reasons such as limited training opportunities, and the urgency of beginning the programmes due to funding as reasons for this. However, it is encouraging to consider the results gained in view of this.

Hover and Packer (1998, as cited in Berzins & Trestman, 2004) assessed sex offenders completing a standard DBT programme in prison and found that the presence of prisoners at a low risk of reoffending, in the same treatment programme as prisoners at a high risk of reoffending, lowered the effect sizes found post treatment for the prisoners at a high risk of reoffending. This suggests that separating offenders on the basis of recidivism risk may improve the effect found within those assessed as a high risk.

Gee and Reed (2013) outlined the modified DBT pilot programme Holloway Skills Therapy Programme (HoST). Due to a remand population resulting in a high turnover of prisoners the DBT programme was modified to be modular and

comprising of eight weeks per module enabling prisoners to complete only one module if their prison term allowed it. The DBT programme was inclusive of weekly skills groups, individual therapy and team consultation. Telephone coaching was replaced with skills coaching for missed sessions, unrecognised by the researchers. This can be seen as in conflict with the behavioural reinforcement strategies of DBT and does not replace in vivo skills coaching as per DBT principles and strategy. Gee and Reed (2013) state the importance of the commitment to treatment cultivated and gained during the pre-treatment sessions and stated that at least three weeks of individual sessions need to be accounted for prior to commencing groups in order to facilitate commitment and improve attrition. They evidenced this point with research presented by Nee and Farman (2008).

Results from the Clinical Outcomes in Routine Evaluation (CORE) which measures global distress consisting of well-being, problems, functioning and risk, showed a positive reliable change. Risk was reduced to the boundary of that seen in a non-clinical population.

Assessment, Care in Custody and Teamwork (ACCT) documents are completed by prison staff and allocated to prisoners to mark their concerns over prisoners who they feel are at risk of self-harm and/or suicide. Regular reviews denote the amount of time a prisoner will be allocated to an ACCT document. Pre-DBT data showed prisoners were allocated to an ACCT on average between nine-16 days per month; this figure reduced to three-nine days during the HoST programme and reduced again to an average of three days per month post HoST. These results should be treated with caution. However, longitudinal data regarding consistent ACCT usage prior to engagement in HoST was not available or published, thus limiting the relevance and impact of these figures.

Adjudications are given to prisoners following a breach of prison rules, Pre-HoST rates of adjudication were seen to be one in every three months. During HoST

this reduced to one in every five months, and post HoST one in every 12 months. Pre and post HoST this represents a 88.2% decrease. This is a promising figure presented within this paper, however no information is given of the period included within the pre data or of the particulars of the participants within these figures in terms of those who completed one module as opposed to those who completed all four DBT modules.

Feedback received from participants was positive with 84% reporting HoST to be 'very' or 'sometimes' useful, with a majority of participants stating the individual component to be of more use than the skills groups; 98% of participants stated that the programme had helped them to make positive changes. Quantitative evidence lacks an explanation for the preference of individual therapy over skills group.

The authors of this paper are presented as both therapists and researchers. This is not addressed within the paper and leaves the question of methodological researcher bias in data collection. A lack of control group, although inherent to this context, limits the generalizability of findings and the small sample group constricts the statistical significance. Researchers highlighted a low attrition rate, from 62 starters to only 29 prisoners completing one or more modules, although they were not able to provide a detailed robust explanation of this beyond logistics such as prison transfer, transfer to hospital and dropout.

As previously stated within this review, in order for a psychological treatment to be considered and evaluated as effective within a prison environment the intervention needs to evidence itself as addressing both clinical and criminogenic outcomes. Unlike the McCann and Ball (2000) CMHIP DBT modification which includes a crime review module, none of the DBT programmes modified for a prison context presented here (Gee & Reed, 2013; Nee & Farman, 2005; Shelton et al., 2011) includes a specific target of offending behaviours. Gee and Reed (2013) addressed this as a clinical implication for future development, along with the need

for future research to investigate and improve attrition, and an improvement in the referral process to ensure continuity post-release. They also highlighted the potential to include DBT within a prisoners sentencing plan and/or licensing conditions. This is in direct conflict with the original Linehan (1993a) model of autonomous commitment from clients. It is of debate as to whether this is a necessary adaptation for this context and with this client group or whether a forced commitment would take the model away from principles central to DBT philosophy. Notwithstanding the limitations presented here, taken within the frame of a pilot investigatory endeavour the HoST programme offers some significant insights and promising outcomes for a modified DBT programme within a prison environment.

Gee and Reed (2013) highlighted the difficulties they faced in gathering meaningful data from HMPS and NOMS contributing to their analysis. Despite both of these researchers being placed within the establishment, research barriers were encountered in reporting and accessing information. This is a significant obstacle to the future of meaningful, longitudinal research within this context and with this client group of significant clinical need.

## **2.10 Factors Influencing the Delivery of DBT within a Prison Context**

The Policy Guidance for Services for People with a Personality Disorder (Department of Health, 2003) presents a model for personality disordered offenders which states that three areas of functioning should be addressed: mental health need, offending behaviour (and risk), and social functioning. Currently therapeutic interventions aimed at treating personality disorders within a forensic context must adhere to the Offender Personality Disorder (OPD) Strategy (DoH, 2015), which is jointly funded by NOMS and NHS England (Joseph & Benefield, 2012). The OPD is a government initiative designed to improve access to psychologically informed



appropriate treatments, for men and women offenders housed within UK prisons, who present as consistent with a personality disorder diagnosis, which is further assessed to be connected to their risk of harm and recidivism (Logan & Ramsden, 2015).

The offender care pathway follows a number of stages through the prison system and is structured from community to community, meaning that one should be able to follow the progression of treatment for offenders diagnosed with a personality disorder from the community, into the prison estate, through the prison system and finally through the gate into community based services. This is in order to show a commitment to the long term care of offenders with personality disorders and is hoped to reduce rates of re-offending (Joseph & Benefield, 2012).

In line with the epistemology of this research the OPD can be criticised for its reliance upon diagnosis as an access to treatment and determining the funding of therapeutic interventions. The focused targeting of this strategic approach to care potentially limits the very demographic it is aimed at helping through a lack of resources in assessing those who come to prison without a predetermined diagnosis. The joint working between NOMS and the NHS has brought about significant challenges in the creation of new services, the merging of current services and the loss of current services, all occurring simultaneously with cost saving initiatives (Logan and Ramsden, 2015). Concerns regarding data ownership, information sharing and a clash of cultures between organisations has meant the transition to implementing the OPD strategy has been fraught with difficulties relevant for the population under investigation within this research (Logan and Ramsden, 2015).

Through a review of offender treatment programmes, Craissati, Horne and Taylor (2002) found that programmes which address criminogenic need in offenders also contributes to the management and reduction of risk of offenders whilst in prison. Research completed by Nee and Farman (2005), McCann and Ball (2000),

Shelton, Kesten, Zhang, and Trestman (2011), and McDonagh, Taylor, and Blanchette (2002) supports the idea that DBT manages both the traits and problem behaviours associated with BPD in a prison setting.

Current research yields some important considerations for the adaptation and implementation of DBT in a prison setting. McCann and Ball (2000) highlighted the importance of assessing each environment individually and making adjustments according to the specific needs of the institution under consideration. They suggested that this assessment will need to be reviewed regularly according to the dynamic nature of risk and need. Both McCann and Ball (2000) and Nee and Farman (2005) noted the importance of staff training, validation and on-going support and supervision. Nee and Farman (2005) outlined the importance of a good working relationship with prison management authority and staff, which affects both the delivery of DBT and patient retention on the programme.

According to the British Isles DBT website (<http://dbt.uk.net/>), DBT is currently available in prisons and correctional institutions in the UK, USA, Canada and Australia. It is possible and likely that there are other countries conducting DBT that have not yet published data. DBT programmes for this population are in their infancy and as such, research pertaining to the efficacy of such programmes is limited.

## **2.11 Qualitative DBT Research Findings**

There are very few studies that have been published which present the qualitative views of clients who have completed DBT programmes. Hodgetts, Wright and Gough (2007) presented qualitative findings from semi structured interviews with five clients who had completed 12 months of outpatient DBT in the NHS from the South-West of England. In utilising IPA, the researchers identified three

superordinate themes of joining a DBT programme, the experiences of DBT, and the evaluation of DBT, all of which contained further sub themes.

In discussing the outcomes of this study the authors highlighted that the participants all stated they had only been offered DBT as a treatment, which seems to have been led by their primary diagnosis. Hodgetts et al. (2007) highlighted the tension present here between treatment approaches being tailored to client need via formulation as opposed to being dictated by diagnosis and the stipulations of a particular approach.

There was also an emphasis noted by all participants on the importance of the therapeutic relationship and their positive, unique experience of the DBT therapists' approach regarding techniques such as validation and self-disclosure. Participants within this study were interviewed up to 12 months post completion of their DBT programme; therefore it is possible that other life experiences may have impacted on their answers.

The researcher completing the interviews is cited as being both a researcher and a DBT therapist within the programme under investigation. There is no mention within this paper as to how this was managed and accounted for, as such, it is possible there was a researcher bias and an overly positive account provided by the participants. Hodgetts et al. (2007) also highlighted the challenges present in interviewing clients who experience intrusive thoughts and dysregulated emotions in terms of both ethics and validity of data. They did not however go on to state how this was managed within the collection or interpretation of data.

Perseius, Ojehagen, Ekdahl, Asberg and Samuelsson (2003) investigated the experience of outpatient DBT for both therapists and clients in Sweden with an aim of understanding the functional components of the therapy. Utilising focused interviews and content analysis, these researchers found that the therapists and patients agreed on the effective components of DBT by highlighting the validation strategies

in combination with explicit skills use, as was also found by the research presented by Hodgetts et al. (2007).

Perseius et al. (2003) found that all ten patients interviewed viewed DBT as having life-saving qualities. Patients also highlighted the importance and effect of individual therapy. However, therapists' views were seen to attribute the success of the individual therapy to the DBT model. The focused interview schedules employed in this research have gained the information that the questions have asked for; this resulted in a limited opportunity for the clients to bring their experience in its subjective entirety.

Perseius et al. (2003) pointed to the difficulties in location for the interview, which took place in the same clinic as the DBT. They stated that this was to reduce drop out and make the environment less stressful for participants; they do note however the potential for a favourable bias from participants. Perseius et al. (2003) also recognised that the opening questions from the interview could have been broader, allowing for more freedom in the participants' responses and therefore an increase representation of their views. Alternatively Perseius et al. (2003) stated they could have asked for both positive and negative directions in their questions. Only participants who completed the full 12 month DBT programme were interviewed. This potentially results in a natural bias as interviewing participants who did not complete for any reason may have yielded negative responses and presented a balanced view.

Cunningham, Wolbert, and Lillie (2004) conducted a second study that aimed to understand what the effective components of DBT are according to the clients from an outpatient DBT programme based in Michigan, USA. Both this study and that conducted by Perseius et al. (2003) are based on the assumption that the DBT programmes undertaken by the clients have been successful. However, neither study stipulated how success was measured and by whom.

Cunningham et al. (2004) reported their results to show that the clients agreed that DBT was a life-changing therapy; it was also reported that the clients highlighted the value of the individual therapeutic relationship. In particular, validation and a lack of negative judgement were identified as themes in both Hodgetts et al. (2007) and Perseus et al.'s (2003) studies. Cunningham et al. (2004) showed that clients in this study reported positive effects for the areas of their lives that are targeted by the DBT skills modules, however this was in line with the questioning utilised by the researchers.

There is value in the qualitative research data provided by Cunningham et al. (2004) and Perseus et al. (2003); however, this type of focused and targeted questioning leaves little room for the clients subjective experience, as is the aim of the research presented here. The participants interviewed for the Cunningham et al.'s (2004) research spanned a length of time in therapy of between six months to three years, which can provide a wider breadth of experience than has been seen in previous qualitative research. The interviews were conducted by experienced ethnographic researchers who were independent from the DBT programme and at a time and place of the participants choosing, thus reducing the potential for bias.

Unique to the Cunningham et al. (2004) research is the provision of data pertaining to parasuicidal behaviours previous to the DBT programme and during the DBT programme. Unfortunately there was no speculation from the researcher on any relationship between this information and the resulting qualitative data, however it poses the question of the potential impact of the relationship between severity in BPD symptomatology and the experience of completing a DBT programme. Quantitative research presented was criticised for not controlling for this variable, having an awareness of this information may help to provide further insights deduced from qualitative data.

McSherry, O'Connor, Hevey and Gibbons (2012) completed semi-structured interviews and focus groups with eight participants who completed a modified outpatient DBT programme in Ireland. The programme ran for the standard one year, however individual therapy was replaced by group support sessions. The individual facilitators for these support groups were not therapeutically trained. The interviews were semi-structured and focused on the service users evaluation of the programme and how it had impacted their daily lives.

As with previously presented research, McSherry et al. (2012) have made an assumption that the DBT programme has indeed impacted the daily lives of the service users without providing the reader with a rationale or any evidence of this being the case. This paper produced both negative and positive feedback regarding the service users experiences, some of which may be attributed to the lack of adherence to DBT within the programme being offered, and a lack of intensive DBT training for the staff, rather than the features of the DBT approach. A lack of DBT training and the resulting lack of adherence to DBT can be seen to have an impact on the validity of the data in terms of the ability to accurately reflect a DBT programme in general, although when considered in the context of the specific programme of completion, the data can be considered representative of those interviewed.

This paper replicated the findings from Cunningham et al. (2004) highlighting a convergence in the service users opinions that DBT facilitated positive changes in their lives; importantly this was reported regardless of the time period participants were engaged in therapy. McSherry et al. (2012) reported that because of the shared experience within the skills group component of the DBT programme, there was a shift in identity for the service users and a normalising of their experience of BPD.

McFetridge and Coakes (2010) completed an IPA analysis of both completers and non-completers of a DBT programme delivered within the context of a

therapeutic community. All clients who had begun the programme between the years of 2000-2007 were sent questionnaires and invited to attend a reunion day and provide feedback on their experiences either individually or within a group. Data from 11 clients including both verbal responses and semi-structured questionnaires were used for analysis.

Three superordinate themes were found in relation to change: changes in sense of identity, changes in life and changes in thinking. Researchers found that the qualitative themes mirrored those found within the quantitative data. This research contributes to existing literature by showing that the experience of completing a DBT programme affects personality change as well as behavioural change. McFetridge and Coakes (2010) stated that they found that those clients who did not complete the DBT programme were potentially not suitable for the approach, supporting the notion that treatment should be dependent upon individual client formulation, rather than diagnosis. This research is unique to the current body of qualitative research by conducting a mixed methods design. By including both completers and non-completers of the DBT programme, the researchers showed a tenacious approach in contacting clients spanning a seven year period, thus providing longitudinal data which is not yet replicated in the literature elsewhere.

The above qualitative investigations into the experiences of service users and the effectiveness of the respective DBT programmes, provide us with enriched data which highlighted components of the individuals experience. It is important not to allow for generalisations from the data provided and to allow the nature of qualitative research to provide us with a unique and subjective interpretation that is not possible within quantitative measures. It is apparent that there is a lack of qualitative research pertaining to the experience of completing a DBT programme and that the research that does exist is limited primarily to an outpatient context with one example of a therapeutic community. Due in part to the methodological challenges (to be

discussed) present in providing qualitative data from prisoners there are currently no published examples giving a voice to this client population. Through the use of IPA the research presented here aims to convey the experience of completing a DBT programme for female prisoners diagnosed with BPD.



## **3.0 Methodology**

### **3.1 Chapter Overview**

This chapter will provide a rationale for the chosen topic and methodology of IPA. I will outline the philosophical underpinnings of this approach and show how the development of this approach lends itself as an appropriate method of analysis to the research presented here. Following this I will provide an explanation of my epistemological position.

I will then detail the practicalities of the research process including the research strategy, design, sampling methods, recruitment, and process of analysis.

The ethical considerations of conducting research with the dual role as both researcher and practitioner are considered and accounted for. Ethical implications of a wider context are discussed and accounted for. The chapter closes with an account of my epistemological and personal reflexivity.

#### **3.1.1 Research Aim**

The purpose of this research was to investigate the lived experience of completing a DBT programme by prisoners who have been given a diagnosis of BPD. There is limited quantitative and qualitative data available pertaining to the experience of prisoners completing a DBT programme and there is no data which can claim to provide prisoners with a forum to convey their experience which may then have the potential to inform clinical practice. Therefore the aim of this research was to provide this forum and contribute to the limited literature available.

### **3.1.2 Research Question**

What is the experience of completing a 16 week DBT programme by prisoners who have been given a diagnosis of BPD?

### **3.1.3 Research Design**

The research presented here is a cross sectional, small sample design utilising an interpretative phenomenological method of analysis.

### **3.1.4 A Qualitative Approach**

The aim of this research is to gain insight into the subjective experience of participants who have completed a 16 week DBT programme. The aim is not to uncover a universal truth or an external fixed reality in positivist, quantitative terms. There is no aim to be able to generalise results across any given population or to have a sample group that could provide this. In order to achieve the aims set out within this research a qualitative methodology is deemed as most appropriate, as qualitative methods seek to understand how people make sense of their world and attribute meaning to their experiences.

Qualitative methodologies allow for individual differences and the subjective nature of peoples meaning making. Second to this is the philosophical positioning of qualitative methods, which allows for culture, context and time period to be considered in relation to this subjective experience. This is considered as important and relevant to the research presented here due to the evolving conception of

personality disorder diagnosis (Skodol, 2012), the recent emergence of DBT as a targeted therapy for BPD (Linehan, 1993a), and the current political agenda within the prison estate to address personality disorders and recidivism (Bartlett, 2007). It is due to this multi-faceted approach to understanding human experience that a qualitative approach was employed in this research.

Specifically IPA as proposed by Smith, Flowers, and Larkin (2009) has been utilised as the method of qualitative enquiry. This is due to the research aim of illuminating the subjective lived experience of participants. It was considered that the aims of other qualitative methodologies such as thematic analysis, patterns in the description of phenomena (Willig, 2001), grounded theory, generating theory facilitated by the defining of categories (Willig, 2001). Narrative analysis, the construction and representation of experience through stories (McLeod, 2001), and discourse analysis, the role of language in constructing social and psychological life (Willig, 2001), were not targeted precisely to the directive of this research project. The following section explores the facets of experience and interpretation further in defining the appropriateness of IPA.

### **3.1.5 Philosophical Paradigm**

#### **3.1.5 i) Phenomenology**

In the endeavour to define a method of gaining access to the essential qualities of human experience, Husserl (1927) developed a philosophical approach to research, termed phenomenology, which is concerned with uncovering unique human experience in order to illuminate the phenomena in question to others. Husserl stated that a return to the specific phenomena in question is needed in order

for subjective understanding to be gained. This is made possible by bracketing previously held knowledge and understanding. The work produced by Husserl was largely concerned with transcendental processes on an individual level, such as awareness and consciousness of something in particular, be it an object with a physical form or a process or concept without a physical form such as an experience, memory or feeling state. In order to access the essence of a phenomena Husserl proposed the concept of eidetic reduction to be applied through a number of techniques that could enable the invariant properties of the phenomena under investigation to be illuminated and communicated.

Husserl's work progressed to explore consciousness in itself. Husserl aimed to be able to bracket the content of consciousness in order to examine it, the process of which is termed as transcendental reduction, whether or not this is possible remains unanswered. Husserl saw science as a second order knowledge system that is dependent upon our experience and understanding of the world as first order. This seems to be of particular importance for the research presented here when considering the use of diagnosis within the participant group, and the forensic context as the setting for the phenomena under investigation (such as the experience of completing a DBT programme in prison). The difference being that Husserl was concerned with understanding the overarching essence of experience, whereas in line with a psychological perspective this research is concerned with the individual experience.

Heidegger (1962/1927) emphasised the ontology of the existing approach to phenomenology and focused on the hermeneutic and existential principles of phenomenological understanding. Heidegger's approach highlighted what has been termed as the 'worldliness' of interpretation: a way of being in the world as opposed to being subsumed in the world. In a move away from Husserl's understanding of

phenomenology Heidegger proposed that nothing could be known without interpretation. In his now infamous book *Being and Time* (1962), Heidegger conceptualised Dasein, there-being, or interact with the other, as the true quality of a human being in order to emphasise existence and how existence comes about and is understood through the interactions we have with others and the physical world and the resulting meaning and interpretations we make upon them. Heidegger's work also recognised how there-being, and the interpretations we make, can be recognised as encompassing self reflection, affect awareness, society, culture, and time, each of which also interact with each other.

Merleau-Ponty (1962) proposed an embodied understanding of the individual's relationship and interpretation of the world. He shared Heidegger's perspective of an interpretive and situated understanding. However Merleau-Ponty added to this the body as a vehicle of relating and understanding the world as external, but as interacting with this body as the first point of reference from which all else exists and is experienced. Following this is the assumption that we can never access the exact experience of another, as by its very nature the others experience is embodied in the perspective and experience of the other.

Important for the research presented here, Sartre (1956/1943) recognised that the self we experience is a continually developing process and that we are always in the process of becoming. Unlike those before him Sartre also recognised that the absence of something gives it an essence as much as the presence of that thing can. Sartre's understanding of phenomenology brings together Heidegger's understanding of worldiness, and Merleau-Ponty's explanation of embodiment. Sartre then adds to them with his understanding of the interaction of affect, interpersonal experience, and morality.

### **3.1.5 ii) Hermeneutics**

Hermeneutics is the theory of interpretation (Smith et al., 2009) of which there have been several theories adopted by qualitative researchers. Those underpinning the IPA methodology are discussed. Schleiermacher (1998) proposed an understanding of interpretation as being both grammatical (a precise and literal associated meaning) and psychological (an individual representation of the source); for Schleiermacher it is the interaction of these two concepts that allows for interpretation to be gained by another. Indeed Schleiermacher suggested that it is possible for the analyst to gain an awareness of the source that may be outside of the sources' own awareness.

For Heidegger (1962/1927) phenomena emerge once under scrutiny; Heidegger identified that phenomena consist of both the seen and the unseen, which are both connected and unconnected. This is what led Heidegger to the hermeneutic understanding phenomenology as it is the seen aspects, and our interpretation of them, that can lead to the knowing of the unseen aspects, which then repeats itself, as more becomes known, more can be known, albeit through this cyclical process of interpretation. This understanding of interpretation led Heidegger to question the concept of bracketing proposed by Husserl. Heidegger felt that it was not possible to not be influenced by prior knowledge, however it is suggested that the prior knowledge can help to gain new knowledge and to test its validity. For Heidegger this worked both ways, whereby new knowledge may refute an existing belief and help to form a new belief. Second to this, and a belief shared by Gadamer (1990, 1960) is the idea that prior knowledge can also be framed as preconceptions; however these

preconceptions may be unconscious to us prior to interpretation. These preconceptions may only become clear to us once the process of interpretation has begun. Taken in its entirety Heidegger's work can be understood as meaning that one goes back and forth from data to interpretation, to data to interpretation, all the while focusing on the seen aspects to gain awareness of the unseen aspects, which once become seen and are focused on give rise to further unseen aspects.

As well as sharing Heidegger's (1962/1927) understanding of preconceptions being dynamic and intrinsic to the interpretation process; occurring throughout and emerging from within. Gadamer (1990/1960) also highlighted the importance of time within interpretation. Gadamer disagreed with Schleiermacher's (1998) belief that an analyst may gain meaning that is unavailable to the source. Gadamer distinguished between meaning and interpretation attributed to the text and the understanding and interpretation attributed to the source, for Gadamer there was a gap between the two. For Gadamer, accessing the original meaning is mediated by the historical gap as meaning can only be interpreted in the context of the present, and the present will have an influence on the meaning interpreted.

A shared concept in hermeneutic theory is the hermeneutic circle. This can be explained as the understanding and interpretation of each part contributing to the understanding and interpretation of the whole; it is the process of going back and forth, from part to sum, with reflection, to gain awareness and insight, which then leads to interpretation and meaning making. It is also the assumption that one makes sense in the context of the other, and that meaning is lost when the analyst does not consider both the part and the sum of the parts, and the interaction between them.

### **3.1.5 iii) Idiography**

Idiography can be understood as focusing on the particular (Smith, Flowers & Larkin, 2009), idiography is in contrast to generalisations or governing rules, and yet embedded within it. As within generalised rules must lay the particular, of which detail and a deeper level of understanding can be gained. Thus idiography can be seen as contributing to governing laws through a different route than traditional nomothetic routes. Idiography, a focus on the particular, can enable an insight of variability, which can then inform a generalised view that becomes more representative of both variance and concurrence when applied to the interpretation of any given phenomena.

### **3.1.6 IPA, overview and philosophy**

Drawing upon the aforementioned philosophical positions is the methodology IPA proposed by Smith et al (2009). IPA focuses on how people make sense of and attach meaning to their life experiences. IPA draws upon Husserlian (1927) phenomenology by returning to the thing itself, and exploring the consciousness of the individual. IPA embraces bracketing. Whilst the method also recognises a limitation to the ability to entirely bracket, IPA manages this through the reflexivity of the researcher.

IPA draws upon a Heideggerian (1962/1927) understanding of our being in the world as temporal and always being in relation to something of which meaning making is rested upon, therefore highlighting the importance of hermeneutics. Merleau-Ponty's (1962) emphasis on embodiment is central to IPA in that our being in the world is mediated throughout being in the world in a body, of which our existence, as it stands under this investigation and within this description, denotes our ability to experience. Sartre's (1956/1943) addition of the interpersonal, affect and moral perspective is also linked to our being in the world according to the



meaning making we place upon it. How this interacts with our experience provides a route of enquiry for the IPA researcher.

IPA utilises Schleiermacherian (1998) ideology of grammatical and psychological interpretation, whilst also honouring Sartre's understanding of what is not there having a presence. The IPA researcher has the interpretive autonomy provided by Schleiermacher to use what is present to decipher meaning from what is missing, as is seen by Sartre. The understanding of bracketing provided by Husserl (1927) gives rise to the double hermeneutic seen within IPA. Firstly, it is the researchers interpretation, of the sources interpretation, of the phenomena under investigation, which is being generated. Secondly, the hermeneutic process comprises of going back and forth, from data to interpretation, whilst which the researcher must also maintain an awareness of their preconceptions that are held both prior to, and emerge during, this interpretive process. For the IPA researcher this awareness is facilitated through the process of reflexivity. Embedded within this interpretive process is the hermeneutic circle, which is understood as working through data both in the parts, and the sum of the parts. With the awareness that one is grounded in the other, and both can give rise to meaning making interpretation and understanding.

IPA is idiographic in that it utilises small, purposively selected samples in order to facilitate a detailed, in depth understanding of a particular phenomenon under investigation. IPA begins with a detailed individual understanding before using this to inform a unified understanding of the phenomenon in general. This understanding is specific to the time and context in which it is gained.

In line with this the epistemological position of this research is in the centre of the realist-relativist continuum, adopting a constructivist paradigm where by the interpretations made are based on the assumption that one can gain access to an

individuals meaning making experience. The resulting interpretations are bound by the temporal, social, and cultural context in which they were gained. IPA supports the relativist ontological position of this research as understanding the existence of multiple truths without a need for a universal truth. IPA adopts a symbolic interactionist approach which assumes that individual experience is influenced by a social reality; in line with a qualitative enquiry this does not need to be controlled for. However, the researcher does need to hold this information in mind when engaging in interpretation.

IPA can be criticised due to its reliance upon language as the medium for conveying experience (Willig, 2008). This criticism can also be understood in the context of the distinction between grammatical and psychological interpretation put forward by Gadamer (1990/1960). For Willig (2008), language is seen as constructing the experience, rather than the experience being adequately portrayed by language. It is suggested that emotions and thoughts cannot be accurately communicated through language and therefore some of the essence of experience will not only be constructed by language but also lost in the use of language as method of communicating the experience. IPA is reliant on the ability of the participant to be able to convey the complexity and multi-faceted texture of their experience.

The phenomenology of IPA is criticised by Willig (2008) and Langdridge (2007) whereby IPA is seen as a method of interpreting the thoughts of the participant, rather than the study of experience, which these authors suggested is phenomenologically pre-cognition. Smith et al. (2009) addressed these criticisms through their explanation that IPA does not just target cognition in attempting to illuminate experience. They postulated that the IPA researcher manages this through the targeting of awareness and conscious experience of the participant, such as the

pre-reflective reflexivity and intuitive reflection, along with the participants meaning making and sense making of the phenomena under investigation. Second to this is the analytic process of enquiry followed by the researcher which is thorough and multi-faceted leading to a comprehensive and rich data set that goes beyond cognition as it is traditionally utilised in qualitative psychological research.

In conflict with the above epistemological and ontological positions is the medicalised model of diagnosis and symptomatology of BPD, which is grounded within a positivist framework. Positivism makes the assumption that all information can be obtained through physically measurable data and reduced to a single objective reality (Willig, 2001). The medical model supports the use of the DSM-5 (2013), which is underpinned by an empirical evidence base. In aiming to understand and illuminate the experience of the women who had completed the DBT programme this research includes women who have been given a medicalised diagnosis of BPD as this is the inclusion criterion for the programme. The epistemological position of this research views diagnosis and the grouping and reduction of symptoms into labels such as BPD as a social construction. In considering the aetiology of BPD, literature has been presented that widely supports a bio-social model, which depicts that the development of BPD is reliant upon an interaction with both biological and environmental factors. The lack of prevalence of personality disorders beyond cultures dominated by the medicalised model supports the idea that some illnesses are embedded within cultural meaning, and socially constructed at the experiential level.

Notwithstanding the positivist framework embedded within the medicalised model of diagnosis, as seen within the culture and context relevant to this research, a pragmatic approach is utilised in the understanding and reiteration of the research aim to illuminate the experience of women who had completed the DBT programme

within the prison, which therefore includes those who have been given a diagnosis of BPD. In line with Husserlian (1927) phenomenology and the chosen methodology, this research considers diagnosis to be a second-order knowledge system and dependent upon first-order personal experience.

In summary an IPA method has been utilised within this research due to the philosophical underpinnings of phenomenological enquiry and hermeneutic interpretation, within an idiographic context. This is considered as appropriate to the research aim of, investigating the lived experience, of completing a DBT programme by prisoners who have been given a diagnosis of borderline personality disorder. The results generated by this research are to be considered within a constructivist paradigm, whereby the results are considered to be based on the assumption that one can gain access to an individuals meaning making experience, and that the resulting interpretations are bound by the temporal, social, and cultural context in which they were gained.

