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ADOLESCENTS' EXPERIENCES OF A THERAPEUTIC INPATIENT SERVICE UTILISING MENTALIZATION-BASED TREATMENT FOR BORDERLINE PERSONALITY DISORDER FEATURES

Section A: Psychotherapeutic Interventions for Adolescent Self-Harm and related Borderline Personality Disorder Features: A Literature Review
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Section B: Adolescents' Experiences of a Therapeutic Inpatient Service utilising Mentalization-Based Treatment for Borderline Personality Disorder Features
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SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgments

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Summary of the MRP[1] Portfolio

Section A reviews research on psychotherapeutic interventions for adolescent self-harm and related borderline personality disorder features. Interventions reviewed include cognitive behavioural therapy, developmental group psychotherapy, dialectical behaviour therapy, cognitive analytic therapy, multisystemic therapy, and mentalization-based treatment. In reviewing research papers investigating these interventions, their underlying theories are also briefly examined. Methodological and conceptual issues are considered and recommendations for future research are made.

Section B presents an investigation into adolescents' experiences of a therapeutic inpatient service utilising mentalization-based treatment for borderline personality disorder features. Eight adolescents were interviewed about their experiences. Interview transcripts were analysed using Interpretative Phenomenological Analysis. The analysis resulted in five superordinate themes which are examined in relation to the literature. Research limitations, recommendations for further research, and clinical implications are discussed.

Section C is a critical appraisal of the research. Research skills and abilities gained from undertaking this project are considered, and future learning is identified. Possible improvements that could have been made are discussed. Finally clinical implications and ideas for future related research projects are presented.

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[1] Major Research Project

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Section A: Literature Review Paper

Psychotherapeutic Interventions for Adolescent Self-Harm and related
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Abstract

Deliberate self-harm in adolescence is a phenomenon which has been studied conceptually and empirically and has been found to be related to emerging personality disorder features, such as emotional instability. 'Borderline Personality Disorder' (BPD) in particular has been linked to self-harm in adults. Current 'National Institute for Health and Clinical Excellence' (NICE; 2009, 2011) guidance for the treatment of self-harm and BPD lacks specificity with regards to recommended interventions, with the exception of 'Dialectical Behaviour Therapy' (DBT) which is recommended specifically for women with a diagnosis of BPD who self-harm. Thus, the present paper aimed to research and review psychotherapeutic interventions on adolescent self-harm and related emerging personality disorder features. A literature search resulted in 10 research papers; six randomised-controlled trials, one on 'Multi-Systemic Therapy' (MST; Huey et al., 2004), three on 'Developmental Group Psychotherapy' (DGP; Wood et al., 2001; Hazzell et al., 2009; Green et al., 2011), one on 'Cognitive Analytic Therapy' (CAT; Channen, et al., 2008), and one on 'Mentalization-Based Treatment' (MBT; Rossouw & Fonagy, 2012); two open feasibility studies on 'Cognitive Behavioural Therapy' (CBT; Brent et al., 2009; Stanley et al., 2009); and two quasi-experimental studies on DBT (Rathus & Miller, 2002; Katz et al., 2004). All of these interventions displayed some benefits either for the treatment of self-harm and/or for related emerging personality disorder features. Some mixed results were reported and no intervention could be deemed to be superior for the treatment of self-harm in adolescents. Recommendations for future research are discussed.

Introduction

Adolescence

Adolescence is a time of transition from childhood into adulthood; a time of great biopsychosocial change. Erikson's (1963) psychosocial model of human development suggests that adolescence is characterised by an 'identity crisis' and 'role confusion', as the adolescent struggles to establish 'who she is' and 'who she wants to be'. Often adolescents distance themselves from their parents during this time of individuation and form intense relationships with peers (Wexler, 1991). Adolescence has been described as a time of turmoil and personal and interpersonal instability, though this is usually transitory as most individuals 'successfully survive' this challenging period (Wexler, 1991).

Physiologically, adolescence is a time of emerging sexuality in the wider sense of the word (Boyle & Senior, 2008). For adolescent girls' physical changes takes place such as the onset of menstruation and associated hormonal changes, particularly increases in the levels of oestrogen secreted by the ovaries. Breasts grow larger and fat deposits increase in the buttocks and thighs. For adolescent boys, the penis and testes grow larger as a result of higher levels of testosterone being secreted by the testes. Other changes include facial hair starting to grow and skeletal muscles growing larger. In other words, the girl is becoming a woman, and the boy is becoming a man. However, this transitional period is protracted over several years. During that time, sexual motivation gradually increases due to a combination of biopsychosocial factors (Sisk & Foster, 2004), and sexual identities begin to emerge including straight, lesbian, gay, bisexual and transgender identities (Tolman & McClelland, 2011).

On a neuropsychological level, adolescence is a time of great reorganisations taking place in the brain (Blakemore & Choudhury, 2006). Synaptic pruning occurs which strengthens existing brain connections and gets rid of neural connections which are dispensable. This ultimately increases the efficiency between brain regions. The prefrontal cortex develops further, which eventually allows the individuals to develop more sophisticated executive skills, such as greater impulse control, as adults. In the meantime, higher levels of risk taking are common as the adolescent may struggle to balance her wishes with her responsibilities. During adolescence the brain is sensitive. For example the adolescent amygdalae, a pair of brain regions which are related to emotional processing, have been found to be hyperactive in adolescents compared to adults. This can make the task of emotion regulation considerably more challenging (Blakemore & Choudhury, 2006).

Deliberate Self-Harm in Adolescence

For some adolescents it is particularly challenging to navigate this phase of their lives; a significant minority of those may engage in deliberate self-harm (DSH). According to Golding (2008, p.209) "self-harm is the expression of and temporary relief from overwhelming, unbearable and often conflicting emotions and feelings." Colman (2003, p.533; parasuicide) offers a more pragmatic definition: "A deliberate self-inflicted injury or poisoning resembling a suicide attempt but probably not intended to be successful."

A survey of 6020, 15 to 16 year-old, pupils across 41 schools in England found that 398 (7%) had engaged in an act of self-harm, consisting of self-poisoning or self-injurious behaviours, in the previous year (Hawton, Rodham, Evans & Weatherall, 2002). DSH was related to previous self-harm, self-harm in the family and/or friends, anxiety, depression, impulsivity, low self-esteem and drug use; while self-harm rates

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amongst girls were four times higher than for boys. Longitudinal research suggests that in some parts of England, self-harm rates amongst adolescents have been steadily increasing over the years (Hawton, Fagg, Simkin, Bale & Bond, 2000). A large population-based cohort study of adolescents in Australia found that 8% had self-harmed at some point during their adolescence; for girls it was 10% while for boys it was 6% (Moran et al., 2012).

Why do some young people self-harm?

The reasons why some young people self-harm are wide-ranging, varied and idiosyncratic. Therefore a plethora of explanations have been provided by authors and researchers in this field. Golding (2008) suggests that those reasons can be interpersonal and/or intrapersonal. Interpersonal reasons may be a communication to others, such as to the young person's family. For example the adolescent may be communicating via self-harm that her emotional needs are not being met. Intrapersonal reasons may be about managing unbearable overwhelming feelings; a coping mechanism. Golding (2008, p.211) wrote: "When emotional pain is difficult to bear, physical pain can feel more tangible and manageable." This understanding was confirmed empirically by Rodham, Hawton and Evans (2004) who investigated adolescents' motives for self-harm. Rodham found that the majority of adolescents engaged in self-harm in order 'to get relief from a terrible state of mind'. Other reasons included 'to die', 'to punish myself' and 'to get some attention'.

Self-harm for intrapersonal reasons may briefly provide relief from negative feelings on a physiological (i.e. endorphin release) and psychological level; however, this can often be followed by negative feelings about the act of self-harming, such as shame and guilt, thus creating its own vicious circle (Hawton, Rodham & Evans, 2006; see

Figure 1). Though there is a relationship between a young person intending to die and self-harm, namely that self-harm increases the risk of suicide, many individuals who self-harm do not intend to die, and the two are not necessarily linked (Skegg, 2005).

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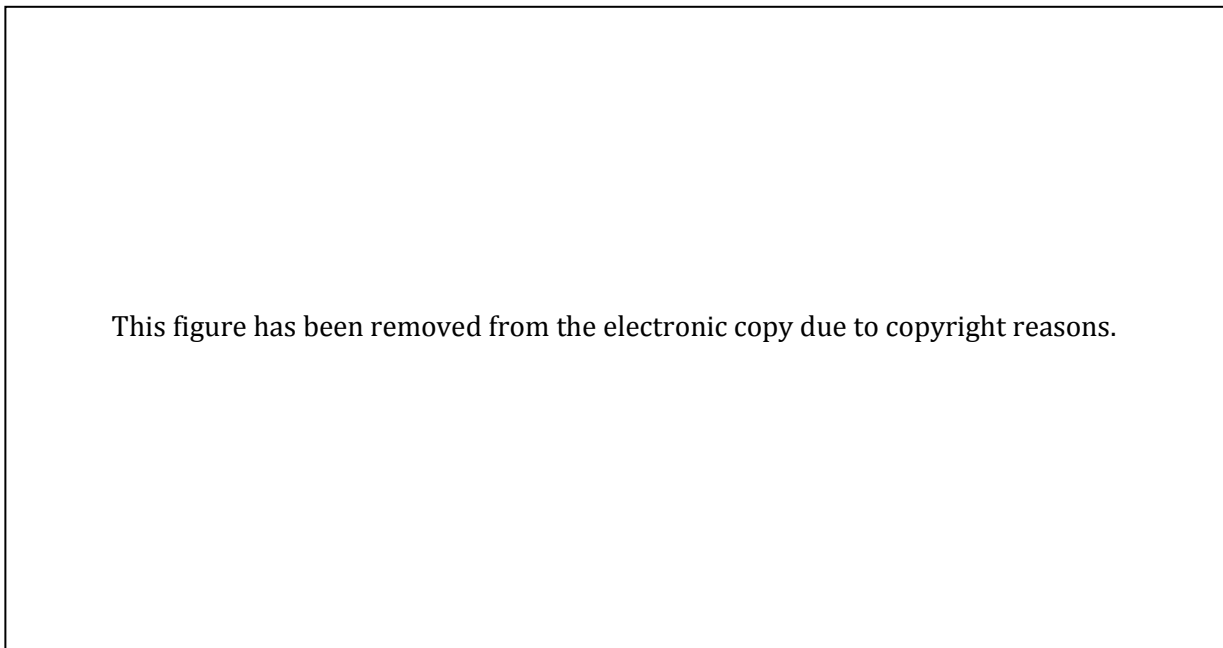
Figure 1. Cycles of self-harm (Hawton et al., 2006).