### **3.1.7 The relationship between IPA and Counselling Psychology**

This research has been conducted as a requirement within the Doctorate of Counselling Psychology. Counselling psychology is defined by the British Psychological Society (BPS, 2005), Division of Counselling Psychology, as the area of psychology that ology that ychology that e of Counselling Psychology. Cby the results are considered to be based on the asadditional scientific psychology' (p. 1). In considering the aforementioned philosophy underpinning IPA and through utilising IPA as the method for this research I consider this research to address this guideline. As a practitioner-researcher the skills needed to effectively conduct research are inherent in the skills of a counselling psychologist. Reflective practice, bracketing, self-awareness, insight and the ability to link theory to practice, whilst simultaneously

formulating with the client at the centre, are the strengths of a counselling psychologist, for both a clinical context and a research domain.

The research presented here is considered to be highly relevant to counselling psychology in that it focuses on DBT, an approach that is grounded in the traditional psychological disciplines of cognitive psychology and behaviourism. DBT is growing in popularity (Swenson, 2000), and is considered to be one the leading therapeutic approaches in managing BPD. DBT is being also being utilised in the treatment of other personality disorders, and Axis I and Axis II diagnoses (Dimeff & Koerner, 2007). There is a lack of qualitative research concerned with psychotherapeutic approaches within a forensic context; the application of IPA to this research aim will contribute to the understanding of the service users experience.

### **3.2 Research procedure**

The following sections will outline the procedure followed throughout the research process including participants, sampling, recruitment, choice of data collection, process of analysis followed, ethical considerations and reflexivity.

#### **3.2.1 Sampling**

In line with IPA this study utilises a homogeneous, purposively selective sample. A snowballing sampling method (Langdridge, 2007) was employed whereby all women who had completed the DBT programme were eligible for inclusion; this was the only inclusion criterion. Exclusions would therefore apply to those women who did not complete the entire programme. This was to maintain homogeneity in the sample as it is was considered that women who had not completed the entire programme would not have undertaken the DBT programme experience under

investigation. Participants who had completed the DBT programme but were already involved in a second quantitative outcome measure research project, being conducted on behalf of Central North West London NHS Trust were also excluded from the potential sample. Exclusions may also have been made on an individual basis depending on the presentation of the potential participant, such as actively suicidal participants may be excluded in order to adhere to ethical considerations of safety and risk to the participant. Although considered, this was not the case following recruitment.

### **3.2.2 Participant Demographics**

In order to comply with confidentiality a full demographic breakdown of the participant group is not reported here due to the limited number of DBT completers targeted for participation in this research and the subsequent potential to be identified. Participants were all female, currently housed within the prison, and aged between 19-42 years old. All participants had been given a diagnosis of BPD as assessed by the Structured Clinical Interview for the Diagnostic Statistical Manual IV (SCID II). This diagnosis was for the purpose of inclusion to the DBT programme and may not have been identified previously. People who were not deemed as being appropriate for a BPD diagnosis were not able to engage with the DBT programme.

Due to ethical confidentiality restrictions specific index offences and offence histories cannot be linked to specific participants. However index offences included murder, manslaughter, wounding with intent, aggravated assault. Offence history included the same and charges of grievous bodily harm, aggravated burglary, and robbery.

Three participants who participated in this research were actively self-harming prior and during their engagement with DBT. As a psychologist with experience in

working with self-harm I would define the self-harming behaviours of these participants as severe in nature. Each participant had a long history of engaging in self-harming acts over a number of years. The current acts of self-harm can be further understood as occurring daily, frequently requiring medical attention, and leaving deep and apparent scarring.

For the purposes of analysis each participant was allocated a letter to which coding was applied and utilised in the appended documents. During the write up of the analysis the letters have been replaced with pseudonyms as depicted within the table below.

### **3.2.3 Figure One Participant letter and associated pseudonym**

<b>Participant Letter</b>	<b>Participant Pseudonym</b>
A	Sharon
B	Natasha
C	Samantha
D	Gemma
E	Julie
F	Michelle
G	Mary

### **3.2.4 Recruitment**

The sample of potential participants consisted of eight prisoners who had completed the DBT programme and were not involved in a second research project being completed on behalf of Central North West London NHS Trust. Participation in

the research was on a voluntary basis; each DBT completer received an invitation to participate in the prison internal mail (see Appendix A). This described the nature of the research, the research rationale, what participants would be asked about and the reasons why. Potential participants were also advised that participation in the research was completely voluntary. Participants were also advised that declining to participate would have no repercussions, and no incentives were provided. Participants were advised that their information could be withdrawn at any stage, and that they could refuse to answer any question that they felt was upsetting, too personal or intrusive.

Prisoners do not have access to email, or a confidential route to advise if they wanted to participate. The office telephone number used to contact me is shared by a number of other professionals within the healthcare department. Therefore in order to adhere to confidentiality I personally visited each potential participant following receipt of the invitation to participate. This ensured that only I knew who was participating in the research. Upon seeing each potential participant I reiterated that there would be no negative impact to not participate and that there would be no incentive to participate. Of eight prisoners provided with an invitation to participate, seven advised they wished to and interview dates were arranged.

### **3.2.5 Semi-Structured Interviews and Procedure**

Phenomenological research stipulates that the aim of the researcher is to enter into the experience of the participants. In order to achieve this aim semi-structured interviews were employed, utilising open-ended, non-directive questions. Semi-structured interviews enable enough structure to focus on a specific research area whilst also giving flexibility to follow the subjective information and lead provided by the participant.



Interviews were conducted within the prison in a pre-booked room to ensure confidentiality and ease of access. The information sheet and consent forms were signed at the beginning of each interview. All security stipulations were adhered to ensuring the safety of both the participant and myself. I had full security clearance within the prison enabling me the mobility and flexibility needed to conduct research within this environment.

Before meeting each participant I checked the notes for each person on the prison recording system and the healthcare recording system. Together these records showed the medical and emotional presentation for each person, as well as their conduct within the prison regime. This gave me the ability to assess their current status in terms of taking due care to carry out the interview in an ethical manner. When I went to meet the participants at the agreed interview time each participant was asked if they wished to participate and given the opportunity to decline. I then personally assessed their wellbeing to proceed through enquiring as to how they felt that day and advised what the interview involved. Of seven participants, six were able to proceed as arranged. Due to a period of emotional instability and self-harming behaviour, one participant rearranged the interview from one set date to a date two weeks later. I then followed this procedure once more and agreed on that date with the participant that she was settled in mind and behaviour and able to ethically proceed at that point.

Interviews were approximated to take anywhere between 60-90 minutes. Participants were advised they could take toilet and cigarette breaks whenever they wished to. Following the interview I spent approximately ten minutes with each participant to ensure they were emotionally settled and able to return to their allocated landing. During this time I provided the participants with the debrief information sheet (see Appendix B) and discussed it with them. Participants were also given the opportunity to ask any questions.

In order to audio record the interviews security and ethical clearance had to be obtained locally from the prison. This involved following an internal security procedure to ensure the device was signed in and out each day that it was on the premises. In line with ethical guidelines and clearance granted by the National Offender Management Service (NOMS) the recordings are securely stored on site at the prison. Interview data was only to be made available to me off site once they had been transcribed. Transcripts were then encrypted with a password only known to myself and emailed via a secure connection.

### **3.2.6 The Interview Schedule**

Having an interview schedule is often seen as being in contrast to a phenomenological method, however Smith et al. (2009) supported its use as they advise that by preparing in this way the researcher is able to be more present and attend to the participants responses with flexibility. As previously stated the questions were open ended and non-directive in order to allow for the subjective nature of the participants answers to remain and be pursued.

The full interview schedule can be found in Appendix C In line with Smith et al. (2009) the interview questions can be understood as evaluative and contrasting. This enabled the participants to talk about varying aspects of their subjective DBT experience. The questions were centred on the therapeutic components of DBT in order to effectively enable the reflection of these parts. Questions were also structured to prompt a reflection on the potential impact and effect of having completed the DBT programme, therefore giving participants an ability to reflect on their subjective experience.

### **3.2.7 IPA Stages of Analysis**

I transcribed each interview verbatim, Willig (2001) suggested that if the researcher is interested in the subtleties of communication then transcription should also include fillers such as 'ummm', 'errr' along with other indicators such as laughter, pauses, volume and tone of speech, and interruptions. I felt that these subtleties provided a context and depth to the data that could be lost if only the spoken word was transcribed. For example within the data, at times, laughter indicated sarcasm and a pause showed a depth of reflection. In investigating the experience of the participant, transcribing these subtleties enabled me to stay close to the participants' meanings; they also provided a rich texture to the data, which helped to bring the data back to life during analysis.

IPA analysis follows four analytic stages. Smith, Flowers and Larkin (2009) provided a detailed account of the analysis involved in this methodology, however Smith et al. (2009) also stated that the researcher has autonomy over the analytical processes they utilise. Smith et al. (2009) stated that a researcher may move backwards and forwards through the stages, rather than a simplistic progression. I found that having this flexibility was useful to give depth to the analysis, and I was mindful to keep in mind the aim of IPA is to illuminate the lived experience of the participant and the meaning the participant attaches to that experience.

The stages of IPA can be summarised as the following: within the first stage the researcher repeatedly listened to the audio and read and re-read the transcripts. This enabled the researcher to become immersed in the data. I found that once I had re-read the transcripts a few times I began to naturally progress to stage two through the use of initial coding by making notes of my initial thoughts and observations that

came to mind during the reading. These thoughts were largely unfocused and took the form of questions, summary statements, associations, observations and descriptive comments.

During the second stage the researcher identified particular comments that were found within each line or section of the transcripts. It is important at this stage of analysis to stay close to the participant's descriptive meaning, whilst also engaging with the phenomenological understanding. Smith et al. (2009) suggested the comments are descriptive, linguistic and conceptual.

Descriptive comments would provide an overarching description of what the participant said, without moving too far into interpretation and staying close to the participants meaning. These describe the DBT experience as defined by the participant.

Linguistic comments highlight the participant's use of language, such as metaphor, silence, or repetition. Metaphors are also seen as a way for the clients to convey meaning beyond their own emotional articulation. Having a focus on linguistic comments within the analysis was useful for this research due to the DBT focus on metaphor. This focus gave rise to understanding a potentially deeper level of meaning, of which would be beyond descriptive commentary to gain.

Conceptual comments are used to illuminate the transcript and bring about interpretations that emerge from the participants' data. This may be gained through an overarching understanding of what the participant is discussing or describing. It also may take the form of questions generated from reading and re-reading the transcript. Smith et al. (2009) advised that there is likely to be some personal reflection at this level of analysis, which they encourage as long as this reflection is conducted with self awareness, insight, and in service of developing meaning from the participants data. In developing conceptual comments I continually returned to

the data to ensure that they represented an inherent quality of the data provided by the participants.

The third stage brings a structure to these initial reflections whereby the researcher lists themes and reflects on the relationship between them, thus developing emergent themes. As a result of this reflection themes are clustered according to those relationships. Those clusters are then given labels that convey their meaning. This process requires that the researcher moves back and forth from the original data to ensure that the original meaning and essence of the data is explicit to the clustering labels. This can be understood within the framework of the hermeneutic circle, whereby the data becomes a set of parts of which the researcher must see both the parts and the sum of the whole. Themes will reflect both the participants meaning and the researchers interpretation in relation to the meaning. In order to manage the evolving data Smith et al. (2009) suggested developing a table that incorporates the emergent themes, the original transcript related to this and the exploratory comments associated to this.

The fourth stage involves developing a summary table that makes a link or connection across these themes and moves towards developing a superordinate theme. This process includes both the labels of the identified themes and quotes to illustrate them. These themes are specific to the phenomena under investigation, this process requires an awareness from the researcher of the objectives of the research and their influence upon the data, reflexivity in the loss of some themes is essential to ensure the originality of the data survives this stage.

This process is then repeated for each participant. At this stage of analysis the researcher must bracket what they have deduced from the previous participants transcripts, in order to ensure that they are not led or influenced by another participants data. As a counselling psychologist bracketing is a skill inherent to

training; it is a significant strength of a counselling psychologist to be able to apply this therapeutic skill to a research discipline with awareness and reflexivity.

Once this process has been repeated for each participant the researcher must look for patterns across each participant in order to inform a cohesive discussion of the overarching superordinate themes that best answer the research question and convey the phenomena under investigation. Smith et al. (2009) suggested a number of enquiries to aid this process in recognising the relationships that exist between themes, how one theme can inform or support another at varying levels whilst maintaining individuality, such as a higher order theme may be shared whilst leading to a different superordinate theme. This is the strength of IPA in that it gives a contextualised and unified view across the sample of participants.

### **3.2.8 Research Credibility**

In assessing the value of qualitative research, Yardley (2000) proposed a four-fold structure of investigation that she suggested, if satisfied, can illuminate the quality of the research data produced and the resulting assumptions made upon it. These areas are sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

The research presented here can be considered as sensitive to context in that I have targeted a sample that is difficult to reach in the research domain and has a lack of current research utilising an IPA methodology, therefore conveying their unique experience.

Sensitivity to context is inherent in being able to complete this research project, as evidenced by four separate ethical board approvals, and the gaining of voluntary participants with no incentives to participate.

Sensitivity to context was demonstrated in the process followed through recruitment of participants and the conduct of the interviews. As fully detailed in sections 3.2.4 and 3.2.5 care was taken to ensure that confidentiality of potential participants was maintained, and that potential participants were autonomous in their decision to participate. Interviews were conducted in pre-booked rooms to provide privacy and a relaxing space to facilitate an ease within the interview setting. Care was taken to ensure participants were debriefed and safe to return to the main population following the interview.

Sensitivity to context was evident within the care and attention to detail involved in the process of analysing the data gained. IPA enables this to be the case and reflexivity shows the integrity of myself as a researcher in being sensitive to the participants and the data gained. In placing this research within the wider area of forensic BPD research available (see chapter two), I have shown sensitivity to context, the discussion provided in chapter five further supports this claim and expands upon how the data provided by the participants can inform clinical practice going forward.

Commitment and rigour is evident within this research through the preparation and conduct of the interview process. Great care was taken to ensure the safety of participants and minimisation of any associated risks to the process. As a counselling psychologist I feel I was particularly well placed to be able to interview with a reflective, engaged attendance to the participant, whilst bracketing my own assumptions and remaining impartial. Commitment and rigour to the qualitative research process is also evident in my training undertaken within IPA as a methodology, and my resulting adherence to this approach. The thorough approach to this research is evident in the production of the thesis, which includes details of sampling and ethical considerations. In evidencing commitment and rigour I have also included an example of the analytic process of coding according to IPA

principles in Appendix D which leads to the subsequent super-ordinate themes presented in chapter four. This shows the process of moving from descriptive coding to an interpretive stance.

In line with transparency and coherence is the detailed explanation of coding and generation of themes provided in section 3.1.13 of this chapter, as further evidenced in Appendix E. Section 3.1.9 and section 3.1.10 explicitly detail the targeting and recruitment of participants. This transparency provides the reader with the evidence needed to adhere to transparency. The thesis in its entirety provides a coherent overview of the research conducted. In the spirit of the hermeneutic circle the information provided within the discussion orientates the reader to each part of the research and how it operates together to form the whole.

This research is also transparent and coherent through the adherence to the underlying philosophical assumptions of the IPA methodology. IPA is influenced by the aforementioned philosophical positions (see section 3.1.5 and section 3.1.6) whereby IPA requires both phenomenological and hermeneutic insights, and an understanding that these insights are temporal and culturally bound. This ethos is particularly relevant to the research presented here due to the evolving nature of DBT as a therapeutic approach, the debated diagnostic criteria of BPD, and the contextual specifics of being a female prisoner within a British culture and at the time that this research has taken place (2014/2015). It has been important to recognise that IPA is reflective of a double hermeneutic, whereby it is the researcher's interpretation, of the participants' interpretations, of their experience, that is being analysed. IPA does not seek to uncover a universal truth or an external fixed reality in positivist terms. IPA does not seek to generalise results across populations: IPA endeavours to gain insight and communicate to others a particular individual's experience. These fundamental principles of IPA have been evidenced throughout



the gathering and reporting of data, therefore showing adherence to Yardley's (2000) concept of transparency and coherence.

The final principle proposed in assessing the validity of qualitative research is that of impact and importance. Due to the lack of current qualitative research in the area of forensic psychotherapeutic approaches to treating BPD this research is seen as important in the illuminating of service user experience and in the potential contribution to the understanding and delivery of current clinical services. Evidence of the lack of published research and therefore the potential impact of this research can be seen within the literature review (2.0) of this thesis. The impact of this research is evident within the results gained and reported in section 4.0. The impact across the wider clinical domain is explained in the discussion of results presented in section 5.0. As previously stated the limited qualitative research evidence understanding the experience of undertaking DBT for BPD within a prison setting is prohibiting the development of successful and replicable treatment strategies. Clinical implications derived from this research analysis which may have the potential to inform further practice are discussed in section 5.0, and are provided to support the principle of impact and importance (Yardley, 2000) in assessing the validity of this research.

### **3.3 Ethical Issues and Considerations of the Dual Role of Practitioner-Researcher**

It is important to note that as the researcher concerned I have a dual role of practitioner-researcher for the participants. I am a practising DBT therapist for the DBT programme under investigation at the prison. My role includes facilitating the skills groups and providing individual therapy. This means that I have had some previous contact with all of the participants, be it just for skills groups, or as was the

case for one participant, for both skills group and individual therapy. Smith et al. (2009) advised on building rapport with participants as this improves the quality of the data obtained during interview. Whilst taking into consideration the potential implications of this dual role, I felt that my previous contact with participants did allow me to have a rapport and was a strength of the resulting data gained.

It is important to note that the ethical considerations of the practitioner-research role are limited to a particular area because all participants had finished their DBT programme prior to their involvement in this research. Therefore the impact of the research upon the participants' current therapeutic experience was not a concern. However the impact of the existing relationship between myself as researcher and the participants, on the data gained from the interview, is important to recognise and will be discussed within the reflexivity section. It is also important to recognise the varying levels of contact I have had with the participants. I do not facilitate all of the skills groups; not all participants are present for every skills group. Therefore the level of contact between the participants and I was limited to approximately twice per month or less, over the four month period of the DBT programme.

Robson (2002) outlined advantages and disadvantages of the researcher-practitioner role; disadvantages include a lack of time, a lack of expertise, lack of confidence and insider problems such as power dynamics. Due to my intensive advanced training as a DBT therapist, and my DPsych Counselling Psychology training I was not concerned about a lack of confidence or a lack of expertise. A lack of time is also not a concern, as I completed the research outside of my normal working hours. It was important for me to be reflexive regarding the issue of insider problems, the internal politics of the prison environment were considered as I will discuss further within the reflexivity section.

The advantages of the researcher-practitioner role as outlined by Robson (2002) include insider opportunities such as having a pre-existing knowledge and

experience of the environment and people involved; it is also likely that implementation issues were reduced. Lastly, Robson highlighted that being an existing practitioner can provide unique insights into the design and analysis of data produced. It is apparent to me that this research would be more complex and possibly impossible to operationalize if I were not already practicing as a DBT therapist within the prison environment. Firstly, a researcher needs to gain ethical approval from four different governing bodies; the National Research Ethics Service (NRES), Her Majesty's Prison Service (HMPS) National Offender Management Service (NOMS), the local NHS providers Research and Development (R&D) department, and lastly the institution to which the researcher is affiliated, in this case City University London. In order to gain this ethical approval one must have an intimate knowledge of how the prison in question operates in order to show how one will be able to adhere to ethical considerations such as safety of the researcher and the participant, confidentiality, safeguarding procedures and security stipulations. My position in the prison meant that I have full systems access, which one would need to report a security breach or safeguarding issue if this arose during the interview or whilst on the prison premises. Secondly, if the research is ethically approved, security checks and vetting procedures can take upwards from six months. It is unusual for these checks and procedures to be approved without the person holding an employed position within the prison. Formal visits, legal and otherwise, are held outside of the internal prison area which then impacts upon confidentiality as the prisoner would have to be escorted there by a prison officer. Thirdly, in order for staff to be approved as a key holder, further training and security checks are needed taking upwards of a further six months. Again it is unlikely for this procedure to be approved without the applicant being employed within the prison services. It is of my advantage that I hold full security clearance; I am a key holder with access to all areas of the prison and an approved lone worker within the stipulations of the prison

regime. This is a significant advantage for me within the researcher-practitioner role, without which this research may not have been possible.

My insights as a current DBT therapist within a forensic environment have provided me with unique insights into the design of the research questions and the client group. Due to my knowledge I have been able to design an interview schedule that focuses on the specifics of the approach. I have an acute awareness of the current controversies and deficits in research when considering a forensic context. As a DPsych Counselling Psychology trainee with several post graduate qualifications I also have an awareness of the importance of remaining ethical and reflexive in order for the research to be ethically approved and hold clinical value upon completion.

Thompson and Russo (2012) write on the ethical considerations of the researcher-practitioner and suggested that a deontological position is appropriate, whereby rations of the researction must be assessed on its intrinsic qualities, independent of its consequences and outcomes' (p. 33). These researchers also highlighted the individuality of each case as grounded in context, culture, theory and political milieu. This approach is deemed as appropriate and relevant, and justification for the subject matter and context presented here. Yanos and Ziedonis (2006) suggested that participants are given a detailed explanation of the research, which includes a discussion of the dual role and its implications. I have considered this and included such information on the information sheet (see Appendix F). Upon recruitment for the research, the potential participants had the information sheet delivered to them via internal prison mail. This was in order to reduce the potential for the existing relationship between the participants and myself to have any influence on their personal decision to participate. Participants were made aware that the data, published or otherwise would be anonymous, therefore there could be no positive implications towards sentencing, parole, privilege level or reputation within the

prison. This also meant that participants were aware that they were able to be honest and negative if they wished to be, inclusive of aspects of the programme, staff and prison regime without any repercussions. The awareness of the participants that this was the case was evident in the data gained from interview.

Participants were advised that confidentiality was assured within the boundaries they were used to within the context of the prison regime. This meant that any information disclosed by the participants that was a breach of prison rules or that put themselves or others in danger would be reported in adherence with the usual prison stipulations. It is a strength of the researcher-practitioner role that both I and the participants involved in this research were familiar with the limits to confidentiality within an intimate setting such as a therapeutic relationship, as this intimacy is somewhat emulated within the researcher-participant interaction. It is a skill of both the prisoner and the staff member within intimate settings such as these to communicate freely, whilst maintaining both professional boundaries, and the limits to confidentiality.

McLeod (1999) stated that 'a good practitioner researcher study will provide sufficient information on the personal engagement of the researcher(s) in the study, and their heuristic process, for the reader to make judgment concerning authenticity, 'ownership', and personal integrity' (p. 18). In order to account for this I kept a reflective diary throughout the interview and analysis process. I used this to record what came up for me throughout the interview process. I then reflected back upon it post analysis to see if I felt that my personal engagement had had any impact on the heuristic process. The insights gained from my reflective diary are discussed further in the personal reflexivity section of this chapter. I also undertook enhanced training in the IPA methodology through London IPA Training (<http://www.londonipatraining.co.uk/>). This was in order to help me to remain as objective as possible whilst simultaneously accounting for my subjective experience.

I have also been engaged in a supervisory relationship through City University, one purpose of which is to support and challenge my role as researcher-practitioner during the research through to completion.

I acknowledge that I will have some impact on the research interviews, and the process of analysing the transcript. In adhering to an IPA methodology it is my aim to be consistently reflexive and self-aware in order to know how my way of being has had an impact on the research and analysis, and in line with the above quote from McLeod (1999), therefore be able to highlight this to my reader.

### **3.3.1 Ethical Issues of a Wider Context**

Participation in the research is on a voluntary basis, and written informed consent (see Appendix G), was sought from all participants. Potential participants were provided with information sheets (see Appendix F), regarding the nature of what participants would be asked and the reasons why. The research information sheet also provided a rationale for the research, and information on how data would be kept confidential and anonymous. Participants were also made aware that they could withdraw their contribution at any time.

As previously stated confidentiality within the limits of the prison context was assured; all identifying information has been removed from the write up and any future dissemination of the results. Participants were also provided with a debrief information sheet (see Appendix B) following the interview, which included an email address which could be used to request access to the research upon completion. As previously stated participants were not explicitly incentivised for their participation. Speculation as to why the participants agreed to be interviewed include the individual benefit of time out of their cell and the wider awareness that the information they provided could help to inform future practice.

Raw data, including tapes, transcripts, and computer based data, have been stored securely for the five years stipulated by the NOMS and the BPS. These are locked and/or password protected where necessary, and will be destroyed according to the requirements of the Data Protection Act (1998) (DPA), the BPS Guidelines, City University London, NOMS, NRES and Central North West London (CNWL) R&D.

It was not anticipated that there would be any potential harm or risk to the participants in gathering the research data. However, in order to safeguard for any potential risks to the participants, all participants had access to their relevant DBT individual therapist post interview, if asked for or deemed necessary. The participant who was my individual therapy client had access to a different DBT therapist. Participants also had access to the usual prison safeguarding alternatives such as their personal officer, the prison listener service, and externally, the Samaritans.

It is an advantage to this research that I am aware of the prison safeguarding procedures such as alerting prison officers to the welfare of a prisoner. I also have the personal authority to open an ACCT document. Prisoners participating in this research were aware of this process and of my ability and professional responsibility to engage in this process if deemed necessary following an interaction of any kind, including both formal contexts such as the research interview, and informal contexts such as a casual conversation. If a prisoner is deemed as a risk to themselves or others, an ACCT document can be opened which results in enhanced observations and a comprehensive treatment plan to maintain the prisoner's safety. I did not have to utilise any of these protective strategies.

### **3.3.2 Ethical Approval and Permission to Proceed**

The research presented here adheres to ethical guidelines as stipulated by both the Health and Care Professions Council (HCPC) (2012) and the BPS (2010). Ethical approval has been awarded by CNWL R&D (See Appendix H), NRES (see Appendix I), HMPS NOMS (see Appendix J) and City University London (see Appendix K).

Each body has its own individual application process, each of which relies upon the ethical approval of another. Due to this research thesis being a requirement of the Doctorate in Counselling Psychology at City University London I applied within this institution first as part of the research proposal process. Once this had been granted I embarked upon the NHS Integrated Research Application System (IRAS), which is the route to obtaining NRES ethical approval which is needed for all research involving NHS patients. Healthcare services are provided by CNWL NHS Trust; this meant that ethical approval from this body was needed before I could proceed further. The IRAS process involves a substantial application form providing information pertaining to the aims and objectives of the research and how it is grounded within existing literature. Detailed information of the research procedure, recruitment of participants, and all information provided to the participants, such as invitation to participate, information sheet, consent and extended information on how I intended to safeguard the participants in terms of safety and confidentiality was also included. Details of the research strategy, methodology, and how the data gained would be stored securely and what the intentions were for the results obtained were also included. Following the written application I attended a peer reviewed meeting consisting of 12 members of the public sector in order for any further queries they had regarding the research process to be discussed in person. I was then required to make various amendments to the information sheets provided to participants



pertaining largely to the wording in order to ensure these were clear to the reader.

Following this, ethical approval was subsequently granted from NRES.

I then completed a written application to CNWL R&D, which largely consisted of similar information detailed above and provided within the IRAS application. This was reviewed internally and ethical approval was granted.

Only once I had ethical approval from City University London, NRES and CNWL R&D I was able to embark on the NOMS ethical approval application process. NOMS will only consider an application once full ethical approval has been granted from the previous bodies. It is considered to be politically correct to obtain local level approval from the Governor of the prison prior to applying for ethical approval from NOMS. This is due in part to the professional hierarchy in prison and secondly due to the eventual need for the prison Governor's approval before NOMS will provide ethical clearance to proceed. Therefore I emailed the Governor my research proposal and evidence pertaining to the ethical approval granted from NRES, CNWL R&D and City University London. I then had a meeting with the Governor in order to discuss the research aims, objectives and the potential implications of the results gained. Following this the Governor gave her support to the NOMS application process. I then completed the written NOMS ethical application form, which again consisted of similar information to that needed by NRES and detailed above. In addition to this NOMS required further information as to what the potential benefits and drawbacks might be resulting from the research to the local prison and wider UK prison service. The application was then forwarded to a local area NOMS representative who had an intimate knowledge of the prison. I was then made aware of local prison regime stipulations to the research, such as the security procedures relating to audio recording the interviews and securely storing information. I then interacted with the localised NOMS representative and the relevant staff members via email in order to initiate and operationalize strategies to adhere to these

stipulations, such as setting up password protected access to restricted areas of the internal computer base. Following this review and satisfying the additional security measures I was granted ethical approval from NOMS to proceed.

Due to the various procedural changes and amendments to the participant information sheet I then had to resubmit an ethics amendment application to City University London. Following the resulting ethical approval from City University London I was able to proceed with the recruitment process. In total I estimate that the process of gaining ethical approval from the relevant bodies specified here took approximately 18-24 months. This time period should be considered by researchers looking to conduct research within in this context. As previously stated my dual role of researcher-practitioner gave me an intimate awareness of the security and confidentiality requirements of the context under investigation and how to consider these when developing a research endeavour within an ethical framework.

### **3.4 Personal and Epistemological Reflexivity**

Reflexivity is considered to be a way of assessing the validity of research. It is integral within an IPA methodology to show how the researcher has impacted upon the research and how this has been managed. Willig (2001) highlighted two approaches to reflexivity: personal reflexivity and epistemological reflexivity. Personal reflexivity is concerned with the ways in which the researcher's personal values, experiences, beliefs, identity and political aims have impacted upon the research process and results generated. It is also concerned with having awareness on how the research may have impacted personally upon the researcher. Epistemological reflexivity is concerned with the philosophical structure of the research and should consider how each area was originally developed and why, and what the implications have been for the results.