Emerging Personality Disorder and Self-Harm

In adults there is an established relationship between self-harm and personality disorders, particularly 'Borderline Personality Disorder' (BPD; American Psychiatric Association [APA], 2000). According to the APA (2000, p.706) "the essential feature of [BPD] is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts." BPD is a severe mental health disorder affecting two percent of adults, with high self-harm rates and suicide mortality rates 10-50% higher than in the general population (Skodol et al., 2002)

The term 'borderline' originally referred to the borderline between psychosis and neurosis, which was thought to describe the presentation of some patients, "who while not frankly psychotic, tend to use psychotic mechanisms" (Steiner, 1979, p.385). Steiner (1979) suggested that a more meaningful use of the term 'borderline' would be to describe the borderline between the paranoid-schizoid and the depressive positions (Klein, 1946) in patients with BPD. The paranoid-schizoid position is a state whereby good and bad feelings are split off; while the depressive position is a state where the two become integrated (Klein, 1946). Steiner (1979) explained that in his opinion 'borderline patients' are capable of adopting the depressive position, but that they often cannot stay with those thoughts as they cause unbearable psychic pain, thus reverting back to the paranoid-schizoid position, where things - and individuals - exist split in black and white, good and bad.

> What I am suggesting is that the problems of the borderline patient can be considered to result from failure to work through the anxieties associated with the depressive position, which lead him to be thrown back on the dependence on schizoid mechanisms. (Steiner, 1979, p.387)

Research suggests that BPD traits in adolescence are a 'good' predictor of later BPD in adulthood (Miller, Muehlenkamp, & Jacobson, 2008). However, diagnosing BPD in children and adolescents is a controversial issue (Miller et al., 2008). One of the reasons for this is because child and adolescent personalities are considered not fully formed, and therefore diagnosing them with a personality disorder can be unnecessarily stigmatising (Miller et al., 2008). Additionally the APA (2000, p.708) cautions that adolescents with 'identity problems' can at times misleadingly appear to meet criteria for BPD, when in fact what they are experiencing is part of the

adolescent 'identity crisis' (Erikson, 1963). Nonetheless, Miller et al. (2008) advise that ignoring BPD as a possible diagnosis for adolescents may prevent them from receiving appropriate treatment. The latter may be particularly relevant in the United States, where sufficient funding and specific treatment are inextricably bound with receiving a diagnosis (Miller et al., 2008).

However, given the current changes in the National Health Service (NHS), including in 'Child and Adolescent Mental Health Services' (CAMHS), the link between accurate diagnoses and specific treatments may become more pertinent; this is particularly the case as diagnostic clustering and payment by results may be linked to specific evidence based interventions (e.g. Department of Health [DoH], 2010). Guidance issued by the 'National Institute for Health and Clinical Excellence' (NICE) on BPD states that: "Young people with a diagnosis of borderline personality disorder, <u>or symptoms and behaviour that suggest it</u>, should have access to the full range of treatments and services recommended in this guideline, but within CAMHS" (NICE, 2009).

The Present Paper

The aim of the present paper is to selectively review psychotherapeutic intervention research on adolescent self-harm and related emerging personality disorder features. In reviewing the intervention research, the underpinning theories of interventions will be briefly described. Therefore, an attempt will be made to answer the following question: "What psychotherapeutic interventions are available for adolescent self-harm and related emerging personality disorder features?" The final aim of the paper is to make recommendations for further research in this field.

Research Review

The NICE (2011) guideline on deliberate self-harm currently lacks specificity with regards to evidence-based psychological interventions:

> Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self harm. In addition: The intervention should be tailored to individual need and could include cognitive-behavioural, psychodynamic or problem-solving elements. (NICE, 2011, p.9)

The NICE guideline on BPD (NICE, 2009) is not much more specific with regards to psychotherapeutic interventions. Overall it states that "an explicit and integrated theoretical approach [should be] used" (NICE, 2009, p.18). However, it does recommend 'Dialectical Behaviour Therapy' (DBT) specifically for women with BPD who self-harm.

Therefore in this section of the paper, psychotherapeutic interventions for adolescent self-harm and related emerging personality disorder will be reviewed, including brief reviews of their theoretical underpinnings. The quality criteria of reliability, validity, generalisability and replicability will be utilised in reviewing quantitative research (Bryman, Becker & Sempik, 2008). The term 'psychotherapy' is used here in its broader sense to denote "the treatment of mental disorders and allied problems by psychological methods" (Colman, 2003, p.603).

Search Strategy (see Appendix 1 for a fuller description)

Numerous research databases including OvidSP, APA PsycNet, and PubMed Central were searched via the Canterbury Christ Church University e-library online

portal. Separate searches were also carried out via Google Scholar. Different combinations of the key words self-harm, therapy, adolescents, and 'emerging personality disorder' were utilised. Research papers which presented original research on psychotherapeutic interventions for adolescent self-harm and related BPD features were included. Reviews of interventions for adolescent self-harm and related BPD features were also included in order to position the present review in relation to them. Original research papers which only presented non-psychotherapeutic interventions (e.g. token economy, medication) for adolescent self-harm and related BPD features were excluded.

Challenges of the Present Review

Several challenges became evident to the present author in attempting to review research on psychotherapeutic interventions for adolescent self-harm and related BPD features, some of which were discussed in the introduction. In brief, it can be difficult to differentiate between self-harm with and without suicidal intent. Excluding papers on adolescent self-harm with suicidal intent could have resulted in relevant papers being excluded. Therefore papers on psychotherapeutic interventions for self-harm were included, regardless of intent. Second, some research papers on adolescent self-harm include BPD measures, while others do not as BPD is not normally diagnosed in adolescence. It was therefore decided to include both types of studies as participants across those studies presented with similar clinical pictures, indicative of at least BPD features (e.g. self-harm, impulsivity, mood and relationship difficulties). Third, a number of the studies which will be reviewed utilised treatment as usual (TAU) groups, but either offered very little detail on what TAU actually

consisted of or presented TAU as a heterogeneous group of interventions, therefore making it difficult to know what the clinical interventions were being compared to.

Previous Reviews

A number of reviews have been previously carried out on treatment interventions for deliberate self-harm in adolescents (e.g. Gonzales & Bergstrom, 2013; Ougrin, Tranah, Leigh, Taylor & Asarnow) and adults (e.g. Hawton et al., 1999; Crawford, Thomas, Khan, & Kulinskaya, 2007; Klonsky & Muehlenkamp, 2007). The author was not able to identify reviews on psychological interventions for emerging BPD features in adolescence, though numerous reviews have been conducted on psychological interventions for BPD in adults (e.g. Cochrane Review; Stoffers et al., 2012).

Ougrin et al. (2012) identified 14 randomised controlled trails (RCTs) of treatment interventions for adolescent self-harm including pharmacological, social interventions and psychological interventions, some of which have been included in the present review. Ougrin et al. (2012) included research on self-harm with and without suicidal intent. Psychological interventions reviewed included 'Developmental Group Psychotherapy' (DGP), 'Cognitive Analytic Therapy' (CAT) and 'Multisystemic Therapy' (MST). As the review only included RCTs, no research on 'Dialectical Behaviour Therapy' (DBT) or 'Cognitive Behavioural Therapy' (CBT) for the treatment of adolescent self-harm was included. The review concluded that: "at present not enough good quality independently replicated RCTs have been conducted to make conclusions about the effectiveness of specific treatment interventions for self-harm in adolescents" (Ougrin et al., 2012, p.345).

Klonsky and Muehlenkamp (2007) conducted a review of treatment interventions for deliberate self-harm in adults. They identified cognitive behavioural interventions, including DBT, psychodynamic interventions, including MBT and CAT, and pharmacological interventions. The review concluded: "Psychotherapies that emphasize emotion regulation, functional assessment, and problem solving appear to be most effective in treating self-injury" (Klonsky & Muehlenkamp, 2007, p.1045).

The most recent 'Cochrane Review' on psychological interventions for adults with BPD (Stoffers et al., 2012) reviewed 28 RCTs of various psychological interventions including DBT, 'Transference-Focused Psychotherapy' (TFP), MBT, and CBT. The review concluded that there was sufficient research demonstrating the effectiveness of DBT for it to be considered a helpful psychological intervention for adults with BPD. For all other interventions reviewed it recognised that favourable outcomes had been reported, but added that further research would be required to conclusively establish their efficacy.

Multisystemic Therapy (MST)

MST is a very intensive (daily contact if needed), yet time-limited (three to six months) family and community based intervention, with a good evidence base for juvenile offending (Henggeler, Clingempeel, Brondino, & Pickrel, 2002). MST teams are often characterised by intensive supervision, small caseloads (four-six cases per clinician), antisocial hours, and flexible outreach work (Henggeler et al., 2002). MST therapists essentially help the adolescents' system to engage in better parenting (Henggeler et al., 2002).

Huey et al. (2004) conducted a randomised controlled trial (RCT) of MST adapted for adolescents who self-harm. The research took place in the USA; 156 adolescents

participated, the majority of whom were African-American males (65%) of low socioeconomic status, with an average age of 13. Participants were recruited after attending the emergency department of one hospital, following a suicide attempt; they were all randomly assigned to either MST or treatment as usual (TAU), which consisted of emergency psychiatric hospital admission. It was not reported how many participants were assigned to each group. Outcome measures were used at assessment, four months after recruitment, and at a one year follow-up.

Huey et al. (2004) found that MST resulted in a significant reduction in self-harm at follow-up, compared to TAU. However, "MST appeared to have no long-term, differential effects on suicidal ideation, youth depressive affect, or youth-rated parental control" (Huey et al., 2004, p.186). The reliability and validity of this study and its measures appeared to be acceptable on the whole. Specifically, Cronbach's alpha levels on psychometric measures for their sample ranged from 'questionable' ($0.6 < a < 0.7$) to 'good' ($0.8 < a < 0.9$), and the measures appeared appropriate for this population. The generalisability and replicability of this intervention to and with other adolescents who self-harm is somewhat questionable, particularly given the disproportionately high numbers of males in this study compared to existing epidemiological data on self-harm. Finally, as this is the only identified study of its kind, more research would be required to establish MST as an evidence-based intervention for adolescent self-harm, though sufficient information was provided for replication.

Developmental Group Psychotherapy (DGP)

Wood, Trainor, Rothwell, Moore and Harrington (2001) developed and evaluated DGP. According to Wood et al. (2001, p.1247) the therapy is 'developmental'

because it "has a focus on the adolescent growing through difficulties by using positive corrective therapeutic relationships". This therapy was influenced by, and contains elements of, cognitive-behavioural therapy, dialectical behaviour therapy, and psychodynamic group psychotherapy. DGP consists of two phases, an 'acute group' phase of six sessions, and a 'long-term group' phase, the duration of which depends on the individual needs of the adolescent.

Wood et al. (2001) conducted an RCT of DGP compared to TAU with 63 adolescents (78% female) in one site in England. Thirty-two adolescents were assigned to DGP and 31 to TAU. Measures were taken before treatment, at six weeks, and seven months after randomisation (Wood et al., 2001). The outcome measures used included depressive symptoms, suicidal ideation, and actual self-harm. Participants receiving DGP attended a median of eight sessions and displayed a significant drop in actual self-harm at follow-up compared to TAU, used services less, attended school more, and displayed less behavioural difficulties. No differences were found with regards to depressive symptoms when comparing DGP participants to those receiving TAU.

Hazell et al. (2009) attempted to replicate this RCT in Australia, across three sites, with 72 adolescents aged 12 to 16 years (91% female). In this study participants receiving DGP actually had a worse development than those receiving TAU, with regards to repeated self-harm at six and 12 month follow-up. However, participants receiving DGP displayed "a trend for greater improvement over time on global symptom ratings" (Hazell, et al., 2009, p.662). Hence this study failed to replicate the findings of Wood et al. (2001) and actually contradicted them. The authors

suggested that factors such as less experience using this model and differences in participant characteristics may have played a role in this failure of replication.

Green et al. (2011) also attempted to replicate the findings of Wood et al. (2001) across eight sites in northwest England, with a larger sample of 183 adolescents (89% female). Participants across TAU and DGP attended a mean number of 10 sessions. As in Hazell et al. (2009) the results were mixed. The primary outcome of reducing self-harm more in DGP compared to TAU was not achieved. However, participants receiving DGP improved significantly more on secondary outcome measures (e.g. severity of self-harm, mood, suicidal ideation) compared to TAU.

The reliability of DGP as an intervention appears to be mixed, given that three RCT's did not produce consistent results. Hazell et al. (2009) proposed some reasons for this, including differing levels of experience amongst teams in delivering DGP. The most recent study on DGP (Green et al., 2011) did produce promising results with regards to secondary outcome measures, and DGP did offer some additional benefits to TAU across all three studies, though these were inconsistent.

Cognitive Behaviour Therapy (CBT)

Stanley et al. (2009) conducted a research study in the USA into the acceptability and feasibility of 'CBT for Suicide Prevention' (CBT-SP) with 110 clinically depressed adolescents who had recently (last three months) made a suicide attempt. CBT-SP is a manualised treatment approach of approximately 12 sessions, which was specifically designed for this clinical population using various techniques drawn from CBT (e.g. cognitive restructuring strategies) and DBT (e.g. distress tolerance skills). According to Stanley et al. (2009, p.3) "the primary goals of this intervention are to reduce suicidal risk factors, enhance coping and to prevent suicidal behaviour."

Following participant interviews Stanley et al. (2009) concluded that CBT-SP is an acceptable and feasible intervention for suicidal adolescents.

Brent et al. (2009) published a companion study to Stanley et al. (2009), in which they evaluated CBT-SP compared to pharmacotherapy, as well as pharmacotherapy plus CBT-SP. This research was originally intended to be an RCT, but as only 22 participants agreed to be randomised, the rest (n=102) were given a choice of treatment. Hence the design was described as an open feasibility study. While this may have reduced the methodological robustness of the study, it did make it more ecologically valid as it offered choice and reflected clinical reality. Most participants received CBT-SP plus pharmacotherapy (n=93), while some received CBT-SP only (n=17), and fewer yet received pharmacotherapy only (n=14).

Participants were assessed at four time-points on a number of measures (e.g. depression and anxiety), though the primary outcome measure was a 'suicidal event', defined as completed or attempted suicide, suicide preparation and suicidal ideation. Due to the small number of participants that only received one therapy, comparisons between groups were not made. Participants were found to improve over time on a number of measures of symptomatology and functioning which were taken; specifically, they were less depressed, anxious, and suicidal, and were functioning better. Unfortunately 24 of the 124 participants had another 'suicidal event' over the 6-months since entering this intervention study, while 15 made at least one suicide re-attempt; one completed suicide occurred shortly after the end of the study. The effects of distinct treatment components were not discussed in the paper due to the small sample sizes of the monotherapy groups; therefore the

effectiveness of CBT-SP only cannot be concluded, though it appears to be a promising intervention.

Cognitive Analytic Therapy (CAT)

CAT is a 16 or 24 session psychotherapeutic intervention developed by Anthony Ryle in the 1980's as a response to the increasing demand for time-limited psychotherapies (Ryle & Kerr, 2002). CAT is influenced by Kelly's personal construct theory, object relations, attachment theory, Mann's time limited psychotherapy, and Bakhtin's dialogism (Ryle & Kerr, 2002). CAT utilises cognitive techniques described as 'Target Problem Procedures' through key concepts such as 'dilemmas' (c.f. black and white thinking) 'traps' (c.f. vicious cycles), and snags (c.f. learned helplessness); however, great emphasis is also placed on the way individuals relate to others, referred to as 'Reciprocal Role Procedures' (RRPs; e.g. abuser – abused; Ryle & Kerr, 2002). Research suggests that CAT can be effective in treating BPD in adults (Ryle & Golynkina, 2000); CAT theory proposes a 'Multiple Self-States Model' of BPD, which suggests that individuals with BPD have a restricted repertoire of RRPs, disrupted processing of their RRPs, and a disrupted self-reflection (Ryle & Kerr, 2002).

Chanen et al. (2008) conducted the only RCT to date of CAT for adolescents displaying BPD features, including self-harm, in Australia. CAT was compared to 'Good Clinical Care' (GCC), "a modular treatment package developed specifically for this study... and explicitly designed... to control for some factors commonly believed to be effective in psychotherapy" (Channen et al., 2008, p.479). GCC contained problem-solving and CBT components. Importantly the same three clinical psychologists delivered CAT and GCC, and both interventions consisted of up to 24

sessions. Participants were aged 15-18; 86 adolescents participated in total, while 78 provided follow-up data. Of the 78 participants, 41 received CAT and 37 received GCC. Participants in both treatment groups demonstrated improvements during the two year period from assessment to follow-up, including a significant reduction in self-harm. However, CAT did not result in greater improvements for participants than GCC, although those receiving CAT improved more rapidly. On the whole this study demonstrated that CAT can be effective in treating BPD features in adolescents, though it was not superior to GCC.

The results of this study appear to be reliable and valid; rigorous randomisation procedures were followed. The authors acknowledged that the sample size was relatively small for an RCT; however the paper provided sufficient information for replication to take place. The results may also be generalisable to similar settings in developed countries, though further research would be needed for this to be established.

Dialectical Behaviour Therapy (DBT)

DBT is a treatment intervention originally developed by Marsha Linehan specifically for individuals with BPD and self-harming behaviours, though its use has been expanded to also treat other BPD comorbidities (Linehan et al., 2006). It originated as a specialist CBT intervention with influences from behaviour therapy, dialectical philosophy and Zen practice, which grew into its own specific approach as it matured and research evidence for its effectiveness accumulated (Linehan et al., 2006). Linehan developed a biosocial theory of BPD which formed the basis of DBT; according to that theory BPD is viewed primarily as a disorder of affect regulation,

and behaviours such as self-harm stem from that difficulty in regulating emotions (Linehan, 1993).