### **3.4.1 Epistemological Reflexivity**

My epistemological position is in the centre of the realist-relativist continuum, I adopt a constructivist paradigm and therefore view that the individual participants experience and the interpretations I make of them are defined and further understood by the temporal, social, and cultural context in which they were gained. I adhere to a relativist ontological position of believing in the existence of multiple subjective truths. This approach is in conflict to the medical model of diagnosis, which is based upon a positivist paradigm and is the dominant model within healthcare services in the UK. As a counselling psychologist and a scientist-practitioner this can be seen as an epistemological conflict however I do not experience it as so. I believe that as counselling psychologists and scientist-practitioners we are in a unique position to be the change we wish to see in the health service by treating clients within the parameters of the philosophical paradigm that we adopt. Therefore I felt that the qualitative approach of this research, utilising IPA was appropriate in achieving this aim as the method does not seek a universal truth but attempts to illuminate the individual's subjective experience and communicate that to a wider audience. This method provides a different route to scientific knowledge to that of traditional empirical sciences, different but valid nonetheless. In engaging with research generation I believe counselling psychologists also have a responsibility to the participants of the research, to scientific knowledge and to humanity in disseminating the research findings as this will contribute to the momentum of evolution within traditionally held views on what is accepted as science and truth.

### **3.4.2 Personal Reflexivity**

The DBT programme that I was employed by within the prison was consistently challenged by funding issues due to a number of different reasons, one of which being it is a newly emerging therapy that is currently lacking a substantial evidence base for the context concerned. Quantitative research was being undertaken to address this, however I felt strongly that qualitative research could provide insights that would not be represented by the quantitative data. I felt lucky that due to my engagement with the DPsych counselling psychology thesis I could embark upon resolving this. I believed that gaining the experiences of the participants held value in developing the DBT programme in accordance with their needs rather than being solely politically led, as is often the case. I also felt that the participant's insights may contribute to the understanding of what, if any, are the effective components of change within the therapy, a second area of research that was lacking. Lastly I was motivated by my experience of the participants as being a neglected group within the wider research arena. My history of working with people who had received various personality disorder diagnoses was that therapy could be challenging and was often not the predominant source of any improvement in the lives of the clients. However working with DBT provided a different experience that I felt showed the potential to help people who found themselves to be in this marginalised forensic cohort and therefore warranted their input as to how they experienced it.

The biggest challenge I faced in completing the research was gaining ethical approval from the various governing bodies. Each approval was dependent upon another and could not be applied for until the previous had been fully granted. This meant that a considerable amount of time was taken by this process, which has impacted upon both the entire time involved and personal costs incurred in

completing a Doctoral thesis. My belief in the value of the research is what motivated me to continue despite the adversity inherent in the process.

The dual role of practitioner-researcher became a double edged sword, whereby it was perceived by some as a barrier to academic validity. However without this intricate knowledge of the safeguarding and prison security procedures, the associated security clearances, the depth of understanding in the therapeutic approach and the existing relationship with the participants, this research and the rich data gained may not have been possible.

I believe that the dual role has been a strength of the research presented here however I have managed the potential limiting impact by remaining reflexive throughout in keeping a research journal and having regular research supervision.

Upon commencing the research interviews I was no longer directly employed as a DBT therapist, this helped me to gain distance from and manage any potential bias generated by the motivations I had towards the clients, research topic and context. Lastly I engaged with a 2 day training workshop specific to the IPA methodology. This helped me to develop my skills as an IPA research and to become aware of motivations and agenda and bracket them in terms of the impact in analysing the data. The bottom line for me was that I wanted to give a voice to the participants and convey their experience to an academic audience with the rigour expected in order for their voices to be received.

## **4.0 Analysis**

### **4.1 Chapter Overview**

This chapter provides an IPA analysis of seven interview transcripts provided by the participants under investigation within this research. The analytic stages of coding are outlined within the methodology chapter, section 3.2.6.

In utilising IPA the themes presented here are an interpretation of the data gathered, and are considered, within the context of interpretation, to represent the central aspects of meaning that the participants attribute to their experience of completing the DBT programme under investigation.

In line with the ontological and epistemological positioning of this research these themes are considered to be representative of the culture, time and context in which the data was generated.

## 4.2 Overview of Themes

Six superordinate themes were identified and related to 17 subordinate themes, presented in Figure two. A full table of superordinate and subordinate themes and the supporting quotes is appended.

### 4.2.1 Figure Two: Superordinate and Subordinate Themes

Prison Life	<ul style="list-style-type: none"><li>• Less strife</li><li>• 'I can't win by fighting the system'</li></ul>
It's a Struggle	<ul style="list-style-type: none"><li>• DBT is hard</li><li>• The challenge of trust</li></ul>
Increased Connection to Others	<ul style="list-style-type: none"><li>• 'She's got her daughter back'</li><li>• 'More talking, less shouting'</li></ul>
Emotional Awareness - 'One Big Emotion'	<ul style="list-style-type: none"><li>• Emotional acceptance, 'It's ok to have emotions'</li><li>• Letting go of old behaviours, 'I don't do that anymore'</li><li>• Managing emotions, 'Another way'</li></ul>
Who Am I?	<ul style="list-style-type: none"><li>• Understanding me</li><li>• Learning to value myself, 'I deserve to be loved'</li><li>• Self acceptance 'I am a normal person'</li></ul>
The Bigger Picture	<ul style="list-style-type: none"><li>• Re-evaluate, 'stop and think'</li><li>• Gaining perspective of the other, 'I don't care about your pride, I care about my money'</li><li>• Empathic understanding, 'I go out of my way to sit and make sure they're alright'</li><li>• Taking responsibility, 'Own it'</li><li>• A positive outlook, 'The hard times go and you'll get the good times back again'</li></ul>

### 4.3 Prison Life

Participants stated that the experience of completing the DBT programme had an impact on their everyday life in prison for reasons attributed to emotional awareness, managing their emotions more successfully, and accepting their circumstances. This implied that they were able to negotiate the forensic environment in a manner that enabled them to achieve their needs. This also meant that the participants were less likely to be subjected to the consequences they had previously experienced with old behaviours.

#### 4.3.1 Less strife

Interestingly participants all agreed, in various ways, that there had been an impact on their everyday lives in prison. Gemma stated,

*'it's weird how the slightest thing can make such a big impact' (43), 'it's making my life a bit easier in here' (224), 'It's changed jail bigtime' (245)*

Gemma shows how she is surprised at the large amount of difference that doing the DBT programme has had on her life in prison. Gemma shows a disparity between what she had to put in and the gains that she experienced as a result. Gemma also shows that she makes a direct link between completing the DBT programme and an improvement in her experiencing of everyday life in prison.

*Sharon advised, 'It's made life in prison easier' (472), 'Cause if I've got any difficulties I know that I can go and ask for help now, whereas before I would, I wouldn't, or I'd end up getting in a fight or something' (474)*



Sharon shows that life in prison is easier because of her willingness to ask for help, and that by asking for help she is able to manage difficult situations and not become aggressive as she did previously.

Julie advised, *'it's not so daunting, you've got to live your life everyday, whether in prison or not, but there was that daunting side of prison, that's easier'* (228)

Julie shows that she sees prison as being more manageable since completing the DBT programme. Julie shows that she experienced life in prison as overwhelming and anxiety provoking and that this has either lessened or become easier to manage, contributing to an improvement to everyday life.

Further interpretation can be made to show that participants felt that the improvement to prison life is associated to their learning in how to manage their emotions. Participants showed that they understood that they previously engaged in behaviours that had negative consequences as a result of their emotional experience. Participants also showed that they understood that these behaviours and consequences had a negative impact of their life in prison. Participants explained that due to an emotional awareness they were able to employ different management strategies that were no longer to the detriment of their everyday life in prison.

Michelle states, *'I haven't been angry with other people when they get in my face'* (808)

For Michelle this meant that she was able to react differently to a situation that she would usually respond aggressively to.

Samantha further supports this development in emotional management and the benefit to her of being able to manage the prison environment.

*'no matter how angry I am when I'm trying to do something, or get something done, I don't lose it' (191).*

For Samantha this means a positive change, she suggests that previously she would 'lose it' and that now she is able to manage this differently, Samantha also conveys that she is able to manage her emotions regardless of how angry she is or what she is doing.

An improvement in prison life was also attributed to an improvement in the relationships between the participants and the prison officers. Gemma showed that changing her communicative approach had an impact on her relationship with prison officers,

*'like the officers and that, the way I used to speak to them before, 'cause that's improved now, I have banter with them though, I'm still cheeky, I just do it in a different way now, I just have banter and a laugh with them'. (85)*

Gemma shows that she understands that the way in which she spoke to the prison officers was promoting a negative response from them and that she has now changed that approach and is able to have a positive interaction with them.

#### **4.3.2 'I can't win by fighting the system'**

'The system' in the discourse used by participants, can be understood as the prison strategies used to manage negative behaviours, rule breaking, and risk to self and others. The internal systems and strategies form part of the community and culture within prison and was mentioned by all the participants in various ways. Sharon makes the link between acceptance of her circumstances in prison, and a change in her behavioural approach

*'I've accepted that I'm in prison, and I've accepted that I can't, I can't win by fighting the system' (139).*

Sharon shows that her acceptance of her circumstances led her to stop fighting against the systems in prison, meaning that she is behaving in adherence to the prison rules, rather than against them. There is an element of defeat and resignation in Sharon's statement, and also an element of peace that acceptance and not fighting the system has brought her.

As part of the 'Incentives and Earned Privileges Scheme' (IEP) prison officers, and other identified prison staff, are able to allocate a prisoner with an 'IEP' if their behaviour is in conflict with a prison rule. A succession of 'negative IEP's' can result in the prisoner being downgraded on their prison privilege level (ranging from basic, up to standard, up to enhanced and linked to an increase or decrease in pleasure items such as time out of the cell, freedom of movement, access to services, etc). Prisoners facing an adjudication for their 'negative IEP' behaviour may also be moved to the segregation wing (referred to as 'seg'), whereby they are housed in a

single cell with reduced time out of their cell and no engagement with the general prison population.

During their interviews participants used the reduction of prison penalties, and an improvement in their privilege status as a way to evidence the improvement in their behaviour. Mary advised,

*'I haven't been put on basic, I haven't been given IEP's, I haven't been put down to seg, nor have I been given an extra charge, so it's helped me, it's helped me quite a lot' (815)*

Mary states the improvement in her behaviour through the absence of prison penalties; she shows that she associates the lack of penalties to completion of the DBT programme. Mary shows that she has had a positive experience of the DBT programme in that it has helped her to not engage in behaviours that would result in her being penalised. Mary states the programme has 'helped' her and repeats this, showing an emphasis and meaning that Mary perceives the DBT programme to have facilitated this change.

The link participants made between completing the DBT programme and a reduction in their engagement with the prison adjudication system was further supported by Sharon,

*'I've come a long way, 'cause even like, erm, my parole officers have said that I've come a long way from before. Like with my behaviour, 'cause I've had no adjudications, no altercations with anyone since doing the DBT course' (120).*

Sharon uses the voice of others (the parole officers) to support her belief and statement that she has changed and that her behaviour has improved. This shows that Sharon is used to having to evidence herself to others for her opinion to be accepted, and potentially that she has a lack of conviction in herself. Sharon shows that she is able to separate her understanding of her emotions and her behaviours by associating the prison penalties to her behaviour only. Sharon also shows that she has made a direct link between this improvement in her behaviour and her completion of the DBT programme. There is a sense of pride in her statement. Gemma shows how a reduction in prison penalties can directly affect the quality of life in prison through the increase of their privilege level.

*'they wouldn't have enhanced me or anything before, whereas now I'm enhanced and everything, I'm good!' (44).*

Gemma is absolute in the language she uses to depict her experience, showing the scope of change she has experienced and her belief that she has moved from nothing to everything. Gemma shows that she sees the power to change her enhancement level as being outside of herself by using the term 'they'. However she then labels herself as 'good' showing that she has made a value judgement on her own behaviour and a further link from the judgement of 'good' to the increase of her privilege level.

In managing risk to self the prison allocate an ACCT document to any prisoner exhibiting an increased risk to self through engaging in behaviours such as deliberate self harm, and suicidal ideation, suicide attempts, and aggressive behaviours. This is an individualised document that provides an increase in appropriate care specific to the presentation of the prisoner. Participants noted a

reduction in both the occurrences of being allocated an ACCT document and the length of time they were on one for, as illustrated by Mary

*‘three weeks ago I self harmed but I was only put on an ACCT for two to three days, but that’s only a blip, compared to if I hadn’t have gone to this group I would have been self harming more’ (91)*

Mary uses the length of time for her ACCT document to be open as evidence that she now sees her self-harming as having reduced in severity and frequency. By referring to this incidence of self-harm as a ‘blip’ Mary shows that she no longer considers self-harm to be a constant in her life. Mary clearly states her belief that completing the DBT programme has helped her to reduce her self-harming behaviours.

*‘I was near enough always on an ACCT when I first come in but because of this group it’s helped me, to think, to use my skills’ (118)*

Here Mary again uses the reduction of an ACCT document to evidence her reduction in self-harm. Mary shows that her experience of the DBT programme is that it has given her an ability to reflect differently, ‘to think’ and to engage in a different behaviour, namely her DBT skills, rather than self-harm. Mary frames her experience as being ‘helpful’, showing the positive meaning she attributes to the DBT programme in relation to this example.

#### **4.4 It’s a Struggle**

Participants all gave meaning to their experience through the challenges they faced and overcame. The difficulties participants faced were varied across facets

such as the group environment and working closely with other prisoners, and understanding and utilising the skills. Participants highlighted the challenges inherent within the individual therapeutic component and the strategies used within the individual therapy to help participants to gain awareness and learn the skills. Participants were also challenged by the vulnerability and fear they experienced in embarking upon trusting one another and the DBT therapists. As Samantha advised

*'I'd be lying if I said I'd enjoyed it all because I didn't, but I learnt something new from everything, and so I did open myself up to learn new things. I might not necessarily have been enjoying myself as I was learning it, but I learnt it and that's what matters'*

(19)

Samantha shows the challenge faced in being willing to embark upon the belief that there may be another way to manage emotions and situations. By stating that it was not enjoyable Samantha shows how difficult it was to attend the programme and be willing to learn new strategies. Samantha shows that she sees the value in that learning process and she depicts that learning as what was important for her in the experience.

Participants showed that in their experience of the challenges they had to commit to the process of therapy. Following this, participants then experienced that those challenges became easier, as Gemma advised,

*'stick with it because sometimes it gets harder before it gets easier, and that's, the tough roads are really hard to get by'* (263)

Gemma shows how challenging it was for her to commit to the programme and see it through to the end. She describes the programme as 'tough roads' that are 'hard to get by'. This shows a double layer of difficulty and conveys the meaning of challenge that Gemma associates with her experience. Gemma shows the commitment needed by advising 'stick with it', suggesting that for her it was worth it in the end and the gains were worth overcoming the challenge.

Natasha advised of how her commitment to overcoming the challenges had resulted in a benefit,

*'just stick it out, it will help, you don't think you learn anything but you do, you do'*

(235)

Like Gemma, Natasha shows that a commitment is needed. She shows that she has made sense of her experience through the learning she has achieved. For Natasha, this seems to have a positivity attributed to it as she reiterates the learning she experienced.

Participants also showed that they valued the challenges they faced and as a result some participants had a personal learning experience that they were able to hold on to after completing the therapy programme. Michelle advised,

*'people have to struggle, do you get what I'm saying, to actually get somewhere, like,*

*that's what has to happen for them, like, to get a realisation'* (1589)

Michelle shows her belief that in order to achieve there has to be a struggle or challenge associated with that. For Michelle it seems that the definition of achieving



something is inextricably linked to overcoming the challenge within it. Michelle's quote lends itself to a process of enlightenment with words such as 'struggle' and 'realisation'. This can suggest that this is how Michelle experienced the DBT programme, in that it was a challenge for her, that brought her to a new awareness.

Sharon shows a unified view between struggle, commitment, and gain.

*'you gotta keep on doing it to benefit from it, but also to erm, not to give up because you won't benefit from it, because nothing's easy in life' (389).*

Sharon shows that for her a commitment results in the gain; she recognises the challenge inherent in this, however Sharon makes a wider reference to the challenge inherent in life in general. For Sharon it seems that she makes a parallel between completing the DBT programme and living life, in that both are challenging and only commitment can bring any rewards.

Some participants experienced a conflict between the endeavour of DBT to promote independence and positive change, and the inherent punitive environment and controlling systems in prison. Participant Michelle described her experience of completing DBT in prison and how she was challenged by trying to implement the DBT skills within the prison environment.

*'if you want the truth yeah, the truth of the matter is, all this [DBT skills] doesn't always work with them [prison officers]. If you kick or scream the loudest, or if they know you're going to go mad, that's when you get what you want, yeah, so this establishment is built on causing this behaviour' (1457)*

Michelle shows insight into the fundamental challenge in the prison environment of the behavioural dialectic between rewarding good and bad behaviour and the resulting reinforcement this reward brings. Michelle shows that she sees herself as having an awareness of how to get her needs met, and an awareness that this may not be in the most appropriate manner. Michelle shows her understanding of the ingrained nature of this problematic process.

#### **4.4.1 DBT is hard**

The format of DBT is unlike any other therapy offered within the prison. It constitutes group work to learn skills and individual therapy to reflect and apply them to the client's own life. Participants referred to the DBT programme as being different from any type of therapy they had experienced before. Samantha advised,

*'it was different for me to actually grasp the concept of what we are doing and what it's about, that's what took some time, but after that I got it and everything was easier'*

(132)

Samantha shows that there may have been confusion for her in the aims, structure and procedure of the therapy and that this took repetition for her to understand. Samantha shows how once she understood the process it became easier for her.

Gemma shows how her expectations for therapy were not matched with the actual process,

*'I just found it really confusing to start off with, I think it's just 'cause when you, because it's called therapy, when you think of therapy, you think of like psychotherapy and that, so that really confused me to start off with and I was like,*

*why do they call it therapy when it's not, but like, when I got the hang of it and that, with like the BCA's and that as well, you really like, I don't know, it really hits you like.'* (165).

Gemma gives an insight into the confusion experienced by stating that for her therapy means that of a traditional frame within talking therapies. This seems to have been her expectation. Gemma's experience was then confusing for her when her experience of DBT did not fit this. In common with Samantha, Gemma shows that over time she is able to understand the format and therapeutic strategies, which then, for Gemma, facilitates a significant process of awareness and learning. Gemma's use of language 'it really hits you' conveys the shock, immediacy, and strength of impact that she experienced.

In addition to the unique experience of the structure of DBT participants found the therapeutic strategies within DBT to be unlike anything they had experienced before. Most of the participants specifically mentioned the Behavioural Chain Analysis (BCA) as a challenge they encountered. The BCA is a diagram collaboratively created within the individual therapy session which focuses on a 'problem behaviour' encountered by the client that week. The problem behaviour is determined according to the hierarchy of targets for treatment, beginning with life threatening behaviours, such as suicidal or parasuicidal behaviours. Followed by therapy interfering behaviours, such as not completing a diary card or not attending a session, followed by quality of life interfering behaviours, such as aggressive acts or self-defeating acts. Once the problem behaviour is identified a chain is formed which defines and incorporates vulnerability factors, prompting events to the problem behaviour, consequences of the problem behaviour – positive and negative. Also included throughout the chain are felt emotions, specific thoughts, any other

behaviours and bodily sensations. Finally a solution analysis is developed involving skills use to manage the vulnerability factors and prompting event in order to not engage in the problem behaviour going forward.

Most of the participants mentioned the difficulty they experienced in completing the BCAs. Mary advised,

*'BCAs, they were awkward, the problem, no, not the problem, the probability, the prompting event, no the bottom one, the problem behaviour, we used to get stuck on that one, so yeah, the BCAs were a bit tricky to do, so yeah, we used to do them together, so that was the only thing that I found hard, was the BCAs'. (723)*

Mary shows the confusion in her experience of BCAs through the time she takes to reach the term 'problem behaviour', Mary shows that the experience of completing BCAs for her was confusing and uncomfortable. Mary shows the support she received in this by her individual therapist. For Mary the meaning attached to this experience is that it was difficult.

Gemma showed that once she had mastered BCAs she experienced the value inherent within them,

*'BCAs as well, they start off well confusing to start off with, and then once you get your head wrapped round them they're actually well helpful. Because when you, you can stand there and think that something's a problem, but actually, when you do the BCA you might not think, you might realise that it actually wasn't that in the end, it was something completely different and that shocks you a little bit, but then it helps you to overcome things more as well and deal with things in a better way'. (185)*

Gemma shows her experience of BCA's as confusing, she also shows that with repetition this confusion lessened and was replaced by understanding the format. Gemma shows that she experienced a process of self-awareness and a change of perspective that was facilitated by completing the BCA. Gemma shows the surprise that this experience of a new awareness and perspective brought her. Gemma shows that she has experienced an increase in self-efficacy to manage her problems and challenging situations as she repeats her ability to do so twice with differing angles.

In managing challenges the participants recognised a lack of consistency in the location of the allocated room for group skills as problematic. One of the rooms made available to the DBT skills groups is within the high dependence wing of the prison which houses prisoners with mental health difficulties, often incorporating psychosis and unpredictable behaviours. Mary states her dislike for this and the implication it has for her mood state and experience upon the beginning of each group,

*'you've got to be searched, and then you've got to wait, it's just ridiculous to be quite honest with you, it's stressful' (28).*

Mary shows that for her being searched and then waiting is an emotionally provoking experience. She conveys anxiety and anger through her description of the experience. For Mary this means that she experiences heightened anxiety directly before she enters the DBT skills group, which would then have an impact upon that experience.

Michelle highlights a different emotional implication of the high dependency wing,

*'I'm not trying to be horrible or nothing, but you see when I'm going there I feel like I'm being in a situation, yeah, 'cause say someone attacks me, yeah, I'm not saying anyone is yeah but I'm just saying for instance right, I feel like I'm in a high risk situation down there'. (1814)*

For Michelle the experience is also anxiety provoking. Michelle shows that her fear is created by her thoughts of the other prisoners on that wing and their potential to attack her. The implication of this for Michelle is that she is primed to defend herself. It can be suggested that this heightened emotional arousal would have an impact on her experience of the DBT skills group.

Participants all faced challenges within the DBT skills group environment. These challenges were in relation to getting to know other members, trusting other members, sharing their personal information, and sharing the space therapeutically.

Many of the participants likened the skills groups as an experience which reminded them of going to school. Most of the participants stated that they had a negative association to their education within schooling. This meant that the participants had a considerable challenge to overcome in committing to attending the groups, as illustrated by Samantha,

*'I didn't really have it good at school, all the memories I've got from school are not good, so the last thing I need is to feel like someone's patronising me when you're talking to me, because I will get angry because I wasn't at an age then but I'm at an age now where I can say something, but no, I didn't feel patronised once' (162)*

Samantha shows that her fear was centred on being patronised as this was her experience at school. Samantha shows her powerlessness that she experienced at

school and how she reacts angrily when she experiences this powerlessness now. It would have taken considerable courage for Samantha to attend the group with these fears in place. Samantha's experience shows how important the conduct was from the facilitators within the DBT skills group in providing a containing space for Samantha to overcome these fears.

Julie showed the difficult emotions she experienced in relation to likening group to school, and how she overcame this,

*'the nervous bit, the only bit I didn't enjoy is the going back to school malarkeys. That initial, 'oh my god, there's loads of people in here, don't know anybody', but as I said, straight away, 'hello my name's Julie', 'my names so and so', and it's, yeah it was great' (40).*

Julie shows that her experience of anxiety was in relation to being in a group of people whom she did not know. She likens that to similar circumstances experienced at school. Julie shows that she managed this anxiety by immediately approaching others and introducing herself, an act of courage that changes her experience and the emotional experience of the situation.

#### **4.4.2 The Challenge of Trust**

There was a link between vulnerability, trust and fear for the participants in relation to both skills groups and individual therapy. All of the participants spoke of the difficulties in trusting each other and trusting the DBT therapists. Sharon advised,

*'I think at first I found it challenging, like, to trust people, but I overcome that, so yeah, but that's just because I've got trust issues, it got easier because the course and the facilitators made it easier'. (76)*

Sharon shows that in her experience it was hard for her to trust people. Sharon also makes a tenacious link to her past experiences in referring to her way of being in general by stating that she commonly finds it difficult to trust people. This can be interpreted to show that past experiences have taught Sharon that people cannot be trusted. Sharon shows how for her the facilitators of the DBT group were instrumental in containing this mistrust and helping her to manage and move past it. For Sharon she was more readily able to trust the facilitators rather than the other group members, which then helped her to manage her vulnerability and be open in the group.

Within the group participants had weekly mindfulness exercises whereby they were required at times to close their eyes. Losing their ability to see in the presence of other people whom they did not trust invoked fear in the participants. As Mary advised,

*'I couldn't relax, the trust weren't there, so yeah, you've got to be in a good zone and place, and you've got to be able to feel at least like you can trust people enough to close your eyes' (524), 'anybody can do anything when you've got your eyes closed' (545)*

Mary shows that for her the experience of closing her eyes was anxiety provoking due to the presence of other people whom she did not trust. Mary shows that for her the possibilities of what may happen to her whilst her eyes were closed is endless;



this uncertainty both promotes and maintains Mary's anxious experience. Mary shows that this anxiety meant that she was not able to relax in this environment which would have had an impact on her overall experience of the group, making it difficult for her to remain present or engage in the learning. Sharon agreed,

*'in the group yeah, where you close your eyes and just let, like, take yourself somewhere else. I found that really difficult because one, it's closing my eyes in front of loads of people and it's like, 'God, I can't see now', 'cause my eye's are closed and anything could happen'. (374)*

Sharon shows that she had a challenge in closing her eyes and experienced anxiety in doing so. Sharon shows that, like Mary, she sees the possibility of what could happen as endless and this promotes uncertainty and is associated to her experience of anxiety.

For both Mary and Sharon the meaning attached to closing their eyes is that of danger, which promotes fear and anxiety. Mary made a link back to her childhood as to why,

*'I feel wary around a lot of people because of what I've been through when I was younger and stuff, it's hard to relax' (515)*

Mary shows here that she believes she finds it hard to trust people because of that trust being betrayed in her childhood. For Mary trusting someone means she is vulnerable to danger that which in her experience does come.

The participants were all able to cite trust as being essential within the individual therapeutic relationship in order for the individual therapy to hold value for them. Mary advised,

*'I felt like I could trust her, I could talk to her about other things that I can't really talk to other people about' (632)*

Mary shows that she had a unique relationship with her individual therapist that was built upon the trust she had in her. For Mary the experience of trusting her individual therapist meant that she was able to confide in her.

Gemma showed how she found it challenging to trust her individual therapist,

*'I just tried getting on with it and I just thought, they're still a person, they're still a professional, and they still know what they're doing, and they've still got the confidentiality rules so I should still try and trust her, so I did try, it's just really difficult' (215)*

Gemma shows how she engaged in a process of challenging her fears and thoughts associated to the fear in order to try to overcome her fear and trust her therapist. Interestingly Gemma makes an assumption that she 'should' trust her therapist, meaning that for Gemma she sees trust as being needed within this relationship. Gemma humanises her therapist and reminds herself of the boundaries in place to protect her in order to try and make it easier for her to trust them. Inherent to the meaning Gemma associates to the experience is the courage evident in her willingness to try and trust.

Samantha shows her understanding of how she had to be willing to engage and trust in the individual therapy,

*'the one to one's helpful, providing you feel like you can talk to that person, if you feel like you can't talk to the person, or even if you don't talk, you feel like you can, but you must don't want to, then that's a problematic situation, that's really problematic'*

(147)

For Samantha the willingness of the client to engage in therapy is central to the success of therapy. Samantha shows that for her the willingness is based on a feeling linked to her experience of the therapist in question. So for Samantha it seems she needs to like the therapist, or feel comfortable enough to be willing to trust and engage.

Sharon and Gemma showed how their individual therapeutic relationship evolved with the building of trust. Sharon advised,

*'I didn't really enjoy it at first, I felt uncomfortable, after about two weeks I started feeling more comfortable and then I was opening up more'* (460)

Sharon shows her emotional experience of being vulnerable and anxious in using the word 'uncomfortable'; Sharon shows that, for her, repetition and time spent with her therapist enabled her feelings of vulnerability to reduce which then allowed her to engage with the therapy.

Gemma supports the factors of time and repetition in the development of the therapeutic relationship,

*'because you see them every week, you get close to them anyway, you get friendly and everything' (175)*

For Gemma the consistency present in the therapeutic relationship was integral in the building of trust and rapport. For the therapist to hold this boundary of commitment, trust and investment in the relationship served as a behavioural model and enabled Gemma to do the same. Gemma shows that she sees her therapist as a friend in that she is able to be open and engaged.

#### **4.5 Increased Connection to Others**

Participants reflected on their experience of the DBT programme as having had an impact upon their personal relationships in a variety of ways that resulted in an increased connection and closeness. Julie states,

*'It's helped me to engage more with other people, erm and take their points of view on, and erm, make friends' (124)*

Julie shows that her experience of DBT has resulted in her being able to see the perspective of others, which in turn has enabled her to build friendships.

Samantha advised of the impact on her personal relationships that she experienced,

*'Any form of relationship, the relationship I've got with my mum, the relationship I've got in general, like, they're both affected by it because I'm at a point where I can actually look at a situation and take responsibility for it' (69), 'relationships in my life are affected massively by doing DBT I'd say' (90).*

Samantha shows that she attributes her ability to take responsibility for her actions to completing the DBT programme. She shows that she believes this ability to take responsibility has improved the quality of the relationships in her life. For Samantha, she has experienced a significant impact on her relationships and she links this directly to her DBT experience.

Participants made reference to the unstable nature of their personal relationships and how completing the DBT programme had helped them to manage this. Samantha advised,

*'DBT helped me in my relationship, yeah, because it's had a lot of highs and a lot of fucking lows, so learning about like, balancing priorities, like, it helped to know that there's a limit' (284)*

In this example Samantha shows that she is using the DBT skill of 'balancing priorities' to help her to manage the boundaries of behaviour within her relationship. Being able to assess a situation according to her own self-respect, her objective, and the maintenance of the relationship has helped Samantha to make an assessment on what is acceptable and when enough is enough.