In reviewing the research literature on DBT for adolescents, Groves, Backer, van den Bosch and Miller (2012) concluded that DBT is a promising intervention for that population for a variety of difficulties, including for BPD features and DSH. DBT for adolescents (DBT-A) is briefer than the adult version (12-16 weeks from 12 months); other adaptations have also been made such as introducing age-appropriate terms and including the young persons' family in the intervention (Groves et al., 2012). This section will only review the controlled, quasi-experimental, research studies on DBT-A; for a review of further research on DBT-A see Groves et al. (2012).

Rathus and Miller (2002) conducted one of the early quasi-experimental research studies into the adapted DBT-A in the USA. One-hundred and eleven adolescents took part in the study, 82 of which were assigned to TAU and 29 to DBT. Participants were mostly female (93% in DBT vs. 73% in TAU) and were on average one year older than those in the TAU group (16 vs. 15). All participants receiving DBT had made a suicide attempt in the previous 16 weeks and had either BPD features or a BPD diagnosis, while participants in the TAU group only met one of the criteria (BPD or DSH). All therapists were either Clinical Psychologists or Trainee Clinical Psychologists.

Participants in the DBT group received 12 weeks of twice-weekly therapy; individual DBT and 'multi-family skills training.' Participants in the TAU group received 12 weeks of twice weekly individual psychodynamic psychotherapy and family therapy. Even though participants in the DBT group displayed more severe symptoms of mental distress prior to treatment, they had no psychiatric hospitalisations during the

intervention, while 13 participants (16%) in the TAU group required a psychiatric hospitalisation. Additionally, 2.5 times more participants in the TAU group made a suicide attempt during treatment. The majority of participants receiving DBT completed treatment, while that was only a minority for TAU (62% vs. 40%). Within the DBT group, participants displayed a statistically significant decrease in psychopathology including in suicidal ideation, overall BPD symptom levels, anxiety, and depression.

On the whole this study provided a very promising picture of DBT for adolescents with BPD and DSH. While the design was non-randomised, participants receiving DBT who displayed greater emotional distress at baseline, improved more than those receiving TAU. There was clearly a tension between clinical reality and methodological robustness; however this only made this study more ecologically valid, thus possibly also increasing its generalisability. Furthermore, even with a small, underpowered sample size, statistically significant effects were found, suggesting a good intervention effect size.

Katz, Cox, Gunasekara, and Miller (2004) conducted the second quasi-experimental study to date, into DBT-A. This was a feasibility study into DBT-A for suicidal adolescent inpatients, comparing DBT-A to TAU. Sixty-two suicidal adolescents participated in total across two inpatient units. One unit utilised DBT-A while the other unit implemented TAU. All participants were assessed before and after treatment, and at one year follow-up. The assessment included outcome measures of suicidality and depression. In addition DSH and other behavioural incidents were recorded at both wards.

The results suggested that "DBT significantly reduced behavioural incidents during admission when compared with TAU. Both groups demonstrated highly significant reductions in parasuicidal behaviour, depressive symptoms, and suicidal ideation at 1 year" (Katz et al., 2004, p.276). DBT was therefore a successful intervention for this group of adolescents. However, it was not significantly superior to TAU, though it did reduce behavioural incidents more than TAU. The non-randomised, naturalistic nature of this study increases its ecological validity, as it reflects clinical reality better. However, a RCT would have been more methodologically robust. Sufficient information for replication was provided.

Mentalisation-Based Treatment (MBT)

MBT is a psychoanalytically oriented psychotherapy which was developed by Bateman and Fonagy (2004) for the treatment of BPD in adults, and has been found to be effective for that population (Bateman & Fonagy, 1999; Bateman & Fonagy 2008). MBT draws greatly on attachment theory (Bowlby, 1978) and mentalizing or 'Theory of Mind' (ToM; Baron-Cohen et al., 1985). Mentalizing can be defined as the ability to infer the mental states of oneself and others based on their behaviour (Baron-Cohen et al., 1985). One of the goals of MBT is to improve the ability to mentalize in individuals with BPD, as this has been found to be deficient, particularly in attachment relationships (Bateman & Fonagy, 2006). The attachment system of people with BPD is thought to be hypersensitive; thus resulting in mentalizing deficits (i.e. non-mentalizing or hyper-mentalizing) when it is aroused (Bateman & Fonagy, 2006). Therefore, while mentalizing may occur in other contexts, it can temporarily 'fail' in attachment relationships in people with BPD.

MBT theory suggests that when mentalizing fails the individual can enter into a non-mentalizing state such as 'psychic equivalence', whereby the world is as it feels (Bateman & Fonagy, 2006). Therefore negative thoughts and feelings can feel 'too real' and the individual may not be able to differentiate between a subjective experience and other possibilities. For example a person may think: "It feels like he hates me, therefore he does hate me". There is no recognition that the other person may have a different subjective experience. This can lead to self-harm as feelings can become too overwhelming and unbearable (Bateman & Fonagy, 2006).

MBT is based on a developmental model (i.e. attachment and ToM), and is therefore well suited to adolescents from a theoretical point of view. Rossouw and Fonagy (2012) conducted the first RCT on MBT for Adolescents (MBT-A) in outpatient settings. The RCT examined whether MBT-A would be more effective than TAU in treating adolescents with BPD traits who self-harmed. The MBT-A programme combined weekly individual with monthly family MBT. TAU consisted of a variety of treatments including counselling, CBT, and psychodynamic psychotherapy. Eighty adolescents with a mean age of 15 took part in the research, of which 85% were female. The participants were randomly allocated to either MBT-A or TAU. Assessments were conducted at baseline and then every three months, over a period of a year. Reliable and valid measures were utilised which investigated BPD features, mood, attachment, risk taking and self-harm behaviours. The reliability and validity of the mentalizing measure called 'How I Feel', could not be established as the measure is unpublished. The results suggested that MBT-A was more effective in treating adolescents with BPD traits who self harmed, than TAU. Specifically, MBT-A was better than TAU in reducing self-harm, depression, and BPD traits. The superior improvements in participants receiving MBT-A were explained by improved

mentalization and reduced attachment avoidance, though it was not possible to make a definitive causal link.

Overall, the Rossouw and Fonagy (2012) study was well designed and executed, and yielded significant results. The intervention was manualised and could therefore be replicated. The results appeared generalisable to the participant population, though replication would be required. However, there were also some limitations to this research. For example, the heterogeneous nature of the TAU group made it difficult to isolate what it was about MBT-A that made it more effective. This also makes the TAU group difficult to replicate. Furthermore, of the 80 participants who were originally randomized, only 37 actually completed their treatments, though all of the data was utilised for analysis. Had all the data not been used, it is possible that the study would not possess sufficient statistical power to detect effects. However, the rate of attrition for the two groups was similar, and significant effects were still detectable.

Discussion

The intervention research reviewed represented a heterogeneous body of interventions with different theoretical underpinnings, aimed broadly at reducing adolescent self-harm and related emerging personality disorder features. Overall, the present review demonstrated that a plethora of interventions have been developed for this population, with varied levels of effectiveness. While some interventions appeared to be more effective than others for certain difficulties, it was not possible to conclude that one psychotherapeutic intervention was most effective for the treatment of self-harm and related emerging personality disorder features in adolescents.

MST resulted in a significant reduction in self-harm compared to TAU, though no long-term effects were found for suicidal ideation and depression (Huey et al., 2004). DGP research provided mixed results; the original research study (Wood et al., 2001) found a drop in self-harm at follow-up, less behavioural difficulties and better school attendance compared to TAU, but no difference in levels of depression. However, later studies (Hazzell et al., 2009; Green et al., 2011) failed to replicate those findings for self-harm, though greater improvements on secondary measures (e.g. depression) were found compared to TAU.

The open feasibility study by Brent et al. (2009) on CBT-SP, found that participants were less depressed, anxious, and suicidal, and that their daily functioning abilities improved after the intervention. CAT was not superior to GCC (good clinical care) in reducing self-harm, though both CAT and GCC produced significant reductions in self-harm behaviours (Channen et al., 2008). Quasi-experimental DBT research found a significant reduction in suicidal ideation, BPD symptoms, anxiety, and

depression, compared to TAU (Rathus & Miller, 2002). However, Katz et al. (2004) did not find DBT to be superior to TAU, though both interventions resulted in a significant reduction in self-harm, depression and suicidal ideation. Finally, MBT was found to be superior to TAU in treating adolescents who engaged in self-harm; a significant reduction in self-harm, depression and BPD features was found compared to TAU.

The present review has a number of limitations which reflect the complexity of research in this area. These were briefly discussed previously. First, though all the research studies reviewed concerned interventions for adolescent deliberate self-harm, it is uncertain whether the participants across these studies represented a homogenous population. For example, the MST group (Huey et al., 2004) was made up predominantly of males, which is not in keeping with epidemiological and other research in this area (e.g. Hawton et al., 2002), thus suggesting that they may represent a slightly different population. Another issue was that some of the research investigated participants who had engaged in self-harm with suicidal intent (e.g. Huey et al., 2004), while other research investigated individuals who engaged in self-harm possibly without suicidal intent (e.g. Rossouw & Fonagy, 2012). It can be difficult to differentiate the two at times, as even an admission to an 'Accident & Emergency Department' does not necessarily mean that a young person intended to end her life. However, adolescents who primarily self-harm as a way of regulating their emotions and those who intend to end their lives may represent different clinical populations, though there may also be areas of overlap, and the same individual can oscillate between different positions.

Third, the RCT's which utilised TAU as a control group, were not all clear on what TAU consisted of, and therefore it was not clear what they were comparing their

interventions to. In other studies (e.g. Rossouw & Fonagy, 2012) TAU represented a heterogeneous group of interventions which made comparisons within and between studies more complicated. In other words, finding no significant difference between an intervention and a potentially effective TAU is not the same as finding a significant difference between an intervention and a psychotherapeutically relatively ineffective TAU (e.g. medication reviews).

Recommendations for Future Research

Given the complexity of this population and research in this area, a number of recommendations could be made for further research. First, it would be useful if future research compared one psychotherapeutic intervention with another, so that it is clear what an intervention is being compared with, and why one is more effective than the other. Comparing an intervention to a heterogeneous TAU may be ecologically valid and reflective of clinical services, but limits the conclusions that can be drawn about the intervention. In reviewing the research, qualitative studies on adolescent patients' experiences of interventions were not excluded, but no studies in this area were identified. Psychotherapeutic interventions that have been found to be helpful for treating adolescent self-harm, such as MBT and DBT, could benefit from exploring with adolescent service users how they experienced the treatment, including what it was about it that was helpful or unhelpful. This could further improve those interventions. Third, more research is required overall on psychotherapeutic interventions for adolescent self-harm, including attempts to replicate existing research in order to establish the reliability and generalisability of the studies. Fourth, future research studies need to make greater attempts to differentiate adolescent deliberate self-harm from attempted suicide, while also acknowledging that the two concepts can overlap.

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Section B: Empirical Paper[2]

Adolescents' Experiences of a Therapeutic Inpatient Service utilising
Mentalization-Based Treatment for Borderline Personality Disorder Features

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Abstract

The present study aimed to investigate adolescents' experiences of a therapeutic inpatient service utilising mentalization-based treatment (MBT) for borderline personality disorder (BPD) features, including deliberate self-harm. A qualitative research approach was chosen and eight adolescents were interviewed on their experiences. Interviews were analysed using interpretative phenomenological analysis (IPA; Smith, Flowers & Larkin, 2009). The analysis resulted in five superordinate themes and 17 corresponding subordinate themes. Adolescents described having felt uncontained, uncontainable and misunderstood, particularly prior to their admission. They talked about a process of seeking containment from others which in some cases led to their admission. Participants described feeling contained and understood in the inpatient service and developing a healthier relationship with self and others. Finally, they talked about their recovery as a long and challenging journey and expressed hope for the future. The study concluded that therapeutic inpatient treatment utilising MBT was experienced as beneficial by adolescents, though methodological limitations were acknowledged. Clinical implications were drawn and recommendations for future research were made.

Introduction

Mentalization

Mentalization can be defined as an "imaginative mental activity that enables us to perceive and interpret human behaviour in terms of intentional mental states" (Fonagy & Allison, 2012, p.11). Mentalization is a heterogeneous concept which can be viewed as existing within four spectrums; automatic-implicit vs. controlled-explicit, self vs. other, cognitive vs. affective, and externally-based vs. internally-based self and other mentalizing (Fonagy & Luyten, 2009). Mentalizing abilities can be empirically tested and have been found to exist as early as infancy (Onishi & Baillargeon, 2005). Neuroscience research suggests that specific brain regions are involved in mentalizing which form part of the 'social brain' (Blakemore, 2008). These include the posterior superior temporal sulcus, the temporoparietal junction, the temporal poles and the medial prefrontal cortex (Blakemore, 2008). There are however some notable differences between how adolescents and adults utilise these brain regions when mentalizing, which suggests that mentalizing abilities and underlying neural pathways are still developing during adolescence (Burnett, Bird, Moll, Frith, & Blakemore, 2008).

Mentalization-Based Treatment (MBT)

'Mentalization-Based Treatment' (MBT) is a psychoanalytically oriented psychotherapy which was developed by Bateman and Fonagy (2004) for the treatment of 'Borderline Personality Disorder' (BPD) in adults. MBT also offers a developmental model of understanding BPD and its features, including its predisposing and maintaining factors (Bateman & Fonagy, 2006). MBT draws on a number of psychodynamic theories and concepts including Winnicott's (1956)

concepts of the 'true and false self', Bion's (1962) concept of containment and Bowlby's (1988) attachment theory in understanding BPD. It is beyond the scope of the present paper to explore these concepts in detail. However, in brief Bion's (1962) concept of containment originally regarded the mother infant interaction and the understanding that a "good-enough mother" (Winnicott, 1956) would be able to contain the anxieties of her infant, by communicating to the infant that she was feeling calm, it was safe, and she was able to meet her needs.

Winnicott (1960) explained that a 'false self' could develop as a way of protecting the 'true self' from external attack, when an infant's needs were not met. Bateman and Fonagy (2006) expanded on Winnicott's concept by developing the concept of an 'alien self' in BPD. This suggests that "when a child cannot develop a representation of his own experience through mirroring (the self), he internalizes the image of the caregiver as part of his self-representation" (Bateman and Fonagy, 2006, p.11). For example, an infant may feel distressed and receive anger from the caregiver instead of a caring response which recognises the distress and attempts to soothe it, and thus internalises alien hateful feelings which were not originally hers.

 MBT theory suggests that insecure disorganised attachments to primary caregivers in childhood, sometimes resulting from abuse and/or neglect (i.e. experiences of not being mentalized), underlie many BPD features (Bateman & Fonagy, 2006). Research with adults with a diagnosis of BPD confirmed that the majority (91%-92%) had suffered abuse and/or neglect in childhood (Zanarini et al., 1997). The attachment system of people with BPD is thought to be hypersensitive, thus resulting in mentalizing deficits when it is aroused (Bateman & Fonagy, 2006). While mentalizing may occur in other contexts, it can temporarily "fail" in attachment

relationships in people with BPD. Therefore the primary goal of MBT is to improve the client's ability to mentalize herself and others (Bateman & Fonagy, 2006).

MBT theory suggests that when mentalizing "fails" the individual can enter into a non-mentalizing state such as 'psychic equivalence', whereby the world is as it feels (Bateman & Fonagy, 2006). Therefore negative thoughts and feelings can feel 'too real' and the individual may not be able to differentiate between a subjective experience and other possibilities. For example she may think: "It feels like he hates me, therefore he does hate me". There is no recognition that the other person may have a different subjective experience. This can lead to concrete destructive actions such as self-harm as feelings can become too overwhelming and unbearable to process (Bateman & Fonagy, 2006). Bateman and Fonagy (2006) call this the 'teleological mode' whereby actions are required to communicate states of mind. Another non-mentalizing mode of being is the 'pretend mode' where there is a significant disconnect between the persons psychological and physical reality (e.g. only talking about a loving father when he was actually an abuser; Bateman & Fonagy, 2006).

Mentalizing deficits in adults with BPD?

Research on the mentalizing abilities of adults with BPD has yielded mixed results, depending in part on the type of mentalizing task used. Fertuck et al. (2009) found that adults with BPD scored higher on a mentalizing task than healthy controls. The study utilised the 'Reading the Mind in the Eyes' task ('eyes task'; Baron-Cohen, Wheelwright, Hill, Raste, & Plumb, 2001), whereby participants are shown pictures of peoples' eye areas displaying different emotions, and have to identify the correct emotion. Fertuck et al. (2009, p.1979) suggested that: "An enhanced sensitivity to the mental states of others may be a basis for the social impairments in BPD."

Preißler, Dziobek, Ritter, Heekeren, and Roepke (2010) utilised the (explicit) 'eyes task' as well as a more sensitive (implicit) video task, the 'movie for the assessment of social cognition' (MASC; Dziobek et al., 2006) to examine the mentalizing abilities of adults with BPD. The results of the study found no difference between healthy controls and participants with BPD on the eyes task. However, participants with BPD displayed significant mentalizing impairments on the MASC in attributing mental states to characters in the movie. This mixed mentalizing profile in patients with BPD, whereby implicit mentalizing can be deficient while explicit mentalizing can be superior, is known as Krohn's paradox (Krohn, 1974). A double dissociation has also been found between affective and cognitive mentalizing abilities in BPD, whereby opposite to healthy controls individuals with a diagnosis of BPD displayed higher affective than cognitive mentalizing abilities (Harari, Shamay-Tsoory, Ravid, & Levkovitz, 2010).

Adult MBT Research

A longitudinal randomised controlled trial (RCT) conducted by Bateman and Fonagy (1999, 2008) with adult inpatients suggested that an 18 month MBT programme consisting of once weekly individual MBT and thrice weekly group MBT was more effective than 'treatment as usual' (TAU) in treating BPD and related symptoms. Specifically, symptoms of depression, self-harm and suicide attempts reduced significantly, and social and interpersonal functioning improved significantly compared to TAU. These findings were broadly maintained at an eight-year follow-up, though some difficulties in social functioning remained. The majority (87%) of MBT participants no longer met diagnostic criteria for BPD at follow-up, while that was only the case for a minority of the TAU group (13%; Bateman & Fonagy, 2008).

Mentalizing deficits in adolescents with BPD features

Sharp et al. (2011) investigated mentalizing and emotion regulation abilities in adolescent inpatients who met diagnostic criteria for BPD. The mentalizing task (MASC; Dziobek et al., 2006) required participants to watch a video of a group of people having dinner together and discussing issues of friendships and relationships which raised different emotions (e.g. anger) in different characters. Participants had to rate what they thought was going on in the minds of different characters. They also completed measures of emotion regulation and BPD traits. The results revealed a significant correlation between hypermentalizing or excessive inaccurate mentalizing, poor emotion regulation and BPD features. In other words, adolescent inpatients who scored the highest on BPD features and had the greatest difficulties in regulating their emotions, attributed considerably more mental states to characters than could be attributed based on what was displayed in the video.