#### **4.5.1 'She's got her daughter back'**

Participants each referred to an improvement in personal relationships as evidence for their increased connection to others, with the majority referring to familial relationships. Samantha spoke of the improvement in the relationship with her mother,

*'the relationship with my mum is like 1000 times better than it possibly could have been' (75)*

Samantha shows that she was not expecting the significant improvement she has experienced in her relationship with her mother. Julie spoke of the change she has experienced within the relationship with her daughter,

*'we've been able to have a good genuine deep chat and get on like sisters if anything now, which is great, yeah you know, stronger, a lot stronger'. (224)*

Julie shows that there has been a change in the communication style between herself and her daughter. Julie speaks of an authenticity and depth of connection between them. Julie likens the relationship to that of sisters in order to illuminate the closeness between them. Julie conveys happiness at this circumstance and shows that she feels the change is stable and consistent by repeating the word 'stronger'.

Participants spoke of their family members perceiving them and their behaviour as being transformed. In speaking about her mother Natasha advised,

*'she's even, she said I'm a different girl totally, she's got her daughter back' (49)*

Natasha shows the dramatic change she has experienced in others perception of her. The change in this description goes beyond behaviour and is presented as encompassing all aspects of Natasha. Natasha shows that for her this has meant she has re-established a relationship with her mother in a form that has not been present between them for a period of time. There is feeling of redemption conveyed

in Natasha's quote, and a sense of the relationship between mother and daughter being repaired.

In referring to her husband's opinion of her Julie advised,

*'he said 'whatever you're doing in there keep doing it, I like the new wifey!' (283)*

Julie shows that her husband is not aware of exactly what she is engaged in, however he is experiencing a different approach from her. Julie shows that she is receiving positive reinforcement for her new approach and encouragement to continue. Julie shows that this is a new way of being for her; she also conveys the closeness in the relationship with her husband and an affirmation of their marriage and commitment through him referring to her as 'wifey'.

A feature of the improved relationships was the participants' willingness to be open towards others which contributed to the experience of an increased connection with others. Julie advised,

*'it's made me feel like I can be more open with my kids as well' (214)*

For Julie this shows that she has had a transition in the way she approaches the relationship with her children. It can be interpreted that Julie feels she now has permission to let her real self be seen by her children.

Sharon also showed a willingness to be open with others,

*'I'm talking more, like if I've got problems, usually I don't just open up to my friends, but now I do, and it's easier having mates around you' (199)*

Sharon shows that she recognises the change in her approach as being that she is willing to talk to people and to be open and forthcoming when she does so. Sharon shows that she has experienced a personal benefit in this approach and an increase in the closeness she shares with her friends. Sharon conveys a humility in her experience.

#### **4.5.2 'More talking, less shouting'**

An improvement in personal relationships was facilitated by participants communicating more successfully with others. Natasha advised when referring to her mother,

*'The way I talk to her, I'm really calm with her and I don't swear at her, I don't call her names no more, I'm just really calm' (45)*

Natasha shows that there has been a change in approach to conversations with her mother. Natasha uses the reference to the absence of old behaviours to evidence her change in approach to communication. Natasha makes the suggestion that this new approach is consistently present across situations by reiterating that she is 'calm' after having noted her old behaviours. Here Natasha conveys a sense of peace and a slow pace to her reactions.

In referring to being less aggressive towards her husband Julie advised,



*'my husband will say to me, 'but why didn't you talk to me like that before?' Because I didn't know how to, I just didn't know (280)*

Julie shows that she attributes this change in communication style to her experience of and learning within the DBT programme. Julie conveys a sense of exasperation and sadness with herself in her previous approach, in that it was outside of her ability and awareness to respond in this new way.

Participants showed that there was a combination of self-awareness, and newly learnt strategies that contributed to improved relationships. Michelle illustrates her insight,

*'So rather than just talk about something, like, say this is how I felt, I'd just be angry straight away, and whatever was hurt, the most hurtful thing to say, is probably what I might say, because I wanted them to feel exactly how I felt. But they have got no clue why' (366)*

Michelle advises that now she is willing to talk to others. Michelle shows that she understands why she used to engage in a different approach, in that she would project her emotions, in this case anger, on to another person by way of both enacting revenge for her anger and also as a route to communicating how she felt without using words. Michelle rightly highlights that one of the problems in this route of communication is that the other person did not understand what her experience of the situation was. This insight and self-awareness has helped Michelle to engage in a different behaviour. There is a sense of hopelessness conveyed from Michelle in repeating her old behaviours, in that there was much effort involved on her part with no gain for her feeling any better in that moment.

Sharon showed that an awareness of her own process enabled her to act differently and improve disputes in her friendships,

*'whereas before I used to be proper stubborn, if I'd had an argument with one of my mates I just wouldn't speak to them, but now I just go up to them straight away, like, 'sorry' (201)*

Sharon shows a willingness to take responsibility for herself and her part in an argument. Sharon shows that she can see the benefit in her friendships in doing so. She shows an awareness of the negative impact her old behaviour of not speaking to them would have for her individually and for the friendship.

#### **4.6 Emotional Awareness –‘One Big Emotion’**

Participants each showed an increase in emotional awareness, both their own and in relation to their understanding of other peoples emotional experience. Each participant gave numerous examples and explanations of how their personal insight and self-awareness had facilitated an increase in firstly understanding their emotions, followed by accepting their emotions and further to this, learning how to deal with them differently. This process of awareness and management, was encapsulated by Samantha,

*'I've only ever learnt this in DBT, throughout my whole life, so, doing DBT helps you to be mindful, to work out what you are feeling, how that situation made you feel, why it made you feel like that, and to accept that you can't change it and it's happened'*  
(236)

Samantha shows that, for her, the process of gaining emotional awareness is broken down into smaller steps of reflection as applied to a specific situation. Samantha also frames this experience within the context of acceptance and change. Samantha places a positive value on this process by advising 'DBT helps you'. Samantha conveys a sense of surprise and enlightenment in her description; she also seems to convey pride in informing the structure of her learning and insights.

Participants all advised of how prior to completing the DBT programme they had felt confused with their emotions. Julie advised,

*'I was a very mixed up emotional person, I still am a bit, but not so much, where I would hold things in, I wouldn't talk about my feelings, I wouldn't talk to a lot of people'. (87)*

Julie shows that she has an increased understanding of her emotions. Julie uses a description of old behaviours to illustrate that she no longer engages in these. Julie conveys the sense that she can now respond to her emotions in a way that helps her.

Sharon advised of the confusion she experienced in relation to understanding her emotions,

*'I didn't want emotions and I never thought there were so many emotions, I just thought it was one big emotion' (98)*

Sharon shows that she had a difficult experience of her emotions previously; she also shows her surprise at the frame put around emotions as being separate, independent from one another and named differently according to the experience

they bring. Sharon shows how her previous experience was lacking this frame and therefore she experienced all emotions without, deciphering between them, under the label of 'emotion'. Sharon conveys a sense of naivety in her previous understanding of her emotions.

Participants gave meaning to the process of becoming emotionally aware by linking this understanding to their own experience. Mary advised,

*'DBT has helped me with the way I'm feeling and helped me to understand the way I feel' (998)*

Mary shows that for her there is a direct link between her increased emotional understanding and management, and her completion of the DBT programme.

Natasha conveyed how she experiences an increase in emotional awareness in relation to her own experience,

*'when an emotion comes up now, I know it's coming up because I know how I feel when an emotion comes up' (85)*

Natasha shows that she experiences emotions as a feeling that increases within her. Natasha shows that she is now able to recognise the change of feeling within her and attribute that feeling to an emotion. There is a sense of self-awareness conveyed in Natasha's experience.

Participants showed their benefit of being able to label their emotions and how this helped them to understand themselves and their emotional experience. Juile advised,

*'with my emotions as I said, it's made me realise that when I am sad, I am sad, when I'm happy, you know, I'm happy, and now I can talk about that' (114)*

Julie shows that she is able to recognise her different emotions and the different feelings they bring. Julie also shows that she is able to express to others what her experience of her emotions is. For Julie, this means that she is better able to understand herself.

Michelle shows her understanding of the links between emotions,

*'What I'm angry about I had to have a look more into because it's, it's not just anger' (360), 'What's underneath that anger?' (383)*

For Michelle there is a reflective depth to her experience; she shows that her awareness enables her to make a link between layers of emotions, and the use of emotions as a protective factor or defence mechanism.

Some participants made a link between their emotions and their bodily sensations, which helped them to understand their emotional experience, as Mary advised,

*'know my body's reacting as well to certain things, whereas before I wouldn't understand if I was shaking that I'm angry, and when I'm getting sweaty palms I'm getting angry, or when my posture changes, stuff like that, but now I understand my body signs as well' (1012)*

Mary shows that her experience of gaining awareness of her emotions has also helped her to understand her associated bodily sensations. Mary conveys a sense of realisation and relief at being able to make this link.

The group environment facilitated an increased understanding in the emotional experience of others, in observing expression of emotions in others Michelle advised,

*'I could see her whole demeanour change, yeah, you know like, when she didn't get her phone call, or the boy didn't say what, er, she wanted him to say, like, it ruined her whole week, and I thought to myself, you know what, maybe people are a bit more sensitive than what I give them for' (840)*

Michelle observed others in the DBT skills group and was able to see other participants' bodily reactions when talking about experiences that were emotionally provoking. For Michelle this helped her to see and understand how others were affected by their emotions. It also helped her to appreciate the genuineness in their experience, and evoked empathy for them. Michelle conveys a sense of interest and insight in observing others.

Julie showed how her experience of the group impacted upon her emotional awareness,

*'it got to the bit where I was sitting in front of everybody and I was accessing my feelings, so erm, every part, it's made an impression on me' (173), 'With going to the group I've been able to explain my emotions in depth, rather than when I came into prison' (270)*

Julie shows that being in the DBT skills group and discussing her emotions was initially challenging and exposing for her, she shows that there was a progression for her whereby she became able to identify and understand her emotions. This led Julie to be able to articulate how she feels and is experienced by her as a different way of being.

#### **4.6.1 Emotional acceptance, 'It's ok to have emotions'**

A significant step for the participants has been the acceptance of their emotions and how this has led to them employing different methods to manage their emotions. The shared experience between participants in the group was also important in normalising their own individual experience of their emotions. Mary advised,

*'you're not beating yourself up because you're crying, it's alright to be crying, it's a natural thing that everybody does it' (279)*

Mary shows that previously she would not allow herself to cry and would have self-defeating thoughts if she did. Mary shows that she now accepts her emotion of sadness and the associated behaviour of crying. She normalises the experience in two different ways to support this belief for herself. Mary conveys a sense of self-acceptance as well as acceptance of her emotions.

Sharon advises of her process of accepting her emotions,

*'I wasn't really aware of my emotions, well I was but I kind of didn't, I didn't accept them, I didn't want emotions' (97), 'it opened me up to realise that it's ok to have emotions' (105)*

Sharon shows that she firstly had to become fully aware of her emotions. It can be interpreted that previously Sharon was avoiding or suppressing her emotions. Sharon shows her self-awareness in that she is able to articulate that she previously did not want to experience her emotions and this led to her not accepting them. Sharon conveys a personally challenging and isolating experience of her emotions previously. Sharon shows that through a process of being willing to accept her emotions she has been able to have a better experience of them. Sharon now conveys a sense of being settled with her acceptance of emotions.

#### **4.6 2 Letting go of old behaviours, 'I don't do that anymore'**

Participants gave examples of behaviour they used to engage in as a result of their heightened emotional experiences by way of evidencing the fact that they do not do this anymore. Mary described such behaviours as

*'not sending nasty letters and not jumping the gun so quick' (224)*

For Mary this meant taking more time to reflect after an event that she found to be emotionally provoking, rather than responding on impulse.

Sharon advised of the behaviours she would commonly engage in prior to completing the DBT programme,

*'smashing TVs up, refusing to go behind my door, fires' (129)*

Sharon's previous behaviours were all localised to the landing that houses her cell, and related to anger outbursts at the boundaries being imposed upon her through the



prison system. Previously Sharon would react impulsively with anger when her needs were not immediately met.

Of the three participants who engaged in self-harming behaviours prior to commencing the DBT programme, each one advised how they attributed their reduction in self-harming behaviours to completing the DBT course. Sharon advised,

*‘while I was doing the DBT course, like my emotions, it helped me, because my self-harming, it stopped, by the time I’d finished the course, it’d stopped’ (149)*

Sharon shows how she links her experience of her emotions to her self-harming behaviours. She goes on to evidence the management of her emotions by stating that she is no longer engaging in self-harm. Sharon conveys a sense of surprise and finality as she repeats the word ‘stopped’. There is a conflict in Sharon’s statement as she shows ownership of her self-harming behaviours by referring to it as ‘my self-harming’, however there is also a sense of the self-harm being something separate from her self, by referring to self-harming as ‘it’, ‘it stopped’ and ‘it had stopped’. This can be interpreted as her perception of a lack of control over the behaviour, or is perhaps a defensive trait in order for her to remain at a distance from the behaviour.

In speaking about how the DBT programme helped her Samantha advised of her reduction in self-harming and her insights as to why she now does not engage in this behaviour,

*‘Like, prime example, I don’t self-harm anymore, I can kind of understand why I self-harmed now, because it was never about the issue, it was just about what I allowed*

*to become the issue' (95) 'I don't have to self-harm, and I don't even think about self-harming, for the simple fact that whatever it is I can deal with it' (101)*

Samantha shows that she has a new awareness into her thoughts and how she is able to manage her thoughts and perception of a situation, which then impacts upon the likelihood of her engaging in self-harm. Samantha conveys a sense of self-efficacy and empowerment in choosing how she receives and responds to a situation. Samantha shows that she has a choice in her reactions and the autonomy to choose whether to engage in self-harm or not; she shows that she has gained a confidence in being able to manage any challenge that she faces.

Mary advised of her experience in gaining skills and how this helped her to reduce her engagement in self-harm

*'so before I wouldn't think about distract, I wouldn't think about picking up knitting needles, ok I used to knit but that wouldn't be my main priority, when I had the urge to cut up, I would cut up but it's thanks to this group, this options that I haven't self-harmed' (98)*

Mary shows that for her having other explicit options of skills available, to utilise in place of self-harm, enabled her to manage the urge to self-harm and therefore choose to engage in a different behaviour. For Mary it was the explicit choice and knowledge of those choices available to her that enabled her to not respond to her learnt urges as she previously would. There is a sense of inevitability present in Marys depiction of how she would respond to her urges previously, which is now replaced by several choices of different behaviours. Mary makes a direct link

between her lack of self-harm on her engagement in DBT and frames this positively with thanks.

#### **4.6.3 Managing emotions, 'Another way'**

Following on from the participants' increased understanding of emotions and their acceptance of their emotions, was the awareness that they could also respond to, and manage, their emotions in a different way. As Julie advised,

*'it's made me realise there is different ways of dealing with your emotions' (177)*

Julie shows a realisation of choice and a subsequent empowerment in how to respond to her emotions. The other participants shared this experience, each of the participants were able to recognise how they utilise DBT skills in order to respond differently to emotionally provoking situations. Mary advised,

*'I'd retaliate, for example this morning, someone wound me up, someone really did wind me up and before I'd get in the persons face, I'd scream, I'd shout, I'd be disrespectful back to that person but instead I went off the landing and I went to the library and I didn't let it ruin my day or my morning, I just carried on' (197)*

For Mary this shows her being able to exert her autonomy over her emotions and impulses to act, there is a sense of achievement and pride conveyed in her approach.

The participants showed that completing the Behavioural Chain Analysis (BCA) within the individual therapy sessions had facilitated the process of learning new ways to manage their emotions. The process of breaking down their experience

within this framework has been portrayed by the participants to have helped them.

Michelle advised,

*'It was enjoyable for me, yeah, it helped me to get a realisation, like, I never really thought about the way that I look at things, and all that before, but then when something is in front of you, in black and white, it makes it different' (1252)*

For Michelle the BCA facilitated a gain in self-awareness and illuminated the perspective she was taking, Michelle shows that completing the BCA provoked her into thinking and reflecting on her perspective. Michelle conveys a sense of interest and intrigue at the processes involved.

Sharon showed that her learning and awareness of her emotions and how to manage them differently was facilitated by the process of completing a BCA,

*'doing that and then realising, learning from where the trigger points were, or your urges, and writing down what you could have done instead, so it helps you next time and then I got to the point where I was doing the BCA after I self-harmed but then I got to the point where I was doing them before I self-harmed, 'cause then I didn't self harm, because I was doing the BCAs and then I was, and I was realising that I could do something differently' (405)*

Sharon shows that her experience of completing the BCAs enabled her gain self-awareness into what triggered the urge to self-harm and helped her to actively engage in a different behaviour. Sharon shows that she received such value from the BCA tool that she was able to complete the BCA prior to engaging in an act of self-harm in order to help her to choose a different behaviour. Sharon shows her

experience as being empowering and with a progression in managing her emotions and associated behaviours.

Participants also showed that the process of gaining self-awareness into their emotions and learning skills to manage their emotions enabled them to experience an emotionally provoking event differently when it re-occurred. As Sharon advised,

*'if I got to a low point before, I wouldn't even go and ask for help or anything, I'd just, I'd just, just try and end things, whereas now, if I feel low, or I feel like, say suicidal, I will go and let someone know' (586)*

Sharon shows that she is able to understand her emotions and has an awareness that she has a choice in how she responds to them. Sharon shows that her experience of feeling suicidal has changed in that rather than responding to these thoughts and feelings with an attempt of suicide, she is able to make a different choice and ask for help. Sharon conveys a sense of willingness in her ability to respond differently.

Samantha advised of her experienced of responding differently to suicidal thoughts,

*'I come across an emotionally stressful situation, it could be with anything, first thing I think of is 'I want to die', that would always be the first thing that I would think of, I'm not saying I don't come across thoughts like that now, but I just know to accept that I thought that and throw it away, now I know that I don't want to die'. (34)*

Samantha shows self-awareness into the link between an external event, her emotions and her thoughts; she shows that she is able to apply strategies of

mindfulness to help her to manage these thoughts. Samantha shows a change in how she experiences suicidal thoughts, rather than accepting their validity she is challenging them and actively engaging in a different perspective. Samantha shows that she has experienced a complete change in the value she places on her life and her desire to live it.

## **4.7 Who Am I?**

Participants all showed that their experience of completing the DBT course had enabled them to gain an understanding of themselves in terms of their identity, who they are, why they are this way and further to this, to value themselves and see the similarities they hold with others whilst honouring the differences. Mary showed her experience of completing the DBT course and the impact it had for her in helping her to understand, value, and accept herself,

*‘Do it, because you’ll understand yourself, you respect yourself more, you really will, and you feel normal, you feel human, you feel alright and it’s alright to feel certain things’ (1040)*

Mary shows that, for her, in addition to understanding herself, inherent to her experience of DBT was that it was normalising for her, which enabled her to gain self-respect and accept herself.

### **4.7.1 Understanding me**

Participants were all explicit in their experience of self-awareness as a result of completing the DBT programme Mary advised,

*'to understand my mind' (71) and 'understanding myself' (305)*

Natasha advised,

*'Learning to get to know about yourself' (231)*

and Sharon advised,

*'knowing myself more' (566)*

For each of the participants knowing themselves and understanding themselves related to the same processes of emotional awareness, being able to make a link between thoughts, emotions and behaviours, and understanding their behavioural reactions and impulses linked to their emotions.

This process of self-discovery was challenging for the participants Natasha advised,

*'it's just, it's just scary, it's a weird thought 'cause I ain't known myself since I was 14'*

*(189)*

Natasha shows how, for her, coming to know herself left her feeling vulnerable and fearful. She also shows how unusual it was for her to have self-enquiry. Natasha states that she had not known herself throughout her adolescence; this promotes a sense of abandonment and loss.

Julie showed the need to be willing in this process,

*'you know, little things what I can, begin to express myself, good and bad, whereas*

*before I couldn't do it, I just wouldn't do it' (98)*

Julie shows that having self-awareness and understanding herself has enabled her to communicate the way she feels to others and that she is aware that she needs to be willing to want to express herself to others.

#### **4.7.2 Learning to value myself, 'I deserve to be loved'**

Participants all showed that they gave meaning to their DBT experience through an increase in value and self-respect for themselves. Samantha advised,

*'the fact that I actually learnt to value myself as a person, like, the fact that I actually found this next love for myself that I didn't even know was there' (280)*

Samantha shows that she has experienced an increase in self-worth, which, for Samantha was unexpected and previously unfathomable. Samantha conveys the authenticity in the way she feels by referring to it as a 'fact'.

Sharon shows what her experience of an increase in self-value is by advising,

*'before I didn't really give a fuck about myself' (583), 'it's helped with my confidence, trust, self-esteem, self-worth' (592)*

Sharon shows that she recognises an increase in valuing herself through the increase in her self-confidence, her ability to experience trust, and her self-esteem and self-worth. This multifaceted description conveys a sense of strength and resilience to Sharon's experience of herself. Sharon shows that she attributes this change to the completion of the DBT programme by contrasting the way she feels now against the derogatory way she felt about herself previously.



Mary advised of the impact of learning to value herself on her personal relationships,

*'I deserve to be treated well, and I deserve to be looked after, and I deserve to be loved' (376)*

Mary shows that in being able to value herself she has raised her expectations of how she wishes to be treated by others. Mary shows how multifaceted the implications are for her of having a value for her by repeating this principle of being treated well by others in three different ways.

Participants showed how not engaging in old behaviours helped them to gain value for themselves. Gemma advised,

*'I struggled to do it before, mainly because of negative comments about myself, like judging myself and that, I'm a lot less harsh on myself now' (119), 'before I would have battered myself on that, like, I probably would have tried to commit suicide'.*  
(122)

Gemma shows how she became aware of her self-defeating thoughts and engaging in judging herself, and how these thought patterns had a negative effect on her self-worth. Gemma shows how this pattern of thinking used to impact her emotional wellbeing and contributed to her engaging in suicidal behaviours.

Participants showed how they were able to be kinder to themselves now. Julie advised,

*'I feel more positive on myself, although I still got my ups and downs, but yeah, I'm definitely more positive' (103)*

Julie shows how she has lessened her engagement with self-defeating thoughts and how this has positively impacted on her self-value.

Mary showed how she approaches herself differently,

*'I'm liking myself, I look in the mirror and I like what I see, whereas before I'd put myself down and call myself names and stuff' (321)*

Mary shows practically how her approach towards herself has changed; she makes a link between her self-defeating thoughts and judgements and the negative impact this had for her. Mary conveys a sense of humbleness in her view of herself.

Participants showed that there was a relationship between an increase in value for themselves and the level of commitment they had to their self-development. Sharon advised,

*'I put all the skills in, 'cause even though deep down I might think, it's, I can't do it anymore, and I might feel like giving up, I'm still here, so there's still a part of me that wants to be here so I have to cling on to that part' (572)*

Sharon illuminates the struggle that she experiences in managing her distress. She shows that she experiences a conflict in thoughts; she shows a willingness to act upon the thoughts that enable her to live another day, showing an inherent value for herself. Sharon shows that she draws upon the skills she has learnt in DBT in managing this distress.

#### 4.7.3 Self Acceptance 'I'm a normal person'

In addition to the experience of an increase in self-awareness and value for themselves, the participants also advised of how the DBT programme had enabled them to feel 'normal', and like other people they observed. Participants showed that in accepting themselves and their emotions they were able to see the similarities between them and others. Julie advised,

*'I've still got little problems with my emotions but I think we're only human' (178)*

Julie shows that she has accepted her emotions and accepted the challenge they can bring her. This acceptance is also extended to herself as shown when Julie uses the plural term 'we're' and in using the adage 'only human'. Julie shows a convergence and solidarity with others.

Mary shows the impact for her of normalising her experience of her emotions,

*'I'm allowed to cry now, I know it's alright to cry. It's making me feel like a normal person, that I can do normal things, and I'm not going to be judged for crying' (285),*

*'it's trained my brain up to be a normal person' (408)*

Mary has given herself permission to experience her emotions; she has stopped engaging in self-defeating thoughts and judging herself. Mary makes a comparison between herself and others and considers herself to be normal now that she has given herself permission to feel. Mary frames the DBT experience as having 'trained her brain', this suggests that Mary experiences a difference in her patterns of thought

and experience of her emotions. There is a sense of relief conveyed through Mary's experience.

Participants highlighted the shared group environment as having had an impact on normalising their experience of themselves. In discussing the group Natasha advised,

*'I learnt more about myself and that there are people like me, and before I didn't know that, I always thought I was alone, and it's only me that feels like this, but it ain't' (64)*

Natasha shows that she was able to relate to the experiences of others in the group, which helped her to see that others also shared her experience of her emotions. For Natasha this helped her to feel connected towards the others in their shared experience.

Julie advised of how the DBT skills group contributed to her normalising experience,

*'that you are a person, you are valid, you know, it's not just about lock and key, it's about you as a human being and you have got that, without me going to this group I didn't see it that way' (238)*

Julie shows that her experience of engaging in the DBT skills group helped her to gain in value for herself, it helped her to see herself as similar to other people. Julie shows how, for her, participating in the skills group helped her to transcend the inherent imbalance of power within the prison, as represented by those with keys and those without, and see the commonalities she shares with others.

## 4.8 The Bigger Picture

All of the participants made a reference to their experience of completing the DBT programme contributing to their ability to now have a more holistic view of themselves and the world. Mary advised '*I see it, the bigger picture*' (1064), Gemma advised '*now I look at the bigger picture*' (109), and Julie advised '*its helped me in general look at the wider picture*' (134). This involved participants processing situations differently through taking more time to gather information pertaining to not only their own view-point but also the views of others. This also involved participants gaining an empathic understanding towards others, and allowing this to have an impact on their resulting behaviours. Within the context of 'the bigger picture' participants also spoke of taking responsibility for their actions and having a new awareness of the consequences of their actions, and how theirs and others lives are affected by their actions. The final facet of this theme is the positive outlook participants portrayed and have attributed to completing the DBT programme.

### 4.8.1 Re-evaluate, 'stop and think'

Participants spoke of the DBT programme helping them to slow down their reactions and employ a balanced and holistic frame in processing situations.

Samantha advised,

*'if I just ran with everything that's happened in my mind the amount of people I would have bitched over man, it's a joke, we'd be having this interview in the seg right now because I'd be living there constantly, so it's helped me to just stop and think more about what's actually just going on'* (298)

Samantha shows that she is aware that if she acted impulsively upon her thoughts she would receive negative consequences for doing so. Samantha shows that slowing down her reactions has enabled her to reflect and be balanced in her response. Samantha attributes this change in approach to the DBT course and frames it positively.

Gemma advised of her experience of a change in pace,

*‘when I was doing DBT, I don’t know, it just helped me to think’ (27), ‘I’m able to think about the situation more clearly’ (106)*

Gemma shows that she has gained the ability to reflect on a situation and have a considered reaction, she attributes this to the DBT programme. Gemma conveys a sense of simplicity in her explanation.

Michelle showed how she felt that her processing of situations had improved,

*‘it helped me a lot, because before that I didn’t really stop and think about things properly yeah, and I didn’t break things down properly, my thinking is very black and white, so I think that it helped me to process it a bit better’ (4)*

Michelle shows how she has slowed down her reaction and employed a method of reflection that encompasses taking into consideration a wider view. Michelle conveys a sense of correction to her previous processing style.

Mary made a link between a change in her thinking style and her emotions Mary advised,

*'it has helped me to calm down and not to self-harm so much and not to jump the gun so much as well, if it wasn't for this programme I would have been cutting up, and I most probably would have been on basic again' (34)*

Mary shows that she has slowed down her reactions and has decreased the intensity of her emotions. Sharon uses the example of a decrease in self-harming behaviours and the maintenance of her current prison privilege level to evidence the improvement in her thinking style. Mary places value on her DBT experience for the credit to this change.

Michelle shows that she attributes her change in thinking style to her experience of completing DBT,

*'This is the thing with DBT yeah, when you're in the class you think you don't get it, yeah, but then something will happen and you'll get some answers somewhere from something, something just clicks and you have to re-evaluate your thought process'*  
(326)

Michelle shows how, for her, the process of learning through DBT had to be lived, in order for it to be realised. Michelle shows how she went through a process of confusion that evolved into understanding and resulted in implementing a different thinking style of reflection.

Gemma gave her example of how she reassessed her thinking style following a mindfulness exercise that she took part in during a DBT skills group. During this exercise the participants were asked to suck on a sweet for three minutes, this sweet

is very sour to the first taste. After approximately 45 seconds the first sour layer melts away to reveal a sweet centre. The exercise is to provide a talking point for skills of distress tolerance and finding a positive in difficult circumstances. Gemma advised,

*'I'm not a sweet person anyway, and then sour on top of that was just like 'oh my god this is like my worst nightmare', but then, when it's like really sweet and everything at the end, and then you realise, and then when everything else gets put into perspective for you as well then, where it is like, it ain't just about a sweet is it, it's about when things go sour in life as well and then it just shows you they can turn out alright, like little things can have such a big impact like yeah, that was mad, proper'*

(149)

Gemma's experience of the mindfulness exercise is that she is able to apply the learning outside of the context of the sweet and to a wider perspective on her way of engaging with the world. Gemma conveys her surprise at the personal impact she experienced from this exercise.

#### **4.8.2 Gaining perspective of the other, 'I don't care about your pride, I care about my money'**

All of the participants showed that they were now taking other people's views into consideration and that this was new for them to do so, as Julie advised,

*'I do think that you've got to sit back a little bit, you know, and take other people's, you know, feelings and views into consideration, which as I said, before I wouldn't do that'* (162)



Julie clearly advises that she experienced a change in her ability and willingness to consider other peoples perspectives. Julie also showed that she sees time and space as essential to consider others.

For Michelle the ability to take another persons perspective was facilitated by the DBT skills group,

*‘there’s something that happens in group, that you feel like, you know, yeah, I’m going to sit and listen to this person, or, that might not be my view but you can get where they’re coming from’ (159)*

Michelle shows how the group environment facilitates the development of the ability to understand the perspective of another person simply by listening to their subjective experience and comparing and contrasting it to her own. Michelle shows how unique this experience was for her by assigning a mystical quality to it.

For Mary the ability to understand another person’s perspective was facilitated by the individual therapy session,

*‘I can’t remember the exact words, but do you think that you could be judging the wrong way? or, and she’d make me see things much more clearly’ (669), ‘because she used to ask me questions about it, she used to challenge me about it’ (682) ‘she made me see things from a different point of view’ (709)*

For Mary, she first had to work with her individual therapist to hypothesise what someone else’s experience and perspective might be. This helped her to develop the ability to look at a situation from someone else’s perspective and then engage in this

way of thinking outside of her therapy session. Mary advises how she was able to apply this skill to her own life,

*'if I didn't hear from someone for like a week, I'd think the person was taking the piss out of me and I'd end up writing a really long nasty letter to the person, but now I'm thinking that person must have stuff to do, they might have appointments, they may not be well, wait another week' (226)*

Mary shows her ability to take the perspective of another person and how this has had a positive impact on her relationships through her responding differently.