Adolescent MBT Research

MBT is based on a developmental model and is therefore well suited to adolescents from a theoretical point of view. Rossouw and Fonagy (2012) conducted the first RCT on MBT for Adolescents (MBT-A) in outpatient settings. The RCT examined whether MBT-A would be more effective than TAU in treating adolescents with BPD features who self-harmed. The MBT-A programme combined weekly individual with monthly family MBT over a year. TAU consisted of a variety of treatments including counselling, CBT, and psychodynamic psychotherapy.

Eighty adolescents with a mean age of 15 took part in the research, of which 85% were female. The participants were randomly allocated to either MBT-A or TAU. Assessments were conducted at baseline and then every three months, over a year.

Reliable and valid measures were utilised which investigated BPD features, mood, attachment, risk taking and self-harm behaviours. The results suggested that MBT-A was more effective in treating adolescents with BPD features who self harmed, than TAU. Specifically, MBT-A was better than TAU in reducing self-harm, depression, and BPD features. The superior improvements in participants receiving MBT-A were explained by improved mentalization and reduced attachment avoidance.

Sharp et al. (2013) also investigated the effect of MBT on adolescents with BPD features. The intervention was conducted in an inpatient setting and focused particularly on achieving a reduction in hypermentalizing (Sharp et al., 2011). One-hundred and sixty-four adolescent inpatients (62 girls and 49 boys; mean age = 15.5; SD = 1.44) took part in the study of which 68 scored highly on BPD features. The treatment was described as a 'milieu-based inpatient treatment' consisting of close individual key working and groups covering issues such as emotion regulation with an emphasis on improving mentalizing skills, within an 'interpersonal-psychodynamic' framework. Participants in the BPD and 'Non-BPD' group received the same treatment and completed a variety of mentalizing tasks at assessment and discharge, including the MASC (Dziobek et al., 2006) and the eyes task (Baron-Cohen et al., 2001), as well as measures of BPD features and other measures of psychopathology.

The results revealed that participants in both groups displayed a significant decrease in their hypermentalizing scores at discharge compared to assessment, while a greater improvement was found in the BPD group than in the 'Non-BPD' group. The hypermentalizing scores were thought to represent an implicit form of mentalizing. On the other hand reductions were not found on the 'eyes task' which was thought to

represent an explicit form of mentalizing. Thus, the authors' concluded that their intervention was specifically useful in reducing implicit hypermentalizing.

A need for qualitative research

Qualitative research can be complementary to quantitative research. Quantitative research can test specific hypotheses, evaluate the reliability of measures, and calculate the effect sizes of interventions on different psychological symptoms (Elliot, Fisher & Rennie, 1999). Qualitative research on the other hand can investigate the subjective lived experiences of individuals on phenomena on which they are experts by experience (Elliot et al., 1999). Both approaches are valuable and can answer different types of questions.

Qualitative research on clients' experiences of psychotherapy can further our understanding of a treatment by, for example, identifying mediating factors between therapy and psychometric outcomes (Elliot, 2008). Psychometric outcome measures can reveal whether a client scored higher or lower at the end compared to the beginning of treatment; however on their own they cannot explain why or how a client changed through treatment. Qualitative research can investigate clients' subjective perceptions of how they think a change occurred.

Mason and Hargreaves (2001) conducted a qualitative study investigating the subjective experiences of adults who received mindfulness-based cognitive therapy (MBCT) for recurrent depression. They acknowledged that quantitative research on MBCT yielded promising results but added: "little is known of the process by which MBCT may bring therapeutic benefits" (Mason & Hargreaves, 2001, p.197). Through this study the authors were able to identify that expectation of treatment was a central factor which influenced the patients' experiences, that mindfulness skills and

attitudes were seen as important factors, that generalising these skills to everyday life was seen as imperative, and that continually practicing these skills was greatly valued by participants.

Perseius, Öjehagen, Ekdahl, Åsberg, and Samuelsson (2003) investigated the experiences of adults with BPD who received dialectical behaviour therapy (DBT). As Mason and Hargreaves (2001), Perseius et al. (2003) acknowledged that quantitative research on DBT supported its use, but recognised that there was a need to investigate the patients' experiences in order to identify mediating factors and perceptions of treatment. The study was able to identify various themes on the patients' experiences of DBT, including that they viewed DBT as life-saving, that they found the DBT skills very valuable, and that it helped them to understand their problems better.

There has been a plethora of quantitative research studies and conceptual papers on mentalizing and MBT for adults, and some quantitative research on MBT for adolescents. Given this body of research, the present author would argue that there is a need for qualitative research on the experiences of inpatient treatment of individuals receiving MBT. To the best of the present author's knowledge no such research has been conducted to date.

The Present Paper

The present paper aims to investigate the experiences of adolescents with BPD features undergoing an MBT-A intervention programme in a therapeutic inpatient setting. In doing so, the paper aims to answer the following research questions:

- What was the experience of adolescents with BPD features prior to their admission to a therapeutic inpatient service utilising MBT-A?
- How do adolescents with BPD features experience a therapeutic inpatient setting utilising MBT-A?
- How do adolescents with BPD features receiving MBT-A in an inpatient service experience their recovery process?

Methodology

Participants

A purposive sample of eight adolescents aged 14 to 18 (Mean = 16.4, S.D. =1.2) took part in the study, of which seven were female and one was male (See Table 1 for participant characteristics). Participants displayed features of emerging BPD as assessed by a Consultant Psychiatrist. Formal diagnoses of BPD were not given as these are not normally made until early adulthood (American Psychiatric Association [APA], 2000). Features displayed by participants included fear of abandonment, intense unstable interpersonal relationships, identity disturbance, impulsivity, recurrent suicidal behaviour and/or self-harm, emotional instability, feelings of emptiness, and dissociative symptoms (APA, 2000).

Participants were recruited from an adolescent inpatient unit in the South East of England, where they were either inpatients or day-patients. All participants were originally admitted as inpatients to the unit as a result of presenting a serious risk to self, most commonly due to suicidal behaviour. The participants that were day-patients at the time of their interview had been stepped down from inpatients. Day-patients normally attended the service Monday to Friday from 9am until 5pm and spent evenings and weekends at home. Most inpatients went home during weekends, but remained at the unit on weekdays. Some participants were stepped down to day-patients and then back up to inpatients depending on the level of risk to self they presented.

Table 1. Summary of Participant Characteristics.
Key: F=Female; M=Male; IT=Individual Therapy; GT= Group Therapy; FT = Family Therapy.

Participant[2]	Age & Gender	Ethnicity	Self-Harm	Time on Unit	Mental Health Problems	Previous Therapy	Patient Status at Interview	Treatment
Jessica	17; F	White British	Cutting, Overdose	14 weeks	Depression, Social Anxiety, Anger	CBT; Anxiety Group	Day-patient	IT, GT, FT
Ellie	17; F	White British	Cutting, Overdose	17 weeks	Depression	Psychotherapy; CBT	Inpatient	IT, GT, No FT
Emily	16; F	White British	Cutting, Overdose	13 weeks	Depression	Psychotherapy; Group	Inpatient	IT, GT, No FT
Sophie	16; F	White British	Cutting, Overdose	17 weeks	Depression, Anxiety, Asperger's Syndrome	Family Therapy; CBT	Day-patient	IT, GT, FT
Katie	14; F	White British	Cutting, Overdose, Burning	17 weeks	Depression, Anger	CBT	Inpatient	IT, GT, FT
Alice	18; F	White British	Cutting, Overdose, Burning	14 weeks	Depression	CBT	Inpatient	IT, GT, No FT
Sam	17; M	White British	Cutting, Overdose	21 weeks	Depression, Anorexia	Dietician Only	Day-patient	IT, GT, FT
Anna	16; F	White Eastern European	Cutting, Overdose	10 weeks	Depression, Eating Difficulties	Counselling	Inpatient	IT, GT, No FT

[2] Participant names are pseudonyms created for the purpose of confidentiality.

Treatment.

Adolescents received an intensive version of MBT-A consisting of twice-weekly hourly individual therapy sessions, twice-weekly group sessions lasting an hour and a half, and weekly family therapy sessions lasting an hour and a half. Three adolescents opted out of the family sessions; one young person (Anna) was due to start her family sessions soon after she took part in the study. In addition to the MBT-A programme many participants were prescribed medication such as antidepressants. Participants accessed education at the unit as well as a variety of other activities including meditation, cooking and exercise classes.

Inclusion criteria.

All adolescents participating in the intervention who had received at least 10 weeks of treatment were given the opportunity to participate in the present study. The 10 week threshold was set so that participants had sufficient experience of the intervention to be able to reflect on it.

Exclusion criteria.

The studies exclusion criteria were the same as for the intervention. Adolescents who were actively psychotic and/or learning disabled were excluded. Active psychosis and learning disability would have made the treatment intervention unsuitable for those adolescents.

Procedure

Participants who met the inclusion criteria were approached by the researcher at the unit and asked whether they would be interested in taking part in a research study about their experiences. Interested participants were given information forms. A mutually convenient time was booked with those participants who wanted to take

part. For participants under the age of consent (i.e. 16) their parents/legal guardians were contacted first to confirm that they were in agreement (see Ethical Considerations). Interviews were conducted with participants at the unit in an interview room and lasted between 35 and 60 minutes. Prior to the commencement of the interview consent/assent forms were signed and an opportunity was provided for participants to ask questions. Participants also completed background information forms (Appendix 6). The first interview acted as a pilot, and was reviewed under supervision before proceeding with further interviews.