In speaking about an unprovoked incident that promoted anger, Sharon showed how taking the perspective of someone else into consideration enabled her to respond differently,

*'I just calmly thought, allow it, she might be having a bad day' (48)*

Sharon conveys a sense of mastery over her emotions when taking into consideration the perspective of the other.

The participants also showed how the ability to take other people's perspectives into consideration had impacted upon their personal relationships. Mary advised,

*'I give them a chance, and friends on the landing as well, like if (name removed) used to be asleep I used to wake her up and when she used to say, 'look I get an officer to lock my door', I used to take that as an insult, that she didn't want to be my friend anymore, and stuff like that, madness, winding yourself up in your head, but*

*now 'cause of relationship effectiveness, I think now more, it's not because she don't want to be my friend, it's because she wants more sleep' (340)*

Mary shows how she uses a combination of her DBT skills to assess a situation differently; she is able to view the world from a different perspective, other than just her own, and this has improved her friendships. Mary conveys a sense of satisfaction in her ability to do so for her benefit.

Understanding another person's perspective led to the participants experiencing empathy for others, as illustrated by Michelle,

*'but when I realised what it was, it's like her pride, her own pride, but before I wouldn't have seen that, I'd be like 'I don't care about your pride, I care about my money', 'why should I care about your pride and lose money?' That would have been my answer, 'cause that's how I would have felt but now I understand' (500)*

Michelle shows that she was able to see the perspective of the other and that this enabled her to respond differently to the situation by putting someone else's needs above her own, through taking a monetary loss herself and having empathy for that person.

#### **4.8.3 Empathic understanding, 'I go out of my way to sit and make sure they're alright'**

Participants gave meaning to their experience of DBT through their increase in empathic understanding. Participants all showed that they were capable of

accessing empathy for others, and that doing so had an impact for them. Michelle advised,

*'just taking into account other peoples thoughts and feelings around things has actually improved a lot of things' (81)*

Michelle shows her awareness at how considering others has had a positive impact for herself. Michelle conveys this as a new way of being for her, of which she is somewhat surprised at the outcome.

In illustrating their experience of empathy towards others Sharon and Julie gave examples from their landings. Sharon advised,

*'I kind of talk to everyone now, even if I don't get on with them, or I don't, don't know them, I will always go out of my way to make sure, like, if someone's upset on the landing and I see it, I go out of my way to sit and make sure they're alright, whereas before I kind of had, I'd be like, 'oh I'm not getting myself involved'' (257)*

Sharon shows that she has gained the ability to see the perspective of the other, and have empathy for that persons experience and in addition to this, respond to that persons needs. Sharon shows that a combination of a gain in self-confidence and emotional awareness has contributed to her having the courage needed to intervene and offer support.

Julie showed how her approach has changed,

*'make friends, yeah, make friends, you know, get to know that person for that person, rather than just being judgmental, 'oh you've got a dirty top on I'm not talking to you', whatever, and it's like yesterday, I gave someone my t-shirt and said 'clean yourself up a bit, you know, you want to feel a bit more pukka' (125)*

Julie shows that in seeing the perspective of the other she has also become less judgemental towards others. Julie shows how she has shown empathy towards another person and also made a personal sacrifice in giving this person an item of her clothing.

Sharon and Samantha both spoke of empathy towards the victims of their index offences (the crime for which they are imprisoned). Sharon advised,

*'I wish I could have asked for more help before I done the crime, and I wish I'd done the DBT course earlier' (497), 'I could have put myself in other people's shoes before' (511), 'just like with my victim, I feel bad for my victim' (517)*

Sharon shows how her experience of DBT has given her a different perspective of her index offence. Sharon states the value she has experienced in completing the DBT programme and how she feels this would have benefitted her prior to committing the index offence. Sharon shows how her ability to empathise extends to the experience of the victim of her index offence. Sharon conveys a sense of remorse and regret at her actions, and a sense of a lack of options available to her at that time.

In discussing any impact of the experience of completing the DBT programme in relation to her index offence Samantha advised,

*'I feel sympathetic towards my victim however I do not have to, that is a fact, but yeah, I feel sorry for the people, the person, times two, I think she was married, because thinking about how it probably impacted on them, so yeah, I feel sorry for them'. (212)*

In showing empathy towards the victim of the index offence, Samantha extends that empathy to the spouse of the victim too, in an awareness that the event would have impacted upon the people close to the victim. She defines the spouse as a victim in the event too. Samantha states the empathy she feels towards them both.

Interestingly Samantha views the empathy she feels as a choice she has made to engage in this feeling. This can be interpreted as a protective factor in order to manage any distress this feeling of empathy towards the victim could bring her. In contrast the authenticity of the statement could be questioned, prompting a debate in the genuineness of the empathy expressed.

#### **4.8.4 Taking responsibility, 'Own it'**

In making sense of their DBT experience participants all showed an awareness of responsibility and a willingness to own that responsibility for themselves; connected to this was their awareness of the consequences to their actions. As Mary advised,

*'if someone wound me up in the past I wouldn't think, right I could lose where I am now, I wouldn't be able to go to the gym, I'd just end up shouting, screaming, getting IEP's here, getting IEP's there, and being threatened to be put on basic. So now I weigh up the pros and cons, I think, if I do that, then this is what's going to happen, so it has helped a lot' (60)*

Mary shows that learning the skill of explicitly listing the potential outcomes/impact of a situation or event into good and bad has helped her to consider the consequences of her actions. Mary shows that she is now assessing a situation in terms of the consequences before reacting, which has resulted in her receiving less prison penalties.

Michelle also showed how the DBT programme had given her an awareness of consequences and impacted upon her usual way of being,

*'I'm just repeating a bad cycle that I always do, yeah, so I thought to myself, you know what, later on it's going to be bad for me. Like normally I'd just say, ah 'I just deal with the consequences of it when it happens' yeah, but I actually thought about it deeply and thought 'is it really worth it?' Do you get what I mean, like, because I know I shouldn't be doing it' (717)*

Michelle shows that, prior to the DBT programme she already had an awareness of the consequences of her actions but she would engage in the behaviour regardless. Since completing the DBT programme Michelle states that she is reflecting upon the situation at a greater depth and considering not only the consequences to the action, but also the inherent moral value in the action. This can be understood by Michelle advising she knows she 'shouldn't be doing it', suggesting a value judgement that the behaviour is wrong.

Connected to an awareness of consequences was the insight participants showed into the responsibility they hold for their actions Julie advised,

*'be responsible for, not only your reactions, but also for others' (324)*

Julie showed that she understands her actions will have an impact for other people around her. She uses this awareness to show that she now feels that she has a responsibility to own in how she treats other people.

It seemed for participants that through both an increase in self-awareness and an adapted process of thinking constructively about a situation they were able to view situations in the context of when to own their responsibility. As illustrated by Michelle,

*'I know that I'm in prison yeah, I've got to take it on the chin, because every action has a consequence, so I'm responsible, yeah, ain't no one else responsible, I'm responsible, so I don't want to be responsible again' (769)*

Michelle shows that she willingly accepts the responsible and associated consequence to her actions. Michelle also shows that she does not want to engage in behaviours that could result in a similar consequence.

Samantha showed insight into the limits of the process of taking responsibility in a situation when other people are also involved, whilst still being able to see the role of her own responsibility,

*'I can own every bit of it, like, why I did this, why I behaved or why I even said that, why I lied, but it's not always guaranteed that that other person will understand, but I can word it in such a way that it's put across correctly, and then still take responsibility for my actions' (79)*



Samantha shows that she is not able to control for the actions or reactions of another person, even if she acts entirely appropriately in taking responsibility for her own actions. Samantha advises how taking responsibility has changed her view of her index offence. Her phrase 'doing a bird' is cockney rhyming slang for a prison sentence.

*'kind of hate to admit this, but yeah, because beforehand the way I saw it is, I'm sitting down here doing a bird for something I didn't do, that's the way I saw it, no one could tell me any different that's just the way it was, but now...[removed for confidentiality] I've actually owned the fact that as responsible as she is, so am I, because I didn't have to be there, like, we're not Siamese twins, I didn't have to be there, you know, I chose to be there, and this is the reaction of me being there' (201)*

Samantha shows how through engaging in processes such as self-awareness, perspective taking, and awareness of consequences and responsibility she has experienced a change in perception in relation to her index offence and the role played by her and the co-defendant. Samantha shows that she takes responsibility for her actions and understands the consequence of that action is to be in prison. Samantha conveys a sense of hurt pride and defiance, which has been replaced by acceptance.

A third facet of responsibility for the participants was that of taking responsibility for themselves to change their overall approach. Samantha showed how she had to own her path to change and take responsibility for that,

*'Some people want to change, want to know things, but they're scared to know things because they don't know what other doorway is going to open for them, I did feel that*

*way but I got to a point where I felt like I wanted to change but I didn't know how to change, and I sat with that for a long time, and then got to the point where I realised I need to do something outside this box to be able to get out of this box'. (263)*

Samantha shows how in order to begin the process of changing she had to be willing to be vulnerable. She shows that she had begun the process of wanting to change prior to engagement with the DBT programme and was looking for something to facilitate that change. Samantha shows that she did not feel able to make changes alone and was looking for something external to her to help her to make changes. Samantha conveys her ability to reflect and a sense of feeling lost; as even when she had the awareness of wanting to change she was without a framework or the support to do so prior to engaging with the DBT programme.

Sharon shows her insight for taking responsibility for herself, and how her learning experience from completing the DBT programme transcends the prison environment.

*"cause if you bottle something on the course, then you might not, when it comes to get outside if you want to do something you're going to bottle it and you might regret the fact that you haven't done it' (556) 'You got to keep on doing it, to benefit from it, but also, erm, not give up, because you won't benefit from it, because nothing's easy in life, and if you want the best out of it then you've gotta, you gotta put yourself forward' (389)*

Sharon shows how committing to completing the DBT course and overcoming the challenges she faced within it has helped her to gain self-efficacy and know that she can apply this ability to commit and overcome challenges outside of the DBT programme. Sharon shows her awareness that, for her, the struggle is inherent to the

gain she has experienced, and that a willingness to engage with this awareness is required.

#### **4.8.5 A Positive Outlook, ‘The hard times go and you’ll get the good times back again’**

The participants all spoke in summary about their experience of completing the DBT programme, they were all positive about the impact their experience had on themselves, their relationships, and their way of being in the world. Sharon described it as *‘life changing’* (561). In discussing the impact the DBT programme had on her life in prison, Gemma advised,

*‘it’s about a more positive outlook as well, do you know what I mean, I don’t need to think about the sentence that I’m doing, and if I do, like my goal was for my release date, but now, well, why don’t I set other goals for before that, like courses that I’m doing’* (230)

Gemma shows that completing the DBT course has helped her to view her life in prison differently and given her the motivation to engage in other prison led courses. By setting goals to achieve Gemma shows an increase in self-efficacy and a value for herself and her life.

Sharon advised of how a positive perception had helped her,

*‘not beating myself up if anything, if I get like, not to think it’s the end of the world, and it’s helped me to move on when I have got back to low points’* (568)

Sharon shows that her ability to apply positive thinking has helped her manage her emotions, let go of judging herself, and be rational and balanced in her thinking style.

Julie advised of how completing the DBT course had changed her view of herself,

*'I have learnt this, and I have learnt that, and this is what's helped me to be the person that I am today, I am a lot better person today, because I have gone to the group and it has brought out a lot of good things in me, well it has, a lot of people have told me that as well' (244)*

Julie shows how she has gained self-confidence and self-worth from completing the DBT programme; she makes a value judgment on herself being a 'better' person than she was prior to completing the course. Julie states the opinion of others in order to evidence her point. Julie conveys a sense of pride in her achievements.

Samantha advised of her DBT experience,

*'it helps you to move forward, and actually be in the more in the moment of what's going on in life. Instead of thinking about, 'oh yeah that thing happened last week, and that pissed me off and god if I see that person again I will weigh them in', you can just let that go, and know that happened last week, and that's what it is, but you're more in the moment' (243)*

Samantha shows that she is able to apply the principles of mindfulness taught within the DBT programme to her everyday life and that this helps her to manage her emotions, behaviours and the prison environment. Samantha shows that she is able

to just observe, notice and let go of unhelpful thinking patterns and vengeful feelings; Samantha conveys a sense of being settled and grounded.

Gemma advised of her DBT experience,

*'sometimes it gets harder before it gets easier, and that's, the tough roads are really hard to get by and so, like that sweet, hard times go, they go eventually anyway whether it's in a day, a week, a year, ten, the hard times go and you'll get the good times back again, its just holding on until that time comes' (265)*

Gemma shows that she able to able to tolerate distress and challenges and views this state of being as temporary until she experiences better times. Through the exercise of eating a sour sweet Gemma shows how she was able to apply this thought process beyond the frame provided by the DBT programme. Gemma conveys a sense of hope in her approach.

In conveying a positive outlook participants showed how valuing themselves and their lives had contributed to this positive approach. Sharon advised,

*'cause it opens up your eyes to what's important, life, your life, we're here for a purpose, that's to make the best out of what you've got' (577)*

Sharon shows that she places value on both life in general and in particular, her life. Sharon shows that she has gained foresight and positive thinking from her DBT experience. Sharon conveys a sense of determination.

Mary advised of her DBT experience and how it has shaped her perception of herself,

*'it helps, it has helped me in so many ways it's unbelievable. I wouldn't think it was going to help me, but it has, it really has' (1038), 'Believe in yourself because only you can, it's going to be hard but just believe, and you will get better'. (1051)*

Mary showed how she was dubious upon commencing the DBT programme but that she has gained from the experience of completing the programme. Mary conveys the depth and scope of benefit she has experienced from the course, inclusive of the challenges she has encountered. Mary displays a gain in self-efficacy and an awareness of how important this self-belief is in the endeavour of change. Mary attributes a sense of achievement and hope to her DBT experience.

#### **4.9 Analysis Summary**

This chapter has presented six superordinate themes and 17 subordinate themes generated by employing IPA methodology in order to convey an understanding of the participant's experiences of completing a DBT programme in prison. The first superordinate theme **prison life** showed the impact participants experienced on their every day life in prison, through a reduction in the prison internal disciplinary procedures, an increase in the prison internal privilege system and a decrease in the internal safeguarding procedures. The second superordinate theme **it's a struggle** represented the various challenges the participants faced within their experience including trusting each other and the DBT therapists'. The third superordinate theme **increased connection to others** illuminated the improvement participants experienced in their personal relationships, particularly through improved communication. The fourth superordinate theme **emotional awareness, 'one big emotion'**, showed how the participants gained an

understanding of their emotions and how to manage their emotions in different ways from prior to the DBT programme. The fifth superordinate theme **who am I?** Represented the participant's experience of understanding, accepting, and valuing themselves. The final superordinate theme **the bigger picture** represented the participant's explanation of being able to reflect and re-evaluate a situation or event, which led to them gaining the perspective of another person, and experiencing empathy for another person. This theme also represented the participants gaining an awareness of the consequences to their actions and their personal responsibility. The final facet of this theme highlighted the participant's experience of having a positive approach to life going forward.

## **5.0 Discussion**

### **5.1 Chapter Overview**

This chapter will first provide a summary of the themes defined from the data pertaining to prisoners' experiences of DBT. I will then discuss these themes within the context of the relevant literature and show how the research presented here can contribute further to each area.

Following this I outline the clinical implications and recommendations for future research that have been developed from the data and are relevant for the context and client group presented here. The strengths and limitations of the research are discussed, and the relevance of this research to counselling psychology is identified. The chapter closes with a summary of the findings.

### **5.2 Overview of Themes**

In investigating prisoners' experiences of completing a DBT programme six superordinate, and seventeen subordinate themes were identified. The first superordinate theme is, **Prison Life**, whereby participants described an impact on their prison life directly related to a reduction in the prison risk and penalty management strategies.

The second superordinate theme is, **'It's a Struggle'** which shows the challenges participants experienced within each therapeutic component, specifically highlighting the challenge of trust.

The third superordinate theme is, **Increased connection to others**, which shows the impact participants experienced in their personal and familial relationships.



The fourth superordinate theme is, **Emotional Awareness – ‘One Big Emotion’** which highlights the participants experience of an increase in emotional awareness and understanding. Which led to the utilisation of new emotional management strategies.

The fifth superordinate theme is, **Who am I?** Which illuminates the process of self-awareness experienced by participants. This theme represents the participants experience of self-acceptance and showed how in the context of accepting themselves participants also identified the commonalities they hold with others.

The sixth superordinate theme is, **‘The bigger picture’** which represents the participants gaining a wider perspective of their worldview and relationships. Participants experienced a process of reflection, an increased awareness of others perspectives, and experienced empathy towards others. Participants showed their willingness to take responsibility for their actions and an awareness of consequences to their actions. Lastly, this theme highlights the positive outlook presented by participants in relation to both the short term management of current challenges and longer term outlook and value gained for life.

### **5.3 Superordinate theme: Prison Life**

The first superordinate theme is, **Prison Life**, which represents the participant's description of the impact their experience of completing the DBT programme had on their everyday lives in prison.

#### **5.3.1 Subordinate theme: 'Less Strife'**

The first subordinate theme of, **‘Less Strife’**, highlights the participants changed approach in managing the prison environment. Participants spoke of

managing their anger and communicating more successfully with officers to get their needs met. This improved the relationships participants had with fellow prisoners and prison officers. Participants of this research described a better quality of everyday life in prison post DBT.

The research presented here suggests that completing a DBT programme may contribute to an improvement in relationships between prisoners and prison staff, which may also result in **'less strife'** for prison officers and contribute to lower stress levels. Supporting this are the case studies of three participants who completed a prison DBT programme presented by Nee and Farman (2007). Reports from prison officers advised that participants of DBT became more willing to interact with them as DBT progressed. Research conducted by Misis, Cheeseman, Hogan and Lambert (2013) found that prison officers who perceived prisoners as cold, antisocial or unfriendly reported higher levels of stress; prison officers who were able to converse with prisoners and build a relationship with them reported lower levels of stress. Research conducted by Nurse, Woodcock and Ormsby (2003) found that both prisoners and prison staff identified negative relationships between them, as contributing factors to stress and mental wellbeing. The participants of this research advised that becoming able to manage their anger had contributed to them being able to communicate more successfully with prison officers, and to get their needs met without becoming frustrated and aggressive.

### **5.3.2 Subordinate theme: 'I can't win by fighting the system'**

This research showed that through a process of gaining emotional awareness, managing their emotions, and accepting their circumstances participants were able to negotiate the prison environment with less reliance on old behaviours that resulted in adverse consequences. This is represented by the second subordinate theme, **'I**

**can't win by fighting the system'**. This theme represents the participant's process of accepting their present circumstances of being in prison, which was followed by the participants adhering to prison rules. This contributed to a reduction in prison adjudications (IEP's) for rule breaking and an increase in their allocated privilege level.

This finding is supported by quantitative data reported by Gee and Reed (2013) who found an 88.2% decrease in rates of prison adjudications for participants post DBT. Nee and Farman (2007) also reported a reduction in IEP's and an increase in privilege level for participants during and post DBT. The participant's views give context to these figures by highlighting their process of emotional awareness and managing their emotions. Participants make a link between this process and a reduction in prison adjudications.

### **5.3.3 An increase in privilege level**

A second facet of the subordinate theme **'I can't win by fighting the system'** can be found in the reports from participants that no longer 'fighting the system' had led to an increase in their allocated privilege level. UK prisoners are allocated a privilege level ranging from basic, to standard, to enhanced. Higher privilege levels enable advantages such as a personal television, further responsibility on the housing landings, freedom of movement around the prison estate, and access to valued jobs, such as working in the prison gardens. An increase in the participants' privilege level is linked to a reduction in IEP's and improved relationships between the participants and the prison officers. During the interviews participants quoted praise they had received from prison officers by way of evidencing the improvement in their behaviours, this shows the improvement in the interactions between participants and prison officers. Leibling (2011) investigated the impact of privilege

level on relationships between prisoners and prison staff and found that positive balanced working relationships between prison officers and prisoners resulted in a higher privilege level.

The importance and impact of the privilege level that prisoners are allocated is illustrated within a review of suicidality and deliberate self-harm in UK prisons conducted by The Prison Reform Trust ([Prisonreformtrust.org.uk](http://Prisonreformtrust.org.uk)), which found that a disproportionate number of prisoners who engage in suicidal and self-harming behaviours are allocated to a basic privilege level. The national average of prisoners allocated to a basic privilege level in the UK is cited as 2%. An investigation by the Prisons and Probation Ombudsman found that 8% of prisoners who committed suicide within UK prisons between 2007-2012 were allocated a basic privilege level ([Prisonreformtrust.org.uk](http://Prisonreformtrust.org.uk)). Further to this the National Institute of Mental Health estimate that 80% of people diagnosed with BPD engage in self-harming behaviours and 4-9% commit suicide ([Nimh.nih.gov](http://Nimh.nih.gov)).

Notwithstanding the epistemological position of this research as viewing diagnostic labels as a social construction, the figures presented here suggest that if a person is in prison, engaging in self-harming and/or suicidal behaviours, and is allocated to a basic privilege level, they are therefore at a further disproportionately higher risk of committing suicide. The views of the participants within this research show that they experienced an increase in privilege level, and a reduction in self-harming behaviours. Thus showing that the DBT programme has potential in reducing the risk of suicide as linked to a basic privilege level.

#### **5.3.4 The potential impact for prison officers**

This research suggests that DBT can contribute to an improvement in the behaviour of prisoners, which may impact upon life in prison for both the clients of

DBT and the prison officers. For prison officers a reduction in engagement with prison disciplinary and risk procedures results in reduced time for administrative processes and more time available to liaise with prisoners and manage the residential landings. The superordinate theme '**Prison Life**' can be understood as representing an improvement in prison life for both the participants of this research and potentially the prison officers via the reciprocal relationship between these factors. A reduction in IEP's for prisoners, results in less administrative time for prison officers, which enables more time to be spent liaising with the prisoners, therefore improving those relationships and contributing to a reduction in IEP's, which then contributes to an increase in privilege level.

#### **5.4 Superordinate theme: 'It's a struggle'**

The second superordinate theme, '**It's a Struggle**' represents the variety of challenges experienced by participants throughout their DBT experience. These challenges related to each of the therapeutic components, individual therapy and skills groups, as well as skills acquisition and utilising the skills to manage their emotions and engage in a different behaviour. The participants each stated how their DBT experience had been frequently unenjoyable and consistently challenging. Common to the narratives provided by participants was the notion of 'sticking it out'. Reports by participants were that the reward of overcoming these challenges and completing the DBT programme was worth the inherent struggle. In line with this finding Hodgetts et al. (2007) reported that clients who had completed an outpatient DBT programme stated that a significant challenge was committing to the programme and not quitting.

#### **5.4.1 Subordinate theme: 'DBT is hard'**

Participants gave accounts of finding the structure of DBT to be difficult to understand as it differed from their traditionally understood frame of what constitutes therapy. Therapeutic techniques such as the behavioural chain analysis (BCA) were new to the participants and were experienced as anxiety provoking until they were mastered. Hodgetts et al. (2007) also specified BCAs as a particular challenge noted by the participants of their qualitative research.

During interviews participants of this research were explicit in naming the skills that they had found helpful. Participants advised that the skills that were conceptually difficult to master, were also the skills that proceeded to offer the most benefit. This was echoed in the findings from Nee and Farman (2007) whereby one participant noted the hardest skills to master brought about the most long-term effectiveness.

Participants of this research were consistent in their reporting of the skills group therapy as being challenging. Some participants advised the setting reminded them of being at school which was associated with difficult and sometimes traumatic memories. Perseus et al. (2003) found that the majority of their participants stated that participating in the skills group was the biggest challenge within the DBT programme. However Perseus et al. (2003) were not able to elaborate on why this was. The finding that participants associated the skills groups with difficult memories from school is unique to this research and can be used to inform the delivery of this setting for DBT therapists'. Taking this into consideration and making changes to the format or style of delivery may help to alleviate the challenges experienced by clients and further contribute to improving treatment retention. Participants advised that the setting of the room that the skills group was held in reminded them of school. DBT

therapists may consider having informal seating arrangements, or sitting in a circle formation to change this dynamic. DBT therapists may consider teaching the skills interactively utilising visual aids or role-plays in order to minimise the utilisation of traditional teaching methods, which may contribute to promoting memories from previous schooling experiences.

A second facet of the theme '**DBT is hard**' was the conflict participants' experienced between the endeavour of DBT to promote independence and positive change, and the inherent punitive environment and controlling systems in prison. Participant Michelle described her experience of completing DBT in prison and how she was challenged by trying to implement the DBT skills within the prison environment. Research conducted by Low et al. (2001) highlighted the challenges associated with security measures in a secure forensic setting and the conflicting promotion of independence within DBT. It was noted by the participants represented within this research that despite engaging skilfully in behaviours learnt through DBT they might not receive the outcome that is appropriate to that behaviour due to the fundamental nature of the context and the people within it.

The principles of behavioural reinforcement strategies are practiced within DBT in order to promote and change behaviours (Linehan, 1993a). However the prison context can be seen to reinforce negative behaviours with positive consequences thus promoting the engagement with negative behaviours, rather than extinguishing negative behaviours through aversive consequences as would be expected within this behaviourist framework. It is beyond the scope of this research to speculate on the validity or impact of this approach for the wider prison population. However in considering the utilisation of DBT skills and the views provided by participants of this research, the housing of prisoners together, who have either completed a DBT programme or are in receipt of DBT, may contribute to managing

this issue and warrants further consideration. This will be discussed further within clinical implications.

#### **5.4.2 Subordinate theme: The Challenge of Trust**

The challenge participants experienced in trusting one another and the DBT therapists featured throughout their accounts of their DBT experience. The group setting was specified by the majority of participants as being highly challenging and anxiety provoking due to a lack of trust for one another. This was particularly the case in the act of having to close their eyes during mindfulness exercises and in having to trust one another in order to be open about their personal experiences.

In light of this specific insight, strategies in line with DBT philosophy can be developed in order to manage these challenges. Such as employing specifically matched DBT skills to manage the adversity/emotional response, thus providing interactive learning and modelling skills use. Using the detailed qualitative feedback from participants describing the exact nature of the challenges they experienced may then have the potential to reduce the anxiety experienced in relation to the group setting. In addition to this the views of clients experienced in DBT may have the potential to contribute to an increase in therapeutic engagement, and treatment commitment and retention.

Participants identified the challenge in trusting their individual therapist and how this trust developed between them over time. Participants were able to identify how integral trusting their individual therapist had been to the success of their individual therapy. Nee and Farman (2007) reported a participant's account of how trusting her therapist had enabled her to engage in the therapy. Participants of this research identified trusting their DBT therapist as a unique experience within a



therapeutic relationship, specifically highlighting the feelings of being understood, respected and validated.

Six of the seven participants stated that they had completed their DBT programme with one consistent individual therapist, and consistency within the group facilitators, suggesting that the consistency contributed to the building of trust. One participant, Gemma, noted that her therapist had a planned absence during her therapy and that a different therapist had completed her individual sessions during this time. Gemma noted the challenge she experienced in this change of therapist in terms of building trust and gaining confidence in the new therapist's approach.

Further investigation has shown that all of the therapists involved in the DBT programme under investigation within this research had received intensive DBT training through the British Isle DBT Training. It may be that this consistency in training resulted in consistency within the therapists' approach and therefore facilitated the change in therapists for Gemma.

The therapists who led the groups and provided individual therapy were consistent across the length of therapy for the remaining participants. McCann and Ball (2000) identified the importance of training and retaining staff as variables affecting the effectiveness of DBT. Nee and Farman (2005) agreed that staff training and retention are integral factors influencing the success of forensic DBT. The research presented here supports the importance placed on the training received by DBT therapists', and their subsequent retention for the therapeutic term. Furthermore this research provides an insight into the potential impact of these factors, such as contributing to the building of trust, and the therapeutic alliance for the clients.

The participant's reports of feeling understood, respected and validated may be particularly important for a prison population. Harvey (2011) reported that prisoners referred for psychological therapies present with a myriad of interwoven traumatic life events, insecure attachment, and several symptoms that lend

themselves to co-morbid Axis I and Axis II diagnosis. Participant Mary spoke of her challenge in trusting others due to childhood trauma, Mary specified that the relationship with her DBT therapist had helped her to overcome this. This shows that the quality of the therapeutic relationship and the building of trust can be fundamental to the success of forensic therapy.

### **5.5 Superordinate theme: Increased connection to others**

The third superordinate theme is **Increased connection to others**. This represents the participants descriptions of how their personal relationships with family and friends was impacted by their DBT experience. The first subordinate theme is **'She's got her daughter back'**: this depicts the experience of participants gaining closeness in their relationships and getting on better with people. Nee and Farman (2007) also cited an improvement in personal relationships within a case study and linked this to the interpersonal effectiveness skills taught within DBT. In reporting the outcome of a therapeutic community McFetridge and Coakes (2010) cited participants as having improved relationships with others.

The research presented here can contribute to the current literature base through the detail offered by qualitative methods, as is encapsulated with the second subordinate theme **'more talking, less shouting'**. This represents the factors that participants advised had facilitated the increased connection in their relationships. These were factors such as, improved communication skills, seeing the perspectives of others, taking responsibility for their actions, having empathy for another person and balancing their needs against the needs of another person. These factors can be interpreted as assertiveness, which is supported by Cunningham et al. (2004) who found that participants of DBT reported increased closeness within their familial relationships due to an improvement in communication skills and assertiveness.

It is possible that an improvement in the personal relationships of participants may contribute to a reduction in the risk of reoffending. In assessing the psychological needs of women offenders for implications to rehabilitation Byrne and Howells (2002) highlight the importance of relationships, depression and abuse. This suggests that if female prisoners reduce the adversity experienced in their personal relationships, this may contribute to a reduction in the risk of recidivism.

## **5.6 Superordinate theme: Emotional Awareness 'One big emotion'**

This theme encapsulates the participant's experience of gaining an awareness and understanding of their emotions and the emotions of others. Participants described how they came to accept their emotions and manage their emotions in new ways, thus letting go of previous (often adverse) coping strategies. This superordinate theme is represented throughout the wider research base; Perseus et al. (2003) reported that participants advised DBT had helped them to accept their emotions. McFetridge and Coakes (2010) reported a subordinate theme 'having feelings', which showed their participants experience of gaining emotional awareness and accepting their emotions. In highlighting emotional acceptance one participant of this research, Mary, showed her experience of accepting her emotions by advising that she had discovered '*it's alright to be crying*' (279). Interestingly, Nee and Farman (2007) reported a similar finding of a participant 'allowing herself to cry' (p. 13). The participants of this research add to the understanding of this by showing that they were engaged in the process of accepting their emotions and that this acceptance led to them experiencing their emotions in ways such as crying, as opposed to their previous process of denying or avoiding their emotions and engaging in behaviours designed to avoid particular emotions, such as aggressive

acts or self-harm. This was seen in the related subordinate theme, **letting go of old behaviours**, as is now discussed.

#### **5.6.1 Subordinate theme: Letting go of old behaviours, 'I don't do that anymore'**

This theme represents the participant's accounts of behaviours they no longer engage in. During interviews participants were found to be explicit in listing these behaviours, which could be grouped in two areas; a reduction in aggressive behaviours, and a reduction in self-harming behaviours. A reduction in aggressive behaviours reported by the participants within this research is consistent with the finding reported by Koons et al. (2001), who found a significant decrease in measures of anger expression following 6 months of outpatient DBT. Importantly the research presented here contributes further to these figures by linking the reason for these reductions to the participants' increased understanding of their emotions and learning new ways to manage their emotions. This led to the participants being able to manage their emotions without being aggressive either outwardly or towards themselves via routes such as self-harm, as will now be further discussed.

#### **5.6.2 Exploring participants accounts of a reduction in self-harm**

Three of the participants involved in this research engaged in self-harming behaviours prior to commencing the DBT programme. Each of these three participants advised of how they had either reduced their self-harming behaviours or had not self-harmed since completing the DBT programme. Gee and Reed (2013) and Nee and Farman (2005) both reported a reduction in self-harming behaviours

post forensic DBT. Quantitative research completed by Linehan et al. (1998), Koons et al. (2001), Low et al. (2001), and Bohus et al. (2004), each showed a statistically significant reduction in self-harming behaviours attributed to the completion of a DBT programme.

This research offers depth to these quantitative findings through the participant's descriptions of the function of their self-harming behaviours. During interviews participants of this research advised of previously using self-harm as a method of coping with their emotions, coping with challenging life events, and coping with relationship difficulties. Participants offered their explanation as to what had contributed to a reduction in their self-harm, most commonly citing learning DBT skills to cope with a variety of challenges, manage their emotions and replace self-harming as a coping method with DBT skills. In line with this finding Perseus et al. (2003) reported that participants stated DBT had given them skills to manage their suicidal and self-harming urges, which led to them not engaging in these behaviours.

Further interpretation of the data provided by participants within this research identifies triggers they cited for self-harming behaviours. These include challenging relationships and life events, and difficult to manage emotions. This suggests that if their relationships are less challenging the participants may experience less urges to self-harm. The superordinate theme **'increased connection to others'** depicts an improvement in the participant's personal relationships; therefore this may have contributed to a reduction in self-harming behaviours. Nee and Farman (2007) reported on a participant who advised of using self-harm as a method of coping with the challenging relationship she experienced with her mother.

Participants advised that they had experienced an improvement in their communication and relationships with prison officers, this is represented within the subordinate theme **'Less strife'**. Participants stated that this improvement had contributed to their ability to ask prison officers for help and support when they were

having difficulties managing their emotions, or experiencing a challenging life event. Participants advised that having the ability to ask for help had contributed to a reduction in their engagement with self-harming behaviours. Supporting this is qualitative research completed by Borrill, Snow, Medicott, Teers and Paton (2005). These researchers interviewed women who had engaged in self-harm and suicide attempts whilst in prison. These participants cited good relationships with prison officers as a potential factor in reducing the likelihood of their engagement in self-harming behaviours.

A reduction in suicidal and self-harming behaviours may contribute to a reduction in recidivism risk. In assessing case-based principles of risk and need Blanchette (2002) found that criminogenic needs for women are largely focused on personal and emotional factors such as low self-esteem, childhood and adulthood personal victimization, and self-harm and suicidal behaviours. This research suggests that if there is a reduction in self-harm and suicidal behaviours this may contribute to reducing the likelihood of reoffending for women.

In summary this research links a reduction in self harming behaviours predominately to participants utilising DBT skills to manage their emotions and challenging life events. Participants highlighted an improvement in their personal relationships as reducing the likelihood of engaging in self-harm, due to decreasing this as a trigger. Lastly, a reduction in the likelihood to engage in self-harm was attributed to an improvement in the quality of life for participants in prison. This was facilitated by an improvement in the relationships with prison officers and an increase in their privilege level.

## 5.7 Superordinate theme: Who am I?

This theme represents the participant's experience of forming an awareness, understanding and acceptance of their identity. This was through understanding themselves, their emotions and the processes they went through with their emotions, which is represented by the subordinate theme **'Understanding me'**. This awareness and understanding led to accepting themselves and seeing themselves as 'normal', which is represented by the subordinate theme **'self-acceptance, I am a normal person'**. Through a process of understanding themselves and accepting themselves participants experienced an increase in self-esteem. Participants also gained in self-respect and in value for themselves. This was represented by the subordinate theme **'Learning to value myself, I deserve to be loved'**. In line with this superordinate theme is the experience of participants highlighted by McFetridge and Coakes (2010) who cited DBT participants within an inpatients therapeutic community as experiencing a gain in pride, self-respect, and self-acceptance.

As found in this research an increase in self-esteem is reported throughout both quantitative and qualitative assessments of DBT. Cunningham et al. (2004) presented accounts from participants of DBT who cited an increase in self-esteem. Nee and Farman (2005) found a statistically significant improvement in measures of self-esteem for prisoners who had completed DBT programmes of a standard one year length. A significant improvement in self-esteem was also found in DBT terms modified to 16 and 12 weeks. Increases in self-esteem are reported throughout the case studies presented by Nee and Farman (2007). For one client this increase in self-esteem is attributed to not committing suicide. This increase in self-esteem that is reported throughout the existing literature is further contextualised with the insights provided by the participants of this research. Collectively the participants' experiences shows us that through the process of coming to understand themselves,

and their emotions, this led to them accepting themselves. Which then led to the participants valuing themselves, which is a further understanding of the reported figures of an increase in self-esteem in research conducted by Cunningham et al. (2004), Nee and Farman (2005) and Gee and Reed (2013). The skills group setting was one element that facilitated this process of understanding and is now discussed.

### **5.7.1 Who am I? And the role of the Skills Group**

The participants of this research noted how sharing their experience and listening to the experiences of others in the skills group setting had helped them to gain an understanding of themselves and their emotions. This is interpreted as contributing to the participants' experience of forming their identities. In reporting on client's experiences of an outpatient DBT programme Hodgetts et al. (2007) found that the group setting and processes within it contributed to the forming of clients identities.

For the participants of this research the experience of sharing and listening in the skills group, and gaining an understanding of themselves and their emotions, contributed to the development of their identity and of accepting themselves. This resulted in the participants relating to others and normalising their own experiences through this relating. The subordinate theme '**self-acceptance, 'I am a normal person'**' represents this experience.

McSherry et al. (2012) completed a thematic analysis of client's perspectives of an outpatient community based DBT programme. McSherry et al. (2012) reported that clients developed a renewed sense of identity in the normalising of their experience, which was a result of relating to the experience of others within the skills group setting. According to the participants of the present research, coming to know



themselves and accept themselves was not a renewed sense of identity: it was the first time they had felt 'normal' and the first time they had experienced self-love. This finding may be unique to a prison population and specific to the vulnerabilities in this client group. The findings from this research support the impact the DBT skills group component can have on identity and self-worth due to the commonalities and shared experiences between clients.

### **5.7.2 Who am I? And the role of individual therapy**

The subordinate theme **'Learning to value myself, 'I deserve to be loved'** encapsulates the clients experiences of gaining value for themselves. Participants highlighted the importance of the individual therapeutic relationship in facilitating this change. Participants each stated how they had felt valued and validated within that interaction. Participants spoke of the power imbalance in prison and that although they felt this imbalance continued to exist within the therapeutic relationship, they had also felt treated equally and with respect. In support of this finding Cunningham et al. (2004) cited the equality participants experienced in their therapeutic relationships within an outpatient DBT programme. Perseus et al. (2003) reported that participants had felt respected and understood within their DBT therapeutic relationships.

The superordinate theme **'Who am I?'** unifies and contextually contributes to the participants experiences seen within the limited qualitative literature currently available. Participant's experiences of DBT can be interpreted as contributing to forming their identity, through gaining an understanding of themselves, their emotions, and their emotional processing. Participants within this and the existing literature report a normalising experience, which is interpreted as facilitating self-

acceptance and an increase in self-esteem, and self-worth. This gain in self-worth may be of particular importance for a forensic context, as is now further discussed.

### **5.7.3 Self-worth, criminality and recidivism**

The participant's reports of an increase in self-worth within this research may have the potential to contribute to a reduction in their risk of reoffending. As previously stated Blanchette (2002) found that criminogenic needs for women are largely focused on personal and emotional factors, such as low self-esteem. This suggests that if these factors are the focus of targeted therapeutic interventions, which then result in a reduction of the adversity experienced in relation to these factors, then the recidivism risk would be reduced.

Low self-esteem has been linked to an increased risk of criminality. Research conducted by Donnellan, Trzesniewski, Robins, Moffitt and Caspi (2005) showed a robust relationship between low self-esteem, aggression, antisocial behaviour, and delinquency. Further research found that low self-esteem during adolescence predicts poor health, criminal behaviour, and limited economic prospects during adulthood (Trzesniewski, et al. 2006). These researchers are diligent in their methodological approach to control for confounding variables and in using objective measures.

However the relationship between self-esteem and criminal behaviour is not clearly defined or predictable. Kernis (2005) suggested that researchers are finding contradictions in results concerning the relationship between criminality and self-esteem due to the manner in which self-esteem is conceptualised and consequently measured. Ostrowsky (2010) highlighted the debate in literature regarding the role of narcissism in contributing to violent and aggressive behaviours and suggested that a further distinction between the concepts of self-esteem and narcissism is needed

prior to linking to violent behaviours. However in utilising a regression analysis to isolate variables, Donnellan et al. (2005) found that the effect of self-esteem on aggression was independent of narcissism.

The debated concepts of self-esteem, self-worth, narcissism and their relationship to criminogenic risk is relevant for the research presented here in terms of the value placed upon DBT as a contributing factor to the targeting of recidivism. If an increase in self-esteem does reduce the risk of offending and/or re-offending, as stated by Blanchette (2002), and if DBT does have an impact to increasing self-esteem, then DBT may have value to add in reducing recidivism. Fagan (2001) contributes to the debated factors relating to criminogenic risk. He highlights the issue of research retrospectively showing that the majority of offenders report adversity (such as child abuse), and yet prospectively adversity has not been shown to inevitably link to criminality. This supports the epistemological position of this research in maintaining the importance of mediating variables specific to client, context, culture and time in assessing and managing recidivism risk. For example, the criminogenic needs of female offenders have been shown to be different from those of male offenders (Motiuk, 1997). Hollin and Palmer (2006) have investigated the impact of socio-economic factors such as education and housing circumstances.

## **5.8 Superordinate theme: The Bigger Picture**

The superordinate theme, '**The bigger picture**' represents the participants gaining a wider perspective on their worldview and relationships. This is further suggested by the related subordinate themes, '**Re-evaluate**', '**Gaining perspective of the other**', '**Empathic understanding**', '**Taking responsibility**', and '**A positive outlook**'. This theme shows how the participants began to re-evaluate situations and take into consideration the perspective of others, and experience empathy towards

others. This theme represents participants taking responsibility for themselves and their actions and having an awareness of the associated consequences of their actions. Finally this theme represents the participants having a positive view of their lives, in the here and now, and of experiencing hope for their future.

The research presented by McFetridge and Coakes (2010) supports the findings of this research. McFetridge and Coakes (2010) advised that participants reported having changes in their thinking style, including gaining insight, an increased awareness of the perspective of others, and a willingness to take responsibility for their own lives. In addition Perseius et al. (2003) reported that post DBT participants advised they viewed their problems as their own responsibility to change.

The subordinate theme '**Empathic understanding, 'I go out of my way to sit and make sure they're alright'**' represents the participants increase in empathy towards others. Particularly important for a forensic context was the explicit examples participants gave of their ability to have empathy towards others and how this had impacted upon and changed their treatment of other people. Participants spoke of empathy towards the victims of their index offence (the crime for which they are imprisoned). Participants articulated how their perspectives on their crimes had changed in terms of taking responsibility for their actions and understanding the consequences of their actions. It can be speculated that this change in perspective from the participants may contribute to reduction in their risk of reoffending.

The participants of this research presented striking accounts of their changed view of their current circumstances and their future. This is represented within the subordinate theme, '**A positive outlook 'The hard times go and you'll get the good times back again'**'. Participants gave positive views of their DBT experience as being '*Life changing*' (Sharon, 561). This is interpreted as representing the significant impact participants experienced in completing the DBT programme.

Participants spoke of previously actively engaging in suicidal behaviours, which had either reduced in severity or entirely ceased post DBT.

Interestingly this depiction of DBT as 'life changing' and 'life saving' is represented throughout the limited qualitative literature. Perseius et al. (2003) reported that participants described DBT in various ways as 'life saving'. McFetridge and Coakes (2010) advised participants described DBT as 'life saving'. Closely aligned with the participants experiences presented within this research are the views of participants reported by Cunningham et al. (2004), who advised that participants described DBT as 'life changing' and described themselves as now having higher levels of hope for the present and the future.

Participants of this research described their increased resilience and ability to experience optimism for the future. McFetridge and Coakes (2010) presented similar accounts from participants within a focus group. In using quantitative methods Koons et al. (2001) found a significant decrease in measures of hopelessness following DBT.

The supporting research detailed here highlights the shared experience of participants within DBT across various contexts such as outpatient, inpatient, and therapeutic community. It is important to note that the finding of having a positive outlook represents the participants' experience of DBT in prison. Some participant's are serving life sentences and indeterminate sentences, meaning they do not know how many years they will spend in prison. Despite the adversity of being in a locked environment, without the knowledge of a release date or parole. The participants of this research advised they had changed their outlook to be positive, towards both their current circumstances, and future direction.

## **6.0 Implications for Clinical Practice**

### **6.1 Reduction of Criminogenic Risk**

The themes presented have, in parts, been linked to a potential reduction in criminogenic risk. As previously stated, Blanchette (2002) assessed case based principles of risk and need and found that criminogenic needs for women are largely focused on personal and emotional factors such as low self-esteem, childhood and adulthood personal victimization, and self-harm and suicidal behaviours. The superordinate themes **'Who Am I?'** and **'Emotional Awareness, One big emotion'** have been discussed and linked to the Blanchette (2002) research in terms of the relationship to the participant's reports of an increase in self-esteem and a reduction in self-harm and suicidal behaviours.

The superordinate theme **'increased connection to others'** represented the participants' experience of an improvement in their personal and familial relationships. Linked to this is research presented by Byrne and Howells (2002), who highlighted the importance of relationships, depression and abuse, in assessing the psychological needs of women offenders for implications to rehabilitation.

The superordinate theme, **'The bigger picture'** represented the increase in the participant's ability to empathise, and understand the perspective of the other. The participants increased their awareness of aversive consequences and their willingness to take personal responsibility for their actions. Participants had also spoken explicitly of having empathy towards the victims of their crimes and a changed view of their index offence. It is suggested that this change in perspective may have the potential to impact upon risk of re-offending.

In an attempt to quantify the potential impact of completing a DBT programme on reducing reoffending risk Nee and Farman (2005) employed a number of

psychometric measures that were strongly associated with criminogenic risk. Nee and Farman (2005) found statistically significant improvements in the areas of impulsivity, anger, locus of control, self-esteem and emotion regulation. A statistically significant improvement was found on a global measure of BPD syndrome. In discussing these results Nee and Farman (2007) state that DBT 'appears to be effective in reducing criminogenic risk' (p. 21). The research presented here supports the Nee and Farman (2007) criminogenic findings through the themes related to emotional awareness, incorporating emotional management and who am I? Learning to value myself and self-acceptance.

This reduction in risk can be understood within the framework provided by the good lives model (GLM) of offender rehabilitation (Ward, Mann and Gannon, 2007). The good lives model is a strengths based approach which understands offending behaviour as being the result of people seeking to attain 'primary human goods' (2007: 246) through means that are maladaptive and essentially, illegal. Primary human goods can be understood as beneficial goals centred on all facets of human life, purpose, and relationships. Ward and colleagues have sought to propose the GLM as understanding human motivation as the pursuit of primary goods, within which criminogenic needs are conceptualised as the obstacles to achieving these human goods. As a strengths based approach, the GLM promotes the attainment of offenders personal goals whilst simultaneously managing their risk (Ward et al, 2007). The central aim of the GLM is to help offenders to develop a life with meaning, this is echoed by the central aim of DBT in building a life worth living. The clinical applications of the GLM is further elaborated within a revision of the model, the good lives model- comprehensive (GLM-C) (Ward et al, 2007).

The theory, structure, components, delivery and ethos of DBT lends itself to those of the GLM-C. The central ethos of which all else is derived displays the convergence between GLM-C and DBT, whereby both are positive models which

view the person as being able to make positive change. The GLM-C highlights the targeting of cognitive restructuring, affecting regulation, social skills and relapse prevention. Each of these are targeted within DBT theory and skills training. The GLM-C respects the offenders autonomous ability to direct their treatment, as is seen within DBT through consulting to the client and facilitating them to navigate their environment. The GLM-C and DBT share the shaping of therapeutic tasks to the individual. Both models highlight the importance of language as conveying the strengths based approach. Conscious effort is employed to ensure the approaches are validating, optimistic, and goal focused, whilst also maintaining authenticity and genuineness to remain realistic.

Throughout a multitude of publications Ward and colleagues (2000, 2003, 2006, 2007) have developed the theory of a strengths based approach to reducing recidivism. The GLM was developed in response to the risk-need-responsivity (RNR) approach to offender treatment (Andrews and Bonta, 1998). Ward and colleagues state that this model is inherently problem-orientated and limited by its lack of appropriate individuation and ability to motivate offenders for treatment (Ward & Brown, 2004). The RNR model (Andrews and Bonta, 1998) has been widely disseminated and boasts an impressive evidence base (Andrews, Bonta and Wormith, 2011). The literature provides us with a lively and enthusiastic debate between these researchers, of which it is my understanding that both parties agree on what the components constituting a successful psychological recidivism intervention are, and part ways on the differing emphasis upon these components. Ward et al (2007) promote the GLM-C as building upon the RNR model by incorporating the effectiveness of the risk management strategies but also building upon an offender's strengths and desire to live a socially acceptable and fulfilling life.

Gannon and Ward (2014) highlight an identity crisis for practitioners in offender psychology, which they attribute to the over-reliance on the RNR. According



to Gannon and Ward (2014) there is a tension for clinicians between building a successful therapeutic alliance, and maintaining risk awareness and targeted interventions. They term this the 'dual relationship problem' (2014: 437). DBT modified for a forensic context deals with this issue through the recommendations put forward by Gannon and Ward (2014) whereby DBT has a strong identity and has been developed firstly as a psychological intervention and secondly modified for a forensic context to incorporate issues of risk and recidivism. Secondly policy such as the OPD strategy is being developed in collaboration with local level services, such as DBT practitioners, to unify the management of both psychology and risk.

The research presented here pertains to provide qualitative evidence to the proposal that successfully targeting an offenders strengths to increase their self-worth, develop their ability to mentalise, gain mastery over their emotions and improve their social relationships does indeed contribute to reducing criminogenic risk. As a result of completing a DBT programme the participants of this research have explicitly stated their increase in self-worth, the development of empathy for the victim(s) of their index offence, and gain in the perspective of others. Each of which have been shown to have an impact in the targeting of recidivism (Andrews et al, 2011; Ward et al, 2007; Marshall, Hudson, Jones & Fernandez, 1995). It may be advantageous to make a theoretical or hypothetical leap from the participants' experiences depicted here to the potential ability of the DBT programme to reduce the risk of reoffending. Participants experiences of DBT, as delivered within this adaptation and this context, have not been shown here to manage other factors related to re-offending risk, such as finance, accommodation, education, and employment (Hollin & Palmer, 2006). However in line with the criminogenic risk factors outlined by Blanchette (2002) and Byrne and Howells (2002), the participants' experiences do support the notion of a potential impact on reducing reoffending risk that warrants further investigation.

## 6.2 DBT for a non-BPD population

The superordinate themes reported within this research have been generated utilising an IPA method and are considered to depict the experience of the participants who have completed the forensic DBT programme. These themes can be interpreted as related to, but not specific to or defined by, the DSM 5 (APA, 2013) diagnostic criteria of BPD. The participants' experience of completing the DBT programme is not explicitly or exclusively linked to BPD symptomology. In line with the relativist ontological positioning of this research regarding the social and cultural construction of diagnostic labels this raises the question of how appropriate it is to provide access to DBT in prison through diagnosis alone. In speaking regarding her opinion that every person in prison could benefit from doing DBT the participant Samantha advised,

*'I don't think there's a module covered in DBT that doesn't apply to someone, somewhere' (268).*

Research conducted by Perseius et al. (2003) investigated patients' and therapists' perceptions of DBT and found that the therapists' reported experiencing a personal benefit to learning DBT theory and skills and utilised the skills in their own lives, to their advantage. This suggests that the potential benefit of DBT is not limited to those in receipt of a BPD diagnosis. Nee and Farman (2007) present a case study for a prisoner with a less severe BPD profile and history and state that according to their results 'considerable progress' (p. 19) can be made with this presentation.

Of the seven participants within this research, according to their self-report, three were engaging in self-harming behaviours prior to beginning the DBT. This is

considered to be a life threatening behaviour within the DBT hierarchy of behaviours to target for treatment priority (Linehan, 1993a). If a client is not engaging in a life threatening behaviour the next target to treat is therapy interfering behaviours, followed by quality of life interfering behaviours (Linehan, 1993a). According to self-report, four participants of this research presented with concerns that fell within the quality of life interfering behaviours to target. These participants may be considered as 'less severe' as seen with the case study presented by Nee and Farman (2007). Each of the participants interviewed, regardless of whether they displayed life threatening behaviours, reported on the benefits and improvements to their lives that they experienced as a result of completing the DBT programme.

Notwithstanding the epistemological position of this research which sees diagnosis as a social construction, rates of BPD for females in the UK prison system have been reported to be as high as 20% (Singleton et al., 1998). However Rotter et al. (2002) questioned the validity of these figures and stated that contextual influences of the prison environment promote Axis I and Axis II disorder diagnosis. Rotter et al. (2002) stated their belief that symptoms associated with personality disorders overlap with behaviours that are adaptive within a prison context. It is beyond the scope of this research to hypothesise regarding the prevalence of personality disorders in prison or the validity of diagnostic labels. However, regardless of whether there is a disproportionately high number of people in prison who fit the diagnostic criteria for BPD, or whether the environment promotes diagnostic symptomatology, the suitability of DBT as an intervention to improve the lives of people in prison through strategies of managing emotions, tolerating distress and improving personal relationships is evident through the research presented here.

Furthermore it can be suggested that the benefits experienced are not limited to people in receipt of a BPD diagnosis. Evidence of this is provided through the therapists' perceptions of DBT, as giving them a personal benefit in learning DBT

theory and utilising DBT skills in their own lives (Perseius et al. 2003). In delivering a prison based DBT programme Gee and Reed (2013) assessed for inclusion based on nine DSM-IV (American Psychiatric Association, 1994) criteria of traits associated to BPD. Although the clients accepted onto this DBT programme may have been eligible for a diagnosis if assessed utilising a recognised diagnostic tool such as the Structured Clinical Interview for DSM-IV Axis II personality disorders (SCID II). The measure used by Gee and Reed (2013) is not a diagnostic tool and participants were not in receipt of a BPD diagnosis. Gee and Reed (2013) report on a number of positive outcomes including a reduction in ACCT use, a reduction in prison adjudication penalties, improved overall mental health and high client satisfaction. DBT may have a contribution to make in improving the lives of people who have not been diagnosed with BPD.

It is the position of this research that the suitability of a person's presentation for DBT as an intervention should be considered through the process of individual case formulation rather than based on the diagnostic criteria of BPD. This recommendation has been generated by this research due to the experience of the participants not mapping directly onto BPD symptomatology. DBT has been shown here to impact participants who were not displaying life-threatening behaviours but were displaying quality of life interfering behaviours (Linehan, 1993a). Rotter and his colleagues (2002) show that these are behaviours that are common to the prison environment, thus supporting the potential for DBT to help others in prison to have a better quality of life regardless of whether they are in receipt of a BPD diagnosis. This would enable the therapy to be closely targeted to the needs of the individual, which may improve the effectiveness of the therapy. In highlighting experiences of an outpatient DBT programme Hodgetts et al. (2007) report that participants advised they would have preferred a bespoke approach that was tailored to their individual experiences rather than led by diagnosis.

Assessing appropriateness for the DBT approach based upon individual presentation rather than diagnosis may contribute to attrition rates. Research conducted by McFetridge and Coakes (2010) suggested that clients who dropped out of DBT treatment could potentially not be suitable for the approach, for reasons such as the rigid structure, or lack of immediate focus on historical trauma, regardless of having a BPD diagnosis. Nee and Farman (2005), and Gee and Reed (2013) each state attrition as a problem that needs further investigation.

Assessing for appropriateness to treatment based on presentation rather than diagnosis may also have an impact upon funding and resources being utilised effectively if treatment is targeted to the client's individual case formulation. It may be that a stepped system of DBT can be employed, whereby the severity of presenting problems dictates the level of DBT utilised. As such a less severe presentation may involve an adaptation to DBT in the delivery of skills groups only and a severe presentation may result in both individual and group therapeutic components being utilised. This is in line with the GLM-C (Ward et al 2007) whereby therapy is individual tailored to the offenders risk and need, of which diagnosis is one factor to be considered.

### **6.3 A DBT wing**

Housing prisoners who are engaged in DBT together may contribute to reducing the challenges experienced by participants in utilising their DBT skills in prison, as represented within the superordinate theme **'it's a struggle'**. A DBT wing will contribute to managing the aforementioned conflict between the endeavour of DBT to promote independence and positive change, and the inherent punitive environment and controlling systems in prison. A landing or wing specifically for participants of DBT may provide an environment that is conducive to learning and

utilising DBT skills. Nee and Farman (2005) housed the control group and the DBT group together on the same wing in prison, and found similar behavioural improvements within the control group who did not receive DBT, as the group of participants who did receive DBT. Nee and Farman (2005) state they found clear evidence of a generalisation of the impact of DBT to the control group when they interviewed the participants and the prison officers (unpublished data).

A DBT wing may contribute to better working relationships between prisoners and prison officers, as represented by the superordinate theme '**Prison life**', and the subordinate theme '**less strife**'. The housing of prisoners receiving DBT together promotes the idea of training prison staff in the basics of DBT skills. The experiences of the participants within this research suggests that training the prison officers may enable the prison to liaise more skilfully with prisoners and reinforce skills acquisition for DBT clients. Previously reported research conducted by Misis et al. (2013) supports the idea that training staff in behavioural management techniques, such as DBT, reduces the levels of stress reported and improves relationships between staff and prisoners.

The participants of this research stated that being able to ask officers for help had contributed to a reduction in their self-harming behaviours, as was represented by the subordinate theme '**letting go of old behaviours, 'I don't do that anymore**'. Research concerned with self-harm among women prisoners conducted by Borrill et al. (2005) showed that women cited good relationships with prison officers as a factor in reducing the likelihood of engagement in self-harming behaviours. This suggests a possible impact of reducing self harm, not only from engagement with DBT but also through improved relationships in being housed on a specific DBT wing, with DBT trained prison officers.

Notwithstanding the points above it can be argued that although prison provides an environment that is unique to the context and different from a community

setting, in considering the world outside of DBT, society is not made up of a majority of people that are DBT aware. Therefore, it may be that becoming adept at utilising DBT skills within the wider prison population, despite the inherent conflicts, will serve the clients of DBT at providing an environment that is more closely linked to what they will experience outside of prison. Rather than establishing a DBT wing, which provides an artificial environment that will not be replicated post release.

A compromise within this dialectic may be to house clients of DBT together during the therapy, thus potentially providing an environment conducive to learning and utilising DBT skills. Following therapy, clients may then be reintegrated back into the main prison population. In line with the Nee and Farman (2005) research, dependent upon the ratio of people involved, it may be that the wider prison population experience a generalisation of the impact of DBT.

#### **6.4 DBT post-release**

In considering the experience of the participants' presented within this research, the existing research into the effectiveness of forensic DBT (McCann & Ball, 2000), the lasting impact of treatment gains, both outpatient (van den Bosch et al., 2005) and inpatient (McFetridge & Coakes, 2010), and the potential impact of DBT on reducing re-offending risk, there is value in engaging appropriately assessed clients in an outpatient DBT programme in the community post-release in contribution to a holistic package of care as part of the resettlement and probation service.

In orchestrating a community based DBT referral clinicians would also satisfy the stipulations of the Offender Personality Disorder (OPD) Strategy (DoH, 2015), which aims to monitor people and their healthcare treatment through the prison system and is structured from community to community.

## **7.0 Relevance to Counselling Psychology**

The research presented here is relevant to counselling psychology due to the political change observed in the clinical treatment of BPD (DoH publication, Personality Disorder: No longer a Diagnosis of Exclusion, 2003) and the focus on treating personality disorders within a forensic context (OPD, DoH, and MoJ, 2011a, 2011b). Counselling psychologists have a role within multi-disciplinary team working within both the NHS and the UK prison system. Therefore counselling psychologists have a responsibility to know what treatments are available and efficacious for the particular presentation of a client developed through the use of formulation. The research presented here has shown that as a therapeutic approach DBT has an established potential, for a particular client group, within a forensic context.

It is important to note the shared philosophy between counselling psychology values and the principles underlying the DBT approach. The BPS Professional Practice Guidelines, define counselling psychology as,

‘to know empathically and to respect first person accounts as valid in their own terms; to elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing’ (p. 1.).