Interview Schedule

A semi-structured interview schedule (Appendix 1) was devised following guidance provided by Smith, Flowers and Larkin (2009). Questions were devised to be open and non-leading. Follow-up questions were also constructed which could aid the interviewer and the interviewee should the initial question be experienced as too abstract for the young person to be able to answer.

Design and Analysis

Interviews were analysed thematically using interpretative phenomenological analysis (IPA; Smith et al., 2009). According to Smith et al. (2009, p.1) "IPA is a qualitative research approach committed to the examination of how people make sense of their major life experiences. IPA is phenomenological in that it is concerned with exploring experience in its own terms." IPA was selected for the analysis as the present author was particularly interested in how participants created meaning from their major life experiences.

The analysis followed the procedures outlined in Smith et al. (2009). Transcripts were read and re-read in order for the author to become immersed in the data. Initial

notes were taken on the left transcript margin; these notes consisted of descriptive comments, linguistic comments, and conceptual comments focusing on different aspects of transcript excerpts. Next, emergent themes were written in the right transcript margin using primarily the notes made in the left margin (Appendix 7). Once this process was completed, emergent themes were grouped together to form superordinate themes. The next stage consisted of looking for patterns across cases in order to develop the final themes and superordinate themes.

Quality Assurance Checks

In order to ensure the quality of the IPA, Yardley's (2000) quality criteria for qualitative research were utilised, as recommended by Smith et al. (2009). The first criterion concerns 'sensitivity to context'. Here the word 'context' encompasses many factors including the setting, the actual data and the interaction with the participant. Sensitivity to the data can be assured in IPA by ensuring that any initial notes and emerging themes are well grounded in actual participant quotes. This was continually checked by the present author and was then confirmed by the author's supervisors (TL and SH) by spot checking the interview transcripts, their codes and comparing them to the themes. Furthermore, TL listened to an entire interview on audio, and both supervisors read at least one transcript fully and reviewed others more briefly, in order to validate the accuracy of the codes and corresponding themes. Sensitivity to the data will also be demonstrated in the results section by accompanying the themes with relevant participant quotes.

The second quality criterion regards 'commitment and rigour'. Commitment can regard how the actual interview was carried out and analysed, by for example paying close attention to what the participant said, during the interview and when analysing the transcript. This was assured by the author taking the same steps as when

considering sensitivity to the data. Additionally, the author carried out the interview following guidance provided in Smith et al. (2009), who suggest that the interviewer takes on the position of an active listener. Rigour refers to how the participants and the actual research questions were selected, the quality of the interview and analysis. The rigour of the interviews was ensured by carrying out a practice pilot as a role play with a clinical psychologist (GT) who knew the client group well and then reflecting on the experience, including the author's interviewing technique. Additionally, TL listened to the entire first interview with a participant at the adolescent unit in order to ensure the quality of the interview. The quality of the interview was considered good and was therefore included in the analysis.

A rigorous analysis follows the specific steps recommended by Smith et al. (2009) such as interpreting the meaning of initial notes accurately when creating themes. A theme needs to be transparently traced back to congruent initial notes and quotes. This was continually checked by the present author and then by the research supervisors; an example has been provided in the appendices (see Appendix 9). Rigour in relation to sample selection in IPA can regard the homogeneity of the participant group. The participant group in the present study was considered by the present author and the research supervisors to be a relatively homogenous; most participants shared a number of features such as gender, age, sociocultural background, setting, mental health difficulties and self-harm behaviour.

The third criterion is 'transparency and coherence'. Transparency is the extent to which aspects of the methodology and analysis can be followed through and also traced back, as in the example above about tracing quotes to themes (see Appendix 9). Coherence refers to whether the final research paper presents a coherent argument, in which it is clear how the research was conducted and how it arrived at

its conclusions. It is hoped that the present paper coherently presents the methodology and findings of the research to the reader. Yardley's final criterion is 'impact and importance' which refers to what the research has offered and why that is significant. The potential impact and importance of the present paper will be considered in the discussion section.

Ethical Considerations

The research received Ethical Approval from an 'NHS Research Ethics Committee' and an 'NHS Trust Research and Development Department'. All client data was kept anonymous and confidential. Participants were informed that their participation was voluntary and that they could withdraw from the study at any point in time without need for further explanation. All participants were asked for their signed consent or assent. For participants under the age of consent (i.e. 16), signed consent was sought from their legal guardian (Appendix 5). It was clarified in the 'Information Sheet' (Appendix 2) and 'Consent/Assent Form' (Appendix 3 & 4) that therapy and research were separate, and that participation or non-participation in the research would not affect their treatment in any way. It was explained that the interviews would be conducted by the researcher, and that the interview content would not be shared with anyone at their service, unless it revealed a significant risk to themselves or to others. It was agreed that while interviews may have brought up difficult issues for participants, the therapeutic setting in which they were based would be able to address them.

Results

Table 2. Superordinate themes, (subordinate) themes, and number of participants displaying each theme (n/8).

Superordinate Themes	Themes	Number of Participants
1) *Feeling Uncontained, Uncontainable & Misunderstood*	**a)** Self as Unwell	8
	b) Feeling Overwhelmed	8
	c) Self as Uncontainable	6
	d) Social Withdrawal	8
	e) Feeling Unsafe & Uncontained	8
	f) Putting on a Brave Face; Protecting the Self & Others from the Unwell Self	7
2) *Seeking Containment*	**a)** Seeking Containment	7
3) *I'm Not Alone; Feeling Contained & Understood*	**a)** Feeling Contained by the Inpatient Service	8
	b) Feeling Contained & Understood in Therapy; Individual, Group & Family	7
	c) I'm Not Alone; Feeling Contained & Understood by Other Patients	7
4) *Developing a Healthier Relationship with Self & Others*	**a)** Developing New Understandings through Therapy	8
	b) Self as Relationally Able	7
	c) Being Your "Real Self"	8
5) *Recovery as Long & Challenging Journey*	**a)** Hope for the Future & Recovery	8
	b) Therapy as Challenging	8
	c) Building Resilience through Therapy	7
	d) Needing Time to Recover	8

The analysis resulted in five superordinate themes and 17 corresponding (subordinate) themes displayed in Table 2. The superordinate themes signify a higher level of collectively representing themes which emerged from the analysis of the transcripts. The superordinate themes and their associated sub-themes are discussed in turn below utilising participant quotations as a way of bringing them to life and evidencing their validity, as recommended by Yardley (2000) and Smith et al. (2009; see Appendix 8 for further quotes).

Bion's (1962) concept of containment was drawn on heavily during the analysis in constructing the themes, as it appeared useful in describing some of the participants' experiences (or the absence thereof). Winnicott's (1960) concept of the 'true and false self' was also used in understanding some of the experiences that adolescents described. These concepts form part of the theoretical underpinnings of MBT, and are therefore in harmony with the MBT approach (Bateman & Fonagy, 2006).

1. Feeling Uncontained, Uncontainable & Misunderstood

This superordinate theme refers to the emotional states that adolescents' described. These states were characterised by feelings such as not belonging, being different, misunderstood, and experiencing great emotional distress which was not or could not be alleviated by the actions of individuals (e.g. family) or institutions (e.g. school).

Self as Unwell

This theme expressed experiences that all eight participants described of feeling emotionally unwell and viewing themselves as being unwell, particularly prior to their inpatient admission.

Ellie said (p.3, l.5)[3]:

I was suicidal and quite depressed and having lots of mood swings and stuff like that.

Emily said (p.1, l.20):

Before I came here I was like a mess really. I couldn't really cope much. I couldn't really process things...

Feeling Overwhelmed

Eight participants talked about feeling overwhelmed by the everyday demands placed on them at home, school, work and socially, prior to their admission.

Sophie said (p.7, l.6):

Yeah, all my troubles was just piled on to one and one and one and it just like stopped me from going to school. I just couldn't do it anymore. I was breaking down every morning and wasn't sleeping.

Self as Uncontainable

Self as uncontainable speaks to a sense in six adolescents that they had crossed a tipping point, whereby negative feelings such as anger poured out from them in a way that they no longer felt able to contain.

Jessica said (p.4, l.29):

I just had a complete freak out and I got really violent and aggressive, I actually hit my mum and threw a drink in her face. I was completely out of it, not in touch with reality.

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[3] Transcript page (p.) and line (l.) numbers.

Social Withdrawal

Experiences of social withdrawal were reported by eight adolescents. This often resulted from feeling emotionally overwhelmed and unwell.

Jessica said (p.3, l.26):

When I'd just been doing too much it really made me anxious, I would just withdraw completely into myself, I wouldn't leave my room, I wouldn't go out for ages, I wouldn't do anything at all, I wouldn't talk to anyone.

Feeling Unsafe & Uncontained

Eight adolescents described feeling unsafe and uncontained, particularly prior to their admission. These feelings applied to different settings including home, school and community CAMHS[4].

Sophie described this in detail when talking about how she felt at home (p.3, l.17).

Home is really difficult (...) we always argued, arguing led to screaming, screaming led to breaking stuff in the house and it would carry on for days and weeks and months and of course I don't think my mum and dad understood what was going wrong with me, why I was so upset all the time and things like that. So it was difficult (...) I struggled a lot, like I didn't sleep, I had no-one to really talk to. I just found home quite a daunting place (...) I used to think that because home was distressing because of arguments that it would lead to cutting. That's the feeling I had always inside me, so that's what made it daunting inside me.

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[4] Child and Adolescent Mental Health Services

Putting on a Brave Face; Protecting the Self & Others from the Unwell Self

This theme was about hiding psychological distress and had two sides. One was about adolescents not wanting to make themselves vulnerable by displaying their weakness; the other was about not wanting to 'contaminate' others with 'the unwell self'. It could be understood using Winnicott's (1960) concepts of the 'true and false self'; 'putting on a brave face' could be seen as a 'false self' aimed at protecting the 'true self' from the reactions of others. Seven adolescents described this theme.

Katie spoke about not wanting to talk to her parents about her experiences (p.5, l.10):

> *I don't want them to know. I feel like I'm protecting them from how I feel because I think they'd be really upset.*

Ellie talked about wanting to protect her therapist from her unwell self (p.21, l.15):

> *I feel like I need to protect her from like my other side, my bad side. (...) thoughts that I have and stuff that I do that are not very nice (...) a mean side (...) and a manipulative side that I try and protect her from because I don't want her to not like me; because I love her.*

2. Seeking Containment

This superordinate theme was not as dominant as others, but was still present in seven interviews. Participants spoke of efforts they made to receive a form of containment from others while experiencing psychological distress, particularly prior to their admission.

Ellie spoke about this in relation to approaching her father when feeling suicidal (p.8, l.15):

> *I said to my dad: "I really want to kill myself, I think … I really know I'm going to do something; Please help me!", because I hadn't really had such strong suicidal urges until that time, so I was quite scared.*

3. I'm Not Alone; Feeling Contained & Understood

This superordinate theme emerged from adolescents' descriptions of feeling that they started receiving the care they required, the realisation that there were other adolescents with similar struggles to them, and that people were trying to understand their experiences.

Feeling Contained by the Inpatient Service

This theme refers to a sense of containment that all eight adolescents interviewed experienced from the inpatient service as a whole, including but not limited to the experience of the therapy they received.

Jessica, who was a day-patient at the time of the interview said (p.5, l.37):

> *I've just found it really so helpful. There's always people around you can talk to, I can call up any time, even at 12 o'clock at night if I'm struggling I can call them and someone will talk to me. And, I'm always around people I can talk to, I've got more therapy now, I see a psychiatrist more regularly so that my medication can be sorted.*

The availability of people at the service appeared to be essential to this young person. This mirrored the availability that a "good enough mother" (Winnicott, 1956) might have in relation to her infant when attempting to contain (Bion, 1962) the infant's distress by responding promptly and empathically to its needs.

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Feeling Contained & Understood in Therapy

This theme emerged from seven adolescents' accounts of feeling that they could express their psychological distress in a safe therapeutic environment, that their emotional needs were being responded to appropriately and that an effort was made to understand them in therapy, including individual, group, and family therapy.

Sophie talked about individual therapy in the following way (p.9, l.17):

> *It's good because you're getting your feelings out, your emotions out; you're getting unwanted stuff out of your body.*

This again mirrors closely the mother infant relationship and Bion's (1962) concept of the mother as a container for the infant's unwanted emotions; only that here the therapist acted as a container to the adolescent patient's emotional distress.

I'm Not Alone; Feeling Contained & Understood by other Patients

This theme was present in seven of the interviews conducted. Participants spoke about feeling understood by other adolescents on the unit, which was often in contrast to previous experiences of not having been understood by peers, prior to their admission. This gave them a feeling of containment and of not being alone in their experiences.

Sam spoke of this in relation to other adolescents on the unit (p.10, l.15):

> *It's very interesting to hear another person tell you their story and it makes me realise that I'm not the only one that goes through these things and it helps because we just all understand each other and get along and we can always support each other if we're struggling.*

4. Developing a Healthier Relationship with Self & Others

This superordinate theme emerged from descriptions of adolescents developing new understandings of themselves and others through therapy, seeing themselves as more relationally able and feeling able to be their "real" selves, without needing to hide.

Developing New Understandings through Therapy

Eight participants described developing new understandings of themselves and others through therapy which shifted their perspectives.

Ellie spoke of this eloquently when thinking about her parents (p.19, l.17):

> *I used to know exactly, my dad was amazing and my mum was horrible, but now it's different because as you grow older you begin to understand your parents more and why they did things they did. So, my dad probably kicked me out perhaps he was terrified because I'd just been in hospital for a year, on and off for a year and it was still like this, so yeah. Still he shouldn't have done it, but he was scared.*

Anna reflected on the impact of therapy on her understandings (p.18, l.30):

> *I think it's just made me think about stuff... and figure them out (....) I kind of... it's sort of made me more understanding...*

Self as Relationally Able

This theme concerned a reported change in seven participants' views of themselves in relation to others. They viewed themselves as more able to interact with others in a way which felt healthier to them; able to form healthier relationships and avoid unhealthy ones.

Jessica described this shift eloquently (p.13, l.12):

I suppose before I came here I was really scared of being alone, I didn't want to be abandoned, I would rather be friends with people who were horrible to me than be alone. But, now I'd rather be alone than have fake friends, so this has taught me to be a bit healthier about my relationships.

Emily talked about being better at mentalizing others, more relationally able, and expressed hope for future relationships (p.14, l.6):

Now that I can see other people's side of view and I can communicate properly with people, it's going to be good really. It's going to be so much better.

Being Your "Real Self"

This theme emerged from eight adolescents' descriptions of feeling that they could display who they were in the unit, without needing to hide. It can be viewed as a counter-theme to 'Putting on a Brave Face', which was discussed earlier. Being your 'real self' could also be viewed as a 'True Self' (Winnicott, 1960), which has integrated the adolescents' strengths and weaknesses.

Sophie described this comprehensively (p.16, l.18):

I've been myself. I've been the real me. I haven't had to come here and just hide. I've actually been myself personality wise as well, because at school, you know, I felt I had to be different, whereas here I am myself. So I've learned how to be myself, outside [the unit] as well.

5. Recovery as a Long & Challenging Journey

This superordinate theme emerged from adolescents' descriptions of their recovery process and their hopes for the future. In speaking about recovery adolescents also touched on how challenging therapy had been for them, the fact that 'full' recovery would take time, as well as on the things they could take from their therapy into the future as part of their recovery journey.

Hope for the Future & Recovery

This theme emerged from eight adolescents talking about hopes they had for the future, including the hope that they would recover from their mental health difficulties.

Jessica said (p.13, l.42):

> *I just want to get on with my life really, and hopefully that will be positive and just managing my feelings in a healthy way.*

Therapy as Challenging

Eight adolescents talked about how challenging therapy could be, sometimes in the context of discussing the challenges of recovery in its wider sense.

Ellie talked about how difficult therapy was for her at the time of the interview and expressed some doubt about her recovery (p.24, l.13):

> *With therapy I sort of go in, I talk about things and I come out feeling pretty bad, like I'm not a fan of therapy right now because at the moment it just makes me feel worse, but they say that you have to get worse before you get better, so don't know.*

Building Resilience through Therapy

This theme regarded the resilience that seven adolescents felt they developed through therapy and how these 'resiliences' could help them in the future.

Emily said (p.13, l.21):

> *I will still have all the things in my head, all the good things that people have said to me from here, like I'll take it away with me and keep it on board and just keep really reminding myself of the good things. Therapy's helped me to do that.*

In this passage Emily talked about a process of having internalised positive messages she received; it could also be argued that perhaps she had internalised her therapist as a positive attachment figure which gave her strength.

Needing Time to Recover

Eight adolescents talked about needing time to recover.

Sam discussed his mother's expectations for his recovery, and how these clashed with his own pace (p.4, l.22):

> *Like she thinks it'll all just happen in a week and it'll be fine after that, but it's much harder than getting over it in a week.*

Alice spoke of her pessimism regarding a full recovery, but also stressed that should she make a full recovery she would require a lot of time and support (p.3, l.28):

> *I honestly don't think I'm going to be able to get out of this mindset and if I am it's going to take a long time and it's kind of like I'm aware I'm going to have to have like mental health help and like outpatient services and stuff for probably quite some time.*

Discussion

The original research questions will be used to structure the discussion of the results and related literature. Superordinate and subordinate themes will be referred to in the discussion using numbers and letters respectively to reference them (e.g. 4a; see Table 2). Research limitations, clinical implications and recommendations for further research will be discussed.

Research Question 1: What was the experience of adolescents with BPD features prior to their admission to a therapeutic inpatient service utilising MBT-A?

This question can be answered in relation to the first superordinate theme: 'Feeling Uncontained, Uncontainable & Misunderstood'. Participants described themselves as unwell (1a), and talked about feeling overwhelmed (1b) across a number of different settings (e.g. school, home, socially) with the demands placed on them prior to their admission. They also talked about reaching a (crisis) point at which they experienced themselves as uncontainable (1c) resulting in aggression directed at the self (i.e. self-harm) and/or others (i.e. physical or verbal aggression). Jessica for example talked about physically assaulting her mother. Participants talked about withdrawing socially (1d) and feeling unsafe and uncontained (1e) across different settings, including home and school. Finally, they described putting on a brave face (1f) to protect themselves and others from their 'unwell self'.

This sense of overwhelming uncontainment that participants described could have been the result of failures in mentalizing, particularly in close attachment relationships (e.g. parents), on their part and/or on the part of the person they were interacting with. For example, Ellie spoke about her father "kicking her out" of his

house when he found her overdosing on medication in his bathroom. One could assume that this was a failure of mentalizing on his part, but perhaps also a failure of mentalizing on Ellie's part who possibly found it difficult to see at the time she took the overdose that there were people who cared about her. MBT theory suggests that when affect is high the ability to mentalize drops (Bateman