DBT shares this philosophy in promoting the autonomy of the client, having an inquiry into their unique experience, and consistently validating the client as a specific strategy of intervention. Counselling psychology and DBT both promote the values of acceptance and change and provide a framework in which to work with these concepts within a forensic environment that also promotes change.



Importantly counselling psychology has the ability to give a voice to people who are marginalised by society as is seen within this research. Prisoner's voices are not often represented within an academic domain or a wider societal context. Counselling psychologists' have the ability to utilise the strengths of their aforementioned central philosophy in enabling the experience and opinions of prisoners to be heard. Counselling psychologists can provide a route to ensuring that the views of marginalised people are considered within the provisions of treatment and policy making in the healthcare service aimed at helping these individuals.

The client group participating in this research can be understood as vulnerable and challenging to engage in therapeutic interventions (Perry et al. 1999). The research presented here has highlighted the participants' experience of feeling understood, respected and validated within the therapeutic relationship. Further to this participants' linked this experience to the building of trust between themselves and their therapist. Counselling psychologists have an acute awareness of the role the therapeutic alliance has in facilitating change and impacting on the overall effectiveness of therapeutic intervention. This awareness and the skill of counselling psychologists to build a strong, empathic, accepting and containing frame may be of particular importance within a forensic context.

## **8.0 Strengths and Limitations**

### **8.1 Limitations**

This study is subject to the usual limitations of qualitative research whereby generalising results falls within a positivist quantitative framework and is therefore beyond the scope of the research presented here. Qualitative research investigating human experience has been criticised by Willig (2011) as she stated that not one

method can pertain to accurately reflect experience. While this may be the case, no one qualitative method can be upheld as superior against another in response to this criticism. The choice of a research method was led by the research aims, with IPA considered the best fit.

This research can be criticised for including only people who had completed the DBT programme into the sample for interview, rather than people who had dropped out of treatment before completion. There were eight eligible and available potential participants who had completed the DBT programme at the time of recruitment who were invited to participate. One person declined and the remaining seven agreed. The decision to include only people who had completed the DBT programme was based upon the research aims of investigating the experience of completing the whole DBT programme. Interviewing people who had not completed would likely have given a less favourable view of DBT, however they would not have experienced the full programme.

There is a consensus in the literature by researchers concerned with the effectiveness of treatments for BPD to include only completers in the analysis in order to adequately assess the treatment concerned in its entirety (see Bateman & Fonagy, 1999; and Bohus et al. 2004). When considering the matching of the participant sample to the research aims this approach is logical. However it is possible that there are commonalities within the group of people who have dropped out of treatment, which depicts a lack of suitability to the treatment, and thus a commonality between completers, which can provide insight as to their suitability to the treatment. This supports the widely held recommendation for further research investigating the factors affecting treatment retention and dropout.

Speculation as to the shared features of the sample included in this research is that they were all willing to engage in the therapy. As previously stated the DBT programme requires an autonomous commitment and clients know that they are able

to end their therapy at any time, and without penalties. Interview data showed that two participants spoke of their wanting to change and looking for an opportunity to help them do so prior to engagement with the DBT programme. This shows the potential for the timing of engagement to be a factor affecting the outcome. Hodgetts et al. (2007) interviewed a non-completer of DBT who advised she wasn't ready to engage with treatment. The active choice to engage that is needed from clients promotes the clients taking responsibility for themselves and their treatment. Thus those clients able and willing to do this are more likely to complete, as was again seen within the interview data. Hodgetts et al. (2007) advised that participants had each described experiences and motivations for change now, that were not present for them previously.

## **8.2 Research Validity**

The analysis was not cross-validated by the participants. This was due to all participants not still being held in the same prison, and ethical considerations of not being able to provide access for support after the cross-validation if needed. This was due to the time lapse between interview date and the data analysis being completed as some individual therapists had moved on from their position, and current therapists had a new case load. Langdridge (2007) questioned the value in having participants review the analysis due to the inaccessibility of the methodological strategy and underlying philosophy to participants without academic training. Therefore in order to assess reliability I participated in an academic IPA research group whose purpose it was to exchange and analyse extracts of data and compare the findings.

The validity of this research is also supported by the methodology utilising semi-structured interviews, which allows for extended scope in the participants

interpretation of the question and answers they gave. Qualitative research conducted by Cunningham et al. (2004) and Perseus et al. (2003) investigated effective components of change, both of which were based on the assumption that the DBT programme the participants had completed had a positive impact for them. However, neither study stipulated how that positive impact was measured and by whom. This led to targeted questioning which was potentially leading and potentially primed the participants for particular answers. In line with the epistemological assumption underpinning the research presented here, there was no assumption of impact, positive or negative, as a result of the participants engagement with DBT. The semi-structured interviews, questioning technique and method of analysis have been utilised in order to illuminate the participant's subjective experience.

### **8.3 Strengths**

A strength of this research was overcoming the challenges presented in gaining ethical approval from the NHS NRES, HMPS NOMS, NHS R&D and City University London. Due to the security stipulations and insider knowledge required to carry out research within UK prisons this ethical approval would not have been possible without first being employed within HMPS and having the support of the immediate establishment and healthcare team. Gee and Reed (2013) and Nee and Farman (2005) highlighted the challenges they faced in gathering meaningful data from HMPS and NOMS in contributing to their quantitative research analysing the effectiveness of DBT in a forensic setting. The completion of this research in adherence to the meticulous ethical guidelines is a representation of the strength inherent within it.

It has been noted in the literature review that the lack of research pertaining to the efficacy of interventions in a forensic environment has resulted in a lack of

consistency in the approach and adaptations of DBT to this context. This is a significant obstacle in the development of meaningful research moving forward and prohibits the development of adaptations that can be employed by a variety of forensic establishments. The research presented here contributes to this body of research and is the first study to utilise IPA in exploring UK prisoners' experiences of DBT.

This research provides insight into the experience of engaging in self-harming behaviours in prison. Importantly, this research provides insight into how the experience of completing DBT facilitated the reduction of engaging in self-harming behaviours for the participants interviewed. The interplay of learning DBT skills to manage adversity, improving upon personal relationships, and improving the overall quality of life in prison has been shown to impact upon the participants' engagement with methods of self-harm. This insight into the underlying processes of behavioural change within DBT is unique to the participants' experiences reported here.

This research illuminates the participants' experiences and has the potential to inform the delivery, adaptation and utilisation of DBT within a forensic setting.

## **9.0 Implications for future research**

The research presented here and the subsequent discussion have highlighted future research needs in several areas concerned with conducting DBT in a forensic setting.

### **9.1 Longitudinal data**

The themes presented within this research show the breadth of impact the participants experienced in their view of themselves, their perception of the world,

and their interpersonal relationships; the implicit value of these themes for the participants is evident within the quotes presented. This research did not provide an insight into the longevity of this impact beyond the date and time that the interviews took place. It is not possible to speculate as to how robust this impact will be beyond the prison environment and into the community post-release. The participants have spoken of the difference in utilising skills in and out of prison, showing an awareness of how the difference in context may affect the way they engage with DBT skills. The experience the participants have articulated can be interpreted to suggest that there is the potential for the impact of the DBT programme to extend beyond the prison environment with the participants post-release.

Research completed by van den Bosch, Koeter, Stijnen, Verheul and van den Brink (2005) found that outpatient DBT treatment gains were maintained six months post completion. McMain, Guimond, Streiner, Cardish, and Links (2012) assessed DBT treatment gains at six-month intervals, up to two years post treatment completion. McMain et al. (2012) found that the treatment gains were maintained throughout this period; however, there was impairment in overall functioning in terms of high rates of unemployment and reliance on disability benefits. This research supports the previously stated point that there is no suggestion that DBT targets all facets of risk associated to rates of re-offending.

The research presented here shows the potential for a lasting impact and supports further research investigating the lasting effects of any treatment gains for clients of forensic DBT post-release. The themes presented have shown a potential for DBT to contribute to a reduction of recidivism. Further research is needed to determine the rates of reoffending for prisoners post-release who have completed a DBT programme. This research will provide further insight into the potential contribution of DBT to the targeting of recidivism.

## **9.2 Treatment based upon individual case formulation**

Research investigating the factors affecting the appropriateness of the treatment approach, and treatment retention and dropout is needed to ensure that DBT is utilised at the optimum level of efficiency for client commitment and engagement, and service funding.

Further research and consideration is needed to determine if DBT can be effective within a prison context following allocation of treatment based upon the presenting concerns of the individual, within the framework of case formulation, rather than being dictated by diagnosis alone.

## **9.3 A DBT wing**

Research is needed to assess the effectiveness of forensic DBT and the impact of housing prisoners together on one landing or within one wing of the prison. Research has been presented to show that this has the potential to contribute to a reduction in engagement with self-harming behaviours, and improve relations between prisoners and prison staff (Borrill et al. 2005), and reduce levels of stress reported by staff (Misis et al. 2013).

## **10.0 Personal Reflexivity**

The influence I have had over the data gained can largely be related to my position as both the researcher and a therapist on the DBT programme. The impact of this is that I have had an intimate knowledge of DBT, the prison and the participants. This intimate knowledge has meant that I have assumptions and awareness that a researcher without this knowledge would not have had. Reading

through the interview transcripts with the vision of someone who was outside of the context showed me that there were questions of clarification that someone would have asked if they were from outside of DBT or prison. These were questions relating to DBT skills, or the prison regime, or local lingo, which I understood. However it would have prompted a different response for the participants to have been asked to clarify their own meaning. Rather than proceeding with my assumption of understanding their meaning due to my prior knowledge of the context and subject matter. Notwithstanding the impact on the data gained, it is my belief that my pre-existing knowledge of the context and therapeutic approach, along with the pre-existing relationship with the participants, contributed to the rapport and rich depth of the data gained. The participant's spoke of the challenges they experienced with trust. Due to the participants' shared experience in the challenge to trust one another, and the DBT therapists, this became a subordinate theme deduced from the data. It is my belief that each participant trusted me to varying extents due to our existing relationship. I believe that without this trust the participants would not have been as willing to divulge the detail of their personal experiences. For example the participants were experienced in speaking with me about self-harming and suicidal behaviours. These are topics that even some healthcare professionals feel ill equipped to discuss. The participants may have had difficulty in the past when discussing these behaviours with professionals, therefore the participants may not have discussed them with a researcher whom they did not know, and therefore not knowing how that researcher would respond to such topics.

I was initially challenged in my analysis of the data as I felt resistant to interpret the participants meaning, I wanted the data to speak for itself and found it hard to define an interpretation without assumption. However it soon became clear to me that a lack of interpretation upon meaning would result in a thematic analysis. This would therefore deny the reader of a deeper grounding and understanding to



the data that interpretation within the method of IPA brings. I reframed the analytic process for myself as a duty that I had as the researcher. To illuminate my interpretation of the participants meaning in order to achieve the research aims and contribute to the wider body of research into forensic therapies.

The data and the themes that emerged during the analytic process surprised me in a number of ways. I was not expecting the participants to be predominantly positive about their experiences; I was also not expecting the participants to frame the challenges they faced as a positive learning experience. My experience as a DBT therapist with this challenging client group was of the numerous aggressive outbursts, arguments and violent altercations within the skills group. I had experienced the difficulties in facilitating the clients to commit to the therapy, and be present and stay for the entirety of their individual and group therapy sessions. Therefore I wasn't expecting the passion and genuine enjoyment with which the participants spoke about their experience. I was surprised at the explicit descriptions that participants gave of their increased value for themselves, and the level of impact participants advised their experience of DBT had on their personal and familial relationships. As a DBT therapist I knew that historically clients of DBT largely experienced a reduction in particular behaviours, such as self-harming behaviours and behaviours that caused them adverse consequences within the prison disciplinary system. These behaviours are tracked and reported by both the clients and the internal prison system and discussed within individual therapy and the DBT therapists' group consultation peer supervision meeting. However I had not experienced explicit and consistent explanations from the clients regarding the change in their internal beliefs and values, and changed view of self. The qualitative evidence from this research brought this to my attention and gave me a new awareness of the participants' internal experience and the potential of DBT to facilitate this change.

I was pleasantly surprised by the quality and positive nature of the data, it gave me a renewed sense of determination to stay involved with DBT and forensic psychology. I fully expect to be influenced in my practice going forward by the data I have gathered. In giving a voice to the already existing quantitative figures I have provided myself with a solid, evidence-based, internal voice of real experience. This will help to validate my own experience of the challenges inherent in being a forensic DBT therapist, and motivate me to commit to overcome those challenges.

The participants' experiences will inform my personal approach both practically and philosophically. Practically, I will take on board the participants' feedback and implement changes to the delivery of the therapy. In terms of the comments regarding the classroom setting and layout, and how emotionally provoking that was for participants. Philosophically, I will have a deeper awareness for the impact of strategies such as validation, irreverence, and self-disclosure. I will further value the process of developing a therapeutic alliance and how integral this is in the process of change for the client. Prior to completing this research I had faith in DBT and its ability to facilitate clients to manage their emotions and adopt adaptive behaviours to replace maladaptive behaviours. Completing this research has enabled me to evidence that faith with the experience of the very people I, and DBT, have aimed to help.

## **11.0 Conclusion**

The participants' experience of DBT has been shown to have the potential to address the risk factors associated to reoffending. Participants identified an impact in areas including self-esteem, personal relationships, and a reduction in self-harming and suicidal behaviours. In addition the participants in this study illustrated an increase in the ability to empathise, in understanding the perspective of the other, in having an awareness of aversive consequences and owning personal responsibility. Each of these areas demonstrates potential within the wider research arena of addressing particular facets of recidivism. Developing targeted adaptations to the original DBT model, which are matched to both the unique individual risk factors identified via case formulation, and the established risk factors for reoffending, would further improve the potential impact on recidivism and adherence to the OPD strategy.

In considering a lack of longitudinal data clinicians are encouraged to provide on-going referral to an outpatient DBT programme in the community post-release. This contributes to a holistic package of care, as part of the resettlement and probation service. 'Through the gate' referral will further satisfy the stipulations of the OPD Strategy. Lastly engaging clients in community-based therapeutic services provides a route for monitoring rates of re-offending in order to contribute to knowledge regarding criminogenic risk and recidivism data.

Going forward, considerations should be made for prisoners who are engaged in, or have completed a programme of DBT, to be temporarily housed together, thus providing an environment consistent to the principles and philosophy of DBT and potentially contributing to the management of challenging behaviours associated with the presentation of DBT clients.

Finally, the experience of the participants has shown that the impact of DBT within a forensic context may not be limited to those people diagnosed with BPD. This research supports the notion of defining suitability for a therapeutic intervention via individual case formulation, as opposed to diagnosis alone. Adaptations to the original DBT model can be made based upon the presenting concerns of the individual. DBT may then be utilised across a wider prison population and contribute to improving the lives of people in prison, both staff and prisoners, through strategies of managing emotions, tolerating distress and improving personal relationships.

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## **Appendix A Invitation to participate**

Invitation to participate

Dear DBT completer,

You are being offered the opportunity to discuss your experience of engaging in the Options Dialectical Behavioural Therapy (DBT) programme. This would involve you being asked questions by a researcher about how you found Options, regarding what you did and did not like, and what you thought helped or did not help. This will take approximately one hour of your time.

The information you provide is confidential and anonymous. The information you provide may help us to improve the Options DBT programme, your information may also help to inform future decisions about therapy in prison. If you would like to share your thoughts with the researcher then please ask your landing officer to call Options on 4840 and ask for the full participant information sheet to be provided to you.

Thank you



## **Appendix B Debrief Information Sheet**

### Debrief Information

Thank you for your participation in this interview, it is hoped that your answers will help us to understand what it is like to do the DBT programme. Please take away the information sheet provided with you.

If you have been adversely affected by the interview today then you can request to see your individual DBT therapist through me now.

Or we can arrange for you to speak to your personal officer, or I can arrange for you to see one of the prison listeners.

You can also discuss any issues anonymously by ringing the Samaritans on 08457 90 90 90.

Thank you for your time and assistance, it is very much appreciated and is a big help towards our understanding.

## **Appendix C Interview Schedule**

### **Interview Schedule**

How would you describe the experience of completing the DBT programme?

- Were there any bits you particularly enjoyed?
- Were there any bits you particularly did not enjoy?

If you reflect back on yourself before and after the DBT programme, are there any thoughts you can share with me?

Do you have any thoughts on your experience of your emotions that you would say has been effected the DBT programme?

Do you have any thoughts on your experience of your friendships and relationships or interactions with other people that you would say has been affected by the DBT programme?

Do you have any thoughts of your experience of how you manage upsetting things in life which cause you distress that you would say has been affected by the DBT programme?

Can you tell me anything about the experience of learning about mindfulness within the DBT programme?

Do you have any thoughts about the experience of individual therapy within the DBT programme?

- Were there any bits you particularly enjoyed ?
- Were there any bits you particularly did not enjoy?

Has the experience of completing the DBT programme has any effect on your experience of life in prison?

Has the experience of completing the DBT programme had any impact of your view of your index offence?

What advice would you give to a friend who was thinking of doing the DBT programme?

Is there anything else you would like to say?



## Appendix E IPA Theme Generation Example



## Appendix F IPA Themes and supporting quotes

Superordinate Theme	Subordinate Theme	Quote
Prison Life	Less Strife	<p>Gemma, <i>'it's weird how the slightest thing can make such a big impact'</i> (43), <i>'it's making my life a bit easier in here'</i> (224), <i>'It's changed jail bigtime'</i> (245).</p> <p>Sharon, <i>'It's made life in prison easier'</i> (472), <i>'Cause if I've got any difficulties I know that I can go and ask for help now, whereas before I would, I wouldn't, or I'd end up getting in a fight or something'</i> (474).</p> <p>Julie, <i>'it's not so daunting, you've got to live your life everyday, whether in prison or not, but there was that daunting side of prison, that's easier'</i> (228).</p> <p>Michelle, <i>'I haven't been angry with other people when they get in my face'</i> (808)</p> <p>Samantha, <i>'no matter how angry I am when I'm trying to do something, or get something done, I don't lose it'</i> (191).</p> <p>Gemma, <i>'like the officers and that, the way I used to speak to them before, 'cause that's improved now, I have banter with them though, I'm still cheeky, I just do it in a different way now, I just have banter and a laugh with them'</i>. (85)</p>
	'I can't win by fighting the system'	<p>Sharon, <i>'I've accepted that I'm in prison, and I've accepted that I can't, I can't win by fighting the system'</i> (139).</p> <p>Mary, <i>'I haven't been put on basic, I haven't been given IEP's, I haven't been put down to seg, nor have I been given an extra charge, so it's helped me, it's helped me quite a lot'</i> (815).</p> <p>Sharon, <i>'I've come a long way, 'cause even like, erm, my parole officers have said that I've come a long way from before. Like with my behaviour, 'cause I've had no adjudications, no altercations with anyone since doing the DBT course'</i> (120).</p> <p>Gemma, <i>'they wouldn't have enhanced me or anything before, whereas now I'm enhanced and everything, I'm</i></p>

		<p>good!' (44).</p> <p>Mary, 'three weeks ago I self harmed but I was only put on an ACCT for two to three days, but that's only a blip, compared to if I hadn't have gone to this group I would have been self harming more' (91). 'I was near enough always on an ACCT when I first come in but because of this group it's helped me, to think, to use my skills' (118).</p>
It's a struggle		<p>Samantha, 'I'd be lying if I said I'd enjoyed it all because I didn't, but I learnt something new from everything, and so I did open myself up to learn new things. I might not necessarily have been enjoying myself as I was learning it, but I learnt it and that's what matters' (19).</p> <p>Gemma, 'stick with it because sometimes it gets harder before it gets easier, and that's, the tough roads are really hard to get by' (263).</p> <p>Natasha, 'just stick it out, it will help, you don't think you learn anything but you do, you do' (235).</p> <p>Michelle, 'people have to struggle, do you get what I'm saying, to actually get somewhere, like, that's what has to happen for them, like, to get a realisation' (1589).</p> <p>Sharon, 'you gotta keep on doing it to benefit from it, but also to erm, not to give up because you won't benefit from it, because nothing's easy in life' (389).</p> <p>Michelle, 'if you want the truth yeah, the truth of the matter is, all this [DBT skills] doesn't always work with them [prison officers]. If you kick or scream the loudest, or if they know you're going to go mad, that's when you get what you want, yeah, so this establishment is built on causing this behaviour' (1457).</p>
	DBT is hard	<p>Samantha, 'it was different for me to actually grasp the concept of what we are doing and what it's about, that's what took some time, but after that I got it and everything was easier' (132).</p> <p>Gemma, 'I just found it really confusing to start off with, I think it's just 'cause when you, because it's called therapy, when you think of therapy, you think of like psychotherapy</p>

		<p><i>and that, so that really confused me to start off with and I was like, why do they call it therapy when it's not, but like, when I got the hang of it and that, with like the BCAs and that as well, you really like, I don't know, it really hits you like.'</i> (165).</p> <p>Mary, <i>'BCAs, they were awkward, the problem, no, not the problem, the probability, the prompting event, no the bottom one, the problem behaviour, we used to get stuck on that one, so yeah, the BCAs were a bit tricky to do, so yeah, we used to do them together, so that was the only thing that I found hard, was the BCAs'</i>. (723).</p> <p>Gemma, <i>'BCAs as well, they start off well confusing to start off with, and then once you get your head wrapped round them they're actually well helpful. Because when you, you can stand there and think that something's a problem, but actually, when you do the BCA you might not think, you might realise that it actually wasn't that in the end, it was something completely different and that shocks you a little bit, but then it helps you to overcome things more as well and deal with things in a better way'</i>. (185).</p> <p>Mary, <i>'you've got to be searched, and then you've got to wait, it's just ridiculous to be quite honest with you, it's stressful'</i> (28).</p> <p>Michelle, <i>'I'm not trying to be horrible or nothing, but you see when I'm going there I feel like I'm being in a situation, yeah, 'cause say someone attacks me, yeah, I'm not saying anyone is yeah but I'm just saying for instance right, I feel like I'm in a high risk situation down there'</i>. (1814).</p> <p>Samantha, <i>'I didn't really have it good at school, all the memories I've got from school are not good, so the last thing I need is to feel like someone's patronising me when you're talking to me, because I will get angry because I wasn't at an age then but I'm at an age now where I can say something, but no, I didn't feel patronised once'</i> (162)</p> <p>Julie, <i>'the nervous bit, the only bit I didn't enjoy is the going</i></p>
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		<p><i>back to school malarkeys. That initial, 'oh my god, there's loads of people in here, don't know anybody', but as I said, straight away, 'hello my name's Julie', 'my names so and so', and it's, yeah it was great' (40).</i></p>
	The challenge of trust	<p><i>Sharon, 'I think at first I found it challenging, like, to trust people, but I overcome that, so yeah, but that's just because I've got trust issues, it got easier because the course and the facilitators made it easier'. (76)</i></p> <p><i>Mary, 'I couldn't relax, the trust weren't there, so yeah, you've got to be in a good zone and place, and you've got to be able to feel at least like you can trust people enough to close your eyes' (524), 'anybody can do anything when you've got your eyes closed' (545).</i></p> <p><i>Sharon, 'in the group yeah, where you close your eyes and just let, like, take yourself somewhere else. I found that really difficult because one, it's closing my eyes in front of loads of people and it's like, 'God, I can't see now', 'cause my eye's are closed and anything could happen'. (374)</i></p> <p><i>Mary, 'I feel wary around a lot of people because of what I've been through when I was younger and stuff, it's hard to relax' (515). 'I felt like I could trust her, I could talk to her about other things that I can't really talk to other people about' (632).</i></p> <p><i>Gemma, 'I just tried getting on with it and I just thought, they're still a person, they're still a professional, and they still know what they're doing, and they've still got the confidentiality rules so I should still try and trust her, so I did try, it's just really difficult' (215)</i></p> <p><i>Samantha, the one to one's helpful, providing you feel like you can talk to that person, if you feel like you can't talk to the person, or even if you don't talk, you feel like you can, but you must don't want to, then that's a problematic situation, that's really problematic' (147).</i></p> <p><i>Sharon, 'I didn't really enjoy it at first, I felt uncomfortable, after about two weeks I started feeling more comfortable and then I was opening up more' (460).</i></p>



		Gemma, <i>'because you see them every week, you get close to them anyway, you get friendly and everything'</i> (175).
Increased connection to others		<p>Julie, <i>'it's helped me to engage more with other people, erm and take their points of view on, and erm, make friends'</i> (124).</p> <p>Samantha, <i>'Any form of relationship, the relationship I've got with my mum, the relationship I've got in general, like, they're both affected by it because I'm at a point where I can actually look at a situation and take responsibility for it'</i> (69), <i>'relationships in my life are affected massively by doing DBT I'd say'</i> (90). <i>'DBT helped me in my relationship, yeah, because it's had a lot of highs and a lot of fucking lows, so learning about like, balancing priorities, like, it helped to know that there's a limit'</i> (284).</p>
	'She's got her daughter back'	<p>Samantha, <i>'the relationship with my mum is like 1000 times better than it possibly could have been'</i> (75).</p> <p>Julie, <i>'we've been able to have a good genuine deep chat and get on like sisters if anything now, which is great, yeah you know, stronger, a lot stronger'</i>. (224).</p> <p>Natasha, <i>'she's even, she said I'm a different girl totally, she's got her daughter back'</i> (49)</p> <p>Julie, <i>'he said 'whatever you're doing in there keep doing it, I like the new wifey!'</i> (283), <i>'it's made me feel like I can be more open with my kids as well'</i> (214).</p> <p>Sharon, <i>'I'm talking more, like if I've got problems, usually I don't just open up to my friends, but now I do, and it's easier having mates around you'</i> (199).</p>
	'More talking, less shouting'	<p>Natasha, <i>'The way I talk to her, I'm really calm with her and I don't swear at her, I don't call her names no more, I'm just really calm'</i> (45).</p> <p>Julie, <i>'my husband will say to me, 'but why didn't you talk to me like that before?' Because I didn't know how to, I just didn't know'</i> (280).</p> <p>Michelle, <i>'So rather than just talk about something, like,</i></p>

		<p><i>say this is how I felt, I'd just be angry straight away, and whatever was hurt, the most hurtful thing to say, is probably what I might say, because I wanted them to feel exactly how I felt. But they have got no clue why' (366).</i></p> <p><i>Sharon, 'whereas before I used to be proper stubborn, if I'd had an argument with one of my mates I just wouldn't speak to them, but now I just go up to them straight away, like, 'sorry' (201).</i></p>
Emotional awareness - 'One big emotion'		<p><i>Samantha, 'I've only ever learnt this in DBT, throughout my whole life, so, doing DBT helps you to be mindful, to work out what you are feeling, how that situation made you feel, why it made you feel like that, and to accept that you can't change it and it's happened' (236).</i></p> <p><i>Julie, 'I was a very mixed up emotional person, I still am a bit, but not so much, where I would hold things in, I wouldn't talk about my feelings, I wouldn't talk to a lot of people'. (87).</i></p> <p><i>Sharon, 'I didn't want emotions and I never thought there were so many emotions, I just thought it was one big emotion' (98).</i></p> <p><i>Mary, 'DBT has helped me with the way I'm feeling and helped me to understand the way I feel' (998).</i></p> <p><i>Natasha, 'when an emotion comes up now, I know it's coming up because I know how I feel when an emotion comes up' (85).</i></p> <p><i>Julie, 'with my emotions as I said, it's made me realise that when I am sad, I am sad, when I'm happy, you know, I'm happy, and now I can talk about that' (114).</i></p> <p><i>Michelle, 'What I'm angry about I had to have a look more into because it's, it's not just anger' (360), 'What's underneath that anger?' (383).</i></p> <p><i>Mary, 'know my body's reacting as well to certain things, whereas before I wouldn't understand if I was shaking that I'm angry, and when I'm getting sweaty palms I'm getting angry, or when my posture changes, stuff like that, but now I understand my body signs as well' (1012).</i></p>

		<p>Michelle, <i>'I could see her whole demeanour change, yeah, you know like, when she didn't get her phone call, or the boy didn't say what, er, she wanted him to say, like, it ruined her whole week, and I thought to myself, you know what, maybe people are a bit more sensitive than what I give them for'</i> (840).</p> <p>Julie, <i>'it got to the bit where I was sitting in front of everybody and I was accessing my feelings, so erm, every part, it's made an impression on me'</i> (173), <i>'With going to the group I've been able to explain my emotions in depth, rather than when I came into prison'</i> (270)</p>
	Emotional acceptance, 'it's ok to have emotions'	<p>Mary, <i>'you're not beating yourself up because you're crying, it's alright to be crying, it's a natural thing that everybody does it'</i> (279).</p> <p>Sharon, <i>'I wasn't really aware of my emotions, well I was but I kind of didn't, I didn't accept them, I didn't want emotions'</i> (97), <i>'it opened me up to realise that it's ok to have emotions'</i> (105).</p>
	Letting go of old behaviours, 'I don't do that anymore'	<p>Mary, <i>'not sending nasty letters and not jumping the gun so quick'</i> (224)</p> <p>Sharon, <i>'smashing TVs up, refusing to go behind my door, fires'</i> (129), <i>'while I was doing the DBT course, like my emotions, it helped me, because my self-harming, it stopped, by the time I'd finished the course, it'd stopped'</i> (149).</p> <p>Samantha, <i>'Like, prime example, I don't self-harm anymore, I can kind of understand why I self-harmed now, because it was never about the issue, it was just about what I allowed to become the issue'</i> (95) <i>'I don't have to self-harm, and I don't even think about self-harming, for the simple fact that whatever it is I can deal with it'</i> (101).</p> <p>Mary, <i>'so before I wouldn't think about distract, I wouldn't think about picking up knitting needles, ok I used to knit but that wouldn't be my main priority, when I had the urge to cut up, I would cut up but it's thanks to this group, this options that I haven't self-harmed'</i> (98).</p>

	Managing emotions, 'Another way'	<p>Julie, <i>'it's made me realise there is different ways of dealing with your emotions'</i> (177).</p> <p>Mary, <i>'I'd retaliate, for example this morning, someone wound me up, someone really did wind me up and before I'd get in the persons face, I'd scream, I'd shout, I'd be disrespectful back to that person but instead I went off the landing and I went to the library and I didn't let it ruin my day or my morning, I just carried on'</i> (197).</p> <p>Michelle, <i>'It was enjoyable for me, yeah, it helped me to get a realisation, like, I never really thought about the way that I look at things, and all that before, but then when something is in front of you, in black and white, it makes it different'</i> (1252)</p> <p>Sharon, <i>'doing that and then realising, learning from where the trigger points were, or your urges, and writing down what you could have done instead, so it helps you next time and then I got to the point where I was doing the BCA after I self-harmed but then I got to the point where I was doing them before I self-harmed, 'cause then I didn't self harm, because I was doing the BCAs and then I was, and I was realising that I could do something differently'</i> (405). <i>'if I got to a low point before, I wouldn't even go and ask for help or anything, I'd just, I'd just, just try and end things, whereas now, if I feel low, or I feel like, say suicidal, I will go and let someone know'</i> (586).</p> <p>Samantha, <i>'I come across an emotionally stressful situation, it could be with anything, first thing I think of is 'I want to die', that would always be the first thing that I would think of, I'm not saying I don't come across thoughts like that now, but I just know to accept that I thought that and throw it way, now I know that I don't want to die'</i>. (34).</p>
Who am I?		<p>Mary, <i>Do it, because you'll understand yourself, you respect yourself more, you really will, and you feel normal, you feel human, you feel alright and it's alright to feel certain things'</i> (1040).</p>

	Understanding me	<p>Mary, <i>'to understand my mind'</i> (71) <i>'understanding myself'</i> (305).</p> <p>Natasha, <i>'Learning to get to know about yourself'</i> (231).</p> <p>Sharon, <i>'knowing myself more'</i> (566).</p> <p>Natasha, <i>'it's just, it's just scary, it's a weird thought 'cause I ain't known myself since I was 14'</i> (189).</p> <p>Julie, <i>'you know, little things what I can, begin to express myself, good and bad, whereas before I couldn't do it, I just wouldn't do it'</i> (98).</p>
	Learning to value myself, 'I deserve to be loved'	<p>Samantha, <i>'the fact that I actually learnt to value myself as a person, like, the fact that I actually found this next love for myself that I didn't even know was there'</i> (280).</p> <p>Sharon, <i>'before I didn't really give a fuck about myself'</i> (583), <i>'it's helped with my confidence, trust, self-esteem, self-worth'</i> (592).</p> <p>Mary, <i>'I deserve to be treated well, and I deserve to be looked after, and I deserve to be loved'</i> (376).</p> <p>Gemma, <i>'I struggled to do it before, mainly because of negative comments about myself, like judging myself and that, I'm a lot less harsh on myself now'</i> (119), <i>'before I would have battered myself on that, like, I probably would have tried to commit suicide'</i>. (122).</p> <p>Julie, <i>'I feel more positive on myself, although I still got my ups and downs, but yeah, I'm definitely more positive'</i> (103).</p> <p>Mary, <i>'I'm liking myself, I look in the mirror and I like what I see, whereas before I'd put myself down and call myself names and stuff'</i> (321).</p> <p>Sharon, <i>'I put all the skills in, 'cause even though deep down I might think, it's, I can't do it anymore, and I might feel like giving up, I'm still here, so there's still a part of me that wants to be here so I have to cling on to that part'</i> (572).</p>
	Self acceptance, 'I am a normal person'	<p>Julie, <i>'I've still got little problems with my emotions but I think we're only human'</i> (178).</p> <p>Mary, <i>'I'm allowed to cry now, I know it's alright to cry. It's</i></p>

		<p><i>making me feel like a normal person, that I can do normal things, and I'm not going to be judged for crying'</i> (285), <i>'it's trained my brain up to be a normal person'</i> (408).</p> <p>Natasha, <i>'I learnt more about myself and that there are people like me, and before I didn't know that, I always thought I was alone, and it's only me that feels like this, but it ain't'</i> (64).</p> <p>Julie, <i>'that you are a person, you are valid, you know, it's not just about lock and key, it's about you as a human being and you have got that, without me going to this group I didn't see it that way'</i> (238).</p>
The bigger picture	Re-evaluate, 'stop and think'	<p>Samantha, <i>'if I just ran with everything that's happened in my mind the amount of people I would have bitched over man, it's a joke, we'd be having this interview in the seg right now because I'd be living there constantly, so it's helped me to just stop and think more about what's actually just going on'</i> (298).</p> <p>Gemma, <i>'when I was doing DBT, I don't know, it just helped me to think'</i> (27), <i>'I'm able to think about the situation more clearly'</i> (106).</p> <p>Michelle, <i>'it helped me a lot, because before that I didn't really stop and think about things properly yeah, and I didn't break things down properly, my thinking is very black and white, so I think that it helped me to process it a bit better'</i> (4).</p> <p>Mary, <i>'it has helped me to calm down and not to self-harm so much and not to jump the gun so much as well, if it wasn't for this programme I would have been cutting up, and I most probably would have been on basic again'</i> (34).</p> <p>Michelle, <i>'This is the thing with DBT yeah, when you're in the class you think you don't get it, yeah, but then something will happen and you'll get some answers somewhere from something, something just clicks and you have to re-evaluate your thought process'</i> (326).</p> <p>Gemma, <i>'I'm not a sweet person anyway, and then sour on top of that was just like 'oh my god this is like my worst</i></p>

		<p><i>nightmare', but then, when it's like really sweet and everything at the end, and then you realise, and then when everything else gets put into perspective for you as well then, where it is like, it ain't just about a sweet is it, it's about when things go sour in life as well and then it just shows you they can turn out alright, like little things can have such a big impact like yeah, that was mad, proper' (149).</i></p>
	<p>Gaining perspective of the other, 'I don't care about your pride, I care about my money'</p>	<p>Julie, <i>'I do think that you've got to sit back a little bit, you know, and take other peoples, you know, feelings and views into consideration, which as I said, before I wouldn't do that' (162).</i></p> <p>Michelle, <i>'there's something that happens in group, that you feel like, you know, yeah, I'm going to sit and listen to this person, or, that might not be my view but you can get where they're coming from' (159).</i></p> <p>Mary, <i>'I can't remember the exact words, but do you think that you could be judging the wrong way? or, and she'd make me see things much more clearly' (669), 'because she used to ask me questions about it, she used to challenge me about it' (682) 'she made me see things from a different point of view' (709).</i></p> <p>Mary, <i>'if I didn't hear from someone for like a week, I'd think the person was taking the piss out of me and I'd end up writing a really long nasty letter to the person, but now I'm thinking that person must have stuff to do, they might have appointments, they may not be well, wait another week' (226).</i></p> <p>Sharon, <i>'I just calmly thought, allow it, she might be having a bad day' (48).</i></p> <p>Mary, <i>'I give them a chance, and friends on the landing as well, like if (name removed) used to be asleep I used to wake her up and when she used to say, 'look I get an officer to lock my door', I used to take that as an insult, that she didn't want to be my friend anymore, and stuff like that, madness, winding yourself up in your head, but now</i></p>

		<p><i>'cause of relationship effectiveness, I think now more, it's not because she don't want to be my friend, it's because she wants more sleep' (340).</i></p> <p><i>Michelle, 'but when I realised what it was, it's like her pride, her own pride, but before I wouldn't have seen that, I'd be like 'I don't care about your pride, I care about my money', 'why should I care about your pride and lose money?' That would have been my answer, 'cause that's how I would have felt but now I understand' (500).</i></p>
	<p>Empathic understanding, 'I go out of my way to sit and make sure they're alright'</p>	<p><i>Michelle, 'just taking into account other peoples thoughts and feelings around things has actually improved a lot of things' (81).</i></p> <p><i>Sharon, 'I kind of talk to everyone now, even if I don't get on with them, or I don't, don't know them, I will always go out of my way to make sure, like, if someone's upset on the landing and I see it, I go out of my way to sit and make sure they're alright, whereas before I kind of had, I'd be like, 'oh I'm not getting myself involved' (257).</i></p> <p><i>Julie, 'make friends, yeah, make friends, you know, get to know that person for that person, rather than just being judgmental, 'oh you've got a dirty top on I'm not talking to you', whatever, and it's like yesterday, I gave someone my t-shirt and said 'clean yourself up a bit, you know, you want to feel a bit more pukka' (125).</i></p> <p><i>Sharon, 'I wish I could have asked for more help before I done the crime, and I wish I'd done the DBT course earlier' (497), 'I could have put myself in other people's shoes before' (511), 'just like with my victim, I feel bad for my victim' (517).</i></p> <p><i>Samantha, 'I feel sympathetic towards my victim however I do not have to, that is a fact, but yeah, I feel sorry for the people, the person, times two, I think she was married, because thinking about how it probably impacted on them, so yeah, I feel sorry for them'. (212).</i></p>
	<p>Taking responsibility, 'own it'</p>	<p><i>Mary, 'if someone wound me up in the past I wouldn't think, right I could lose where I am now, I wouldn't be able</i></p>



		<p><i>to go to the gym, I'd just end up shouting, screaming, getting IEP's here, getting IEP's there, and being threatened to be put on basic. So now I weigh up the pros and cons, I think, if I do that, then this is what's going to happen, so it has helped a lot' (60).</i></p> <p><i>Michelle, 'I'm just repeating a bad cycle that I always do, yeah, so I thought to myself, you know what, later on it's going to be bad for me. Like normally I'd just say, ah 'I just deal with the consequences of it when it happens' yeah, but I actually thought about it deeply and thought 'is it really worth it?' Do you get what I mean, like, because I know I shouldn't be doing it' (717).</i></p> <p><i>Julie, 'be responsible for, not only your reactions, but also for others' (324)</i></p> <p><i>Michelle, 'I know that I'm in prison yeah, I've got to take it on the chin, because every action has a consequence, so I'm responsible, yeah, ain't no one else responsible, I'm responsible, so I don't want to be responsible again' (769).</i></p> <p><i>Samantha, 'I can own every bit of it, like, why I did this, why I behaved or why I even said that, why I lied, but it's not always guaranteed that that other person will understand, but I can word it in such a way that it's put across correctly, and then still take responsibility for my actions' (79).</i></p> <p><i>Samantha, 'kind of hate to admit this, but yeah, because beforehand the way I saw it is, I'm sitting down here doing a bird for something I didn't do, that's the way I saw it, no one could tell me any different that's just the way it was, but now...[removed for confidentiality] I've actually owned the fact that as responsible as she is, so am I, because I didn't have to be there, like, we're not Siamese twins, I didn't have to be there, you know, I chose to be there, and this is the reaction of me being there' (201).</i></p> <p><i>Samantha, 'Some people want to change, want to know things, but they're scared to know things because they don't know what other doorway is going to open for them, I</i></p>
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		<p><i>did feel that way but I got to a point where I felt like I wanted to change but I didn't know how to change, and I sat with that for a long time, and then got to the point where I realised I need to do something outside this box to be able to get out of this box'. (263)</i></p> <p><i>Sharon, "cause if you bottle something on the course, then you might not, when it comes to get outside if you want to do something you're going to bottle it and you might regret the fact that you haven't done it' (556) 'You got to keep on doing it, to benefit from it, but also, erm, not give up, because you won't benefit from it, because nothing's easy in life, and if you want the best out of it then you've gotta, you gotta put yourself forward' (389).</i></p>
	<p>A positive outlook, 'The hard times go and you'll get the good times back again'</p>	<p><i>Gemma, 'it's about a more positive outlook as well, do you know what I mean, I don't need to think about the sentence that I'm doing, and if I do, like my goal was for my release date, but now, well, why don't I set other goals for before that, like courses that I'm doing' (230).</i></p> <p><i>Sharon, 'not beating myself up if anything, if I get like, not to think it's the end of the world, and it's helped me to move on when I have got back to low points' (568).</i></p> <p><i>Julie, 'I have learnt this, and I have learnt that, and this is what's helped me to be the person that I am today, I am a lot better person today, because I have gone to the group and it has brought out a lot of good things in me, well it has, a lot of people have told me that as well' (244).</i></p> <p><i>Samantha, 'it helps you to move forward, and actually be in the more in the moment of what's going on in life. Instead of thinking about, 'oh yeah that thing happened last week, and that pissed me off and god if I see that person again I will weigh them in', you can just let that go, and know that happened last week, and that's what it is, but you're more in the moment' (243).</i></p> <p><i>Gemma, 'sometimes it gets harder before it gets easier, and that's, the tough roads are really hard to get by and</i></p>

		<p><i>so, like that sweet, hard times go, they go eventually anyway whether it's in a day, a week, a year, ten, the hard times go and you'll get the good times back again, its just holding on until that time comes' (265).</i></p> <p><i>Sharon, 'cause it opens up your eyes to what's important, life, your life, we're here for a purpose, that's to make the best out of what you've got' (577).</i></p> <p><i>Mary, 'it helps, it has helped me in so may ways it's unbelievable. I wouldn't think it was going to help me, but it has, it really has' (1038), 'Believe in yourself because only you can, it's going to be hard but just believe, and you will get better' (1051).</i></p>
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## **Appendix G Information Sheet**

### Information Sheet

Dear DBT completer,

My name is Sarah Ralph, I am asking everybody who has completed the DBT programme if they would like to speak to me about the experience of doing it. This is completely voluntary, you do not have to speak to me, it is your choice.

In psychology we have two main ways of finding out about the therapies that we offer, one is for the clients to fill out questionnaires and assessments, and the other way is for clients to talk to us about how they found the experience of doing the therapy.

In psychology we don't yet have any research that has been produced from the spoken word of female prisoners who have been diagnosed with borderline personality disorder and have completed a DBT programme, it would help us to understand how you found the DBT programme that you have completed if you are happy to talk about it to me. I would like to record the conversation we may have so that I can transcribe and analyse the information – in order to see what people say.

I may have met some of you before, as for some people I have been an individual DBT therapist, and I have facilitated some of the DBT skills groups. However, when talking to you about your experience of doing the DBT programme I will be doing so in the role of an interviewer about your experience, rather than as a therapist or skills coach. Therefore, my role will be to listen to your experience, not to address any difficulties you are having currently, or to explore any changes like a DBT therapist would.

However, if any difficulties come up for you during the process of telling me about your experience of doing DBT then you will have the opportunity to either speak to your relevant individual DBT therapist, or you can access the prison listener service, or you can talk to your personal officer.

Participation in this research is completely of your own choice, it is voluntary. Also, once you have talked to me about your experience you can withdraw the information that you have provided at any stage, you can also refuse to answer any question that you feel is upsetting or too personal or intrusive.

Thank you for considering to talk to me about your experience, if you are happy to do this then please have an officer on your landing call the DBT office on extension 4840 and arrangements for the interview will be made with you accordingly.

If you do not wish to participate then I wish you well and you can simply throw this information sheet away.

### **Thank you for your consideration,**

Any information you provide during the interview will be stored securely and confidentially. All information will be stored and destroyed according to NHS and NOMS ethical and City University procedures.

If there are any publications which result from this research your identity will be 100% protected and all information will be completely anonymised.

If you require any further information regarding the research, or if you would like to know the overall results of the research then you may advise me of that during the interview and we can arrange for the information to be provided to you.

If you would like to talk to someone independent from the research for advice about participation you can contact the British Psychological Society, St Andrews House, 48 Princess Road East, Leicester, LE1 7DR, Tel:0116 254 9568, Email: [enquiries@bps.org.uk](mailto:enquiries@bps.org.uk). In order to ask specific questions about participating in this specific research project, or to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to Senate Research Ethics Committee. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: An Interpretive Phenomenological Analysis of the experience of completing a modified Dialectical Behavioural Therapy programme for UK female prisoners diagnosed with Borderline Personality Disorder.

You could also write to the Secretary at:

Anna Ramberg, Secretary to Senate Research Ethics Committee , CRIDO, City University London, Northampton Square, London, EC1V 0HB . Email: [Anna.Ramberg.1@city.ac.uk](mailto:Anna.Ramberg.1@city.ac.uk)

## **Appendix H Participant Consent**

### **Consent**

If you consent please initial each box and provide your signature at the bottom of the page.

Project title: An Interpretive Phenomenological Analysis of the experience of completing a modified Dialectical Behavioural Therapy programme for UK female prisoners diagnosed with Borderline Personality Disorder.

I agree to take part in the above City University research project.

I have had the project explained to me, and I have read the Information sheet, which I may keep for my records.

I understand that agreeing to take part means that I am willing to complete a recorded interview which will ask me about my experience of doing the DBT programme. This information will be held securely and processed for the purpose of this research project only.

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.

I understand that all information which is collected about me during the course of the research will be kept strictly confidential, and any information about me which leaves the prison will have my name and all personal details removed so that I cannot be recognised or identified.

I understand the limit of confidentiality in this context, such that if I disclose information that compromises the safety of myself, prison staff, other prisoners, the public and the prison this information will be shared with the prison authorities and the police service if necessary.

I agree to City University recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this

statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

Name: .....(please print)

Signature: .....Date: .....

Independent witness to participant's voluntary and informed consent

I believe that ..... understands the above project and gives her consent voluntarily

Name: .....(please print)

Signature.....Date:.....

Address:.....

## Appendix I CNWL R&D Ethical Approval

**noclor** **NHS**  
Research Support Service  
Bedford House, 3rd Floor  
125-133 Camden High Street  
London, NW1 7JR  
Tel: 020 3317 3045  
Fax: 020 7685 5830/5788  
www.noclor.nhs.uk

10 June 2014

Miss Sarah Ralph  
Researcher/ Trainee Counselling Psychologist  
CNWL NHS Foundation Trust  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

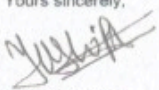
Dear Miss Ralph,

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in the trust(s) identified below:

<b>Study Title:</b> An Interpretive Phenomenological Analysis of the experience of completing a modified Dialectical Behavioural Therapy programme for UK female prisoners diagnosed with Borderline Personality Disorder <b>R&amp;D reference:</b> 137814 <b>REC reference:</b> 14/LO/0173		
This NHS Permission is based on the REC favourable opinion given on <b>17 April 2014</b> .		
<b>Name of the trust</b>	<b>Name of current PI/LC</b>	<b>Date of permission issue(d)</b>
Central North West London NHS Foundation Trust	Sarah Ralph	10 June 2014
If any information on this document is altered after the date of issue, this document will be deemed <b>INVALID</b>		

<b>Specific Conditions of Permission (if applicable)</b>
Research Should be conducted in accordance with the conditions listed in Ministry of Justice (NOMS) approval letter issued on 4 April 2014 and NHS Research Ethics Committee favourable opinion dated 17 April 2014.
If any information on this document is altered after the date of issue, this document will be deemed <b>INVALID</b>

Yours sincerely,

  
Pushpsen Joshi  
Research Operations Manager

Cc: Principle Investigator(s)/Local Collaborator(s), Sponsor Contact


R&D approval letter, REC reference: 14/LO/0173, R&D reference: 137814      Page 1 of 2



May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Serious Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Research Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Research Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Research Ethics Committee and R&D Office as soon as possible.
- **Monthly / Annually Progress report:** you are required to provide us and the Research Ethics Committee with a progress report and end of project report as part of the research governance guidance.
- **Recruitment data:** if your study is a portfolio study, you are required to upload the recruitment data on a monthly basis in the website:  
[http://www.crccc.nihr.ac.uk/about\\_us/processes/portfolio/p\\_recruitment/](http://www.crccc.nihr.ac.uk/about_us/processes/portfolio/p_recruitment/)
- **Amendments:** if your study requires an amendment, you will need to contact the Research Ethics Committee. Once they have responded, and confirmed what kind of amendment it will be defined as, please contact the R&D office and we will arrange R&D approval for the amendment.
- **Audits:** each year, noclor select 10% of the studies from each service we have approved to be audited. You will be contacted by the R&D office if your study is selected for audit. A member of the governance team will request you complete an audit monitoring form before arranging a meeting to discuss your study.

## Appendix J NRES Ethical Approval

  
**Health Research Authority**

**NRES Committee London - South East**  
Bristol Research Ethics Committee Centre  
Level 3, Block B  
Whitefriars,  
Lewins Mead,  
Bristol  
BS1 2NT

Telephone: (0117) 3421382  
Facsimile: (0117) 3420445

17 April 2014

Miss Sarah Ralph  
Researcher/Trainee Counselling Psychologist  
CNWL NHS Trust  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Dear Miss Ralph

**Study title:** An Interpretive Phenomenological Analysis of the experience of completing a modified Dialectical Behavioural Therapy programme for UK female prisoners diagnosed with Borderline Personality Disorder

**REC reference:** 14/LO/0173

**IRAS project ID:** 137814

Thank you for your letter of 07 April 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Mr Raj Khullar, [nrescommittee.london-southeast@nhs.net](mailto:nrescommittee.london-southeast@nhs.net).

**Issues Discussed in Correspondence**

The Committee raised the following issues with regards to the responses provided to the provisional opinion –

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- 1) As previously requested (Point 2 of our letter of 26 Feb), the PIS should follow the layout of the NRES template (give website address), utilising those headings that are appropriate.
- 2) It was the Committee's understanding (Point 4 of our letter of 26 Feb) that an initial brief invitation letter would be circulated widely through the prison mail system. This letter would not identify the researcher, so as to avoid any possible perceived coercion; it would tell the invitee how to obtain more detailed information (the PIS). The Committee requested to be provided with approval for the research by the prison authorities.

You provided the revised PIS and Consent Form as well as the approval for the research by the prison authorities. The Committee was satisfied with the revisions and explanations.

#### **Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

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

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

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

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

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

#### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

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To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett ([catherineblewett@nhs.net](mailto:catherineblewett@nhs.net)), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

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

#### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Invitation Letter to Participate		14 April 2014
Response to Request for Further Information	Email only	07 April 2014
Participant Information Sheet	2	
Participant Consent Form	2	30 January 2014
Other: Research letter SR [REDACTED]		
Response to Request for Further Information	Email	
Protocol		16 January 2014
Investigator CV	Sarah Ralph	16 January 2014
Evidence of insurance or indemnity		
Interview Schedules/Topic Guides		16 January 2014
Other: CV [REDACTED] [REDACTED]		16 January 2014
REC application		17 January 2014

#### Statement of compliance

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

#### After ethical review

##### Reporting requirements

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

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports

A Research Ethics Committee established by the Health Research Authority



- Notifying the end of the study

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

#### Feedback

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

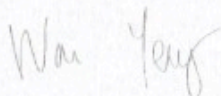
Further information is available at National Research Ethics Service website > After Review

14/LO/0173	Please quote this number on all correspondence
------------	--

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

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

Yours sincerely



**Mr Wai Yeung**  
Research Ethics Committee (REC) Assistant

**pp Professor David Caplin**  
Chair

Email: [nrescommittee.london-southeast@nhs.net](mailto:nrescommittee.london-southeast@nhs.net)



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

*"After ethical review – guidance for researchers"*

*Copy to: Ms Anna Ramberg  
Mr Pushpsen Joshi, Central And North West London Mental Health NHS Trust*

A Research Ethics Committee established by the Health Research Authority

## Appendix K HMPS NOMS ethical approval

 <b>Ministry of JUSTICE</b> National Offender Management Service	 <b>HM Prison Service</b> Public Sector Prisons	
	<b>HM Prison Service</b> Greater London Psychological Services (GLPS)	
Sarah Ralph [Redacted] [Redacted] [Redacted] [Redacted]	[Redacted] [Redacted] [Redacted] [Redacted]	
	Telephone: [Redacted] Email: [Redacted]	
		20 September 2015

Dear Sarah,

**Research Title: "An Interpretive Phenomenological Analysis of the experience of completing a modified Dialectical Behavioural Therapy programme for UK female prisoners diagnosed with Borderline Personality Disorder" (2014-026)**

Please accept this letter as confirmation that your application to conduct research at [Redacted] has been approved in line with PSI 13/2012. However, I must make you aware of a number of conditions that have been applied:

- Limits of confidentiality must be explained in full to all participants prior to them giving consent to take part in your study; the revised information sheet and consent forms should be used in all cases (i.e. documents attached to the email dated 4<sup>th</sup> April 2014).
- A copy of the final research report must be sent to the Governor of [Redacted] and the Lead Psychologist for Greater London, [Redacted] ([Redacted]).
- The findings should be shared with the Senior Management Team at [Redacted].
- The findings of the research should only be published with the express permission of the Governor of [Redacted] and/or the Lead Psychologist for Greater London. This decision will be made **AFTER** the findings are known and the project report is completed (this does not include the final dissertation report).
- This letter does not commit any staff and/or resources from [Redacted].
- This letter does not give approval to take electronic equipment (e.g. a dictophone) into [Redacted]. In order to use such equipment or bring it into the prison, permission must be sought from the security department (contact [Redacted]).
- The research must comply with The Data Protection Act and all NOMS information assurance protocols.
- At the end of the project the researcher must prepare a research summary for the NOMS National Research Committee and the Regional Psychology Lead (approximately three pages; maximum of five pages) which (i) summarises the research aims and approach,

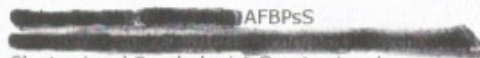


(ii) highlights the key findings, and (iii) sets out the implications for NOMS decision-makers. It must be submitted to the [NRC](#) alongside the NRC project review form (which covers lessons learnt and asks for ratings on key questions). Provision of the research summary and project review form is essential if the research is to be of real use to NOMS. The report must use language that a lay person would understand. It must be concise, well organised and self-contained. The conclusions must be impartial and adequately supported by the research findings.

Please let me know if you require any further information and good luck with your research.

Regards,

**Sent via email – no hard copy to follow**

 AFBPsS  
Cluster Lead Psychologist Greater London

## Appendix L City University London Ethical Approval

### Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) [Guidelines for minimum standards of ethical approval in psychological research](#) (BPS: Leicester) should be referred to when planning your research.
- Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.

#### Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

D.Psych

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

An Interpretive Phenomenological Analysis of the experience of completing a modified Dialectical Behavioural Therapy programme for UK female prisoners diagnosed with Borderline Personality Disorder.

2. Name of student researcher (please include contact address and telephone number)

Sarah Ralph, [redacted]  
[redacted]

3. Name of research supervisor

[redacted]



4. Is a research proposal appended to this ethics release form? Yes

5. Does the research involve the use of human subjects/participants? Yes

If yes,

a. Approximately how many are planned to be involved?

Up to 10

b. How will you recruit them?

Participants are a purposive sample selected due to having completed a modified dialectical behavioural therapy (DBT) programme at [REDACTED]. All prisoners who have completed the programme to date will be provided with an information sheet and offered the voluntary opportunity to participate in the study.

c. What are your recruitment criteria?

(Please append your recruitment material/advertisement/flyer)

Inclusion is defined as all those who have completed [REDACTED] programme, ethical considerations do not allow for any exclusions.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? No

d1. If yes, will signed parental/carers consent be obtained? N/A

d2. If yes, has a CRB check been obtained? N/A  
(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

Participants will be asked to complete a semi-structured interview, [REDACTED]

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes

If yes,

a. Please detail the possible harm?

It is possible that talking about their experience of completing the DBT programme may bring up difficult issues for the participants. It is not the aim of the interview and questions are not aimed at personal experiences but it is a possibility that needs to be accounted for.

b. How can this be justified?

This is justified as the research area is limited and in need of qualitative data from service users in order to inform practice.

c. What precautions are you taking to address the risks posed?

The researcher concerned is a third year DPsych Counselling Psychology with considerable clinical experience in managing emotional distress, it is anticipated that the researcher will be able to utilise their skills to manage the risk. Research participants will also have access to their individual DBT therapist post interview. As per the usual prison safeguarding initiatives, the participants will also have access to their personal officer and the prisoner listener service. Lastly, prisoners will be able to ring the Samaritans, as

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes

*(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Dictaphone recordings of the interviews, computerised transcripts of the recordings, and relevant participant demographic information.

12. What provision will there be for the safe-keeping of these records?

These records will all be kept on a laptop, encrypted, and within in password protected files. This laptop will be backed up on an external hard drive, again relevant files will be encrypted and password protected.

13. What will happen to the records at the end of the project?

In line with BPS requirements the records will be kept for 5 years, after which they will be confidentially destroyed.

14. How will you protect the anonymity of the subjects/participants?

All identifying information will be removed from the transcripts and write up. Identifying information will be encrypted, password protected and stored separately from resulting analysis.



15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Participants will be provided with a de-brief sheet and advised that they can discuss any issues they need to with their individual DBT therapist. Due to the context of the research being undertaken with a prison there are also other support services available to the participants at all times, details of how to access these are also included on the debrief sheet.

*(Please append any de-brief information sheets or resource lists detailing possible support options)*

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

In addition to my DPsych Counselling Psychology course at City University I have undertaken additional training and am currently an intensively trained and qualified DBT therapist. I work at [redacted] with the client group in question. It is my endeavour to enable past completers of the modified DBT programme the voluntary opportunity to be interviewed for this research regarding their experience of completing the DBT programme. I have accounted for the dual role of practitioner-researcher within the attached proposal, however it is possible that none of the participants for this research will have engaged with me in a past therapeutic relationship. It is due to my dual role as practitioner-researcher that I have the advantage of full security clearance and therefore access to this neglected and difficult to reach client group. It is my hope that I may be able to utilise my skills as a DPsych Counselling Psychologist and researcher to provide a voice to their experience.

I would like to add that I have obtained an agreement in principle for this research from the Director of Offender Care at CNWL, and from the Deputy Head of Healthcare at [redacted]. In order for NOMS and NHS ethical clearance to be granted there needs to be local level approval. It is considered good practice to gain local level approval prior to completing an IRAS application, I have therefore followed this protocol in gaining local level agreement in principle for the research proposal presented herein.

Signature of student researcher : Sarah Ralph

Date 22/10/13

**CHECKLIST:** the following forms should be appended unless justified otherwise

Research Proposal  
Recruitment Material  
Information Sheet  
Consent Form  
De-brief Information

#### Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? No  
If yes,

a. Please detail possible harm?

b. How can this be justified?

c. What precautions are to be taken to address the risks posed?

**Section C: To be completed by the research supervisor**

*(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)*

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee \*

Refer to the School's Research and Ethics Committee

Signature Jessica Jones-Nelson Date 15/11/2017

**Section D: To be completed by the 2<sup>nd</sup> Departmental staff member**

*(Please read this ethics release form fully and pay particular attention to any answers on the form where underlined bold items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature [Signature] Date 10/11/13

\_\_\_\_\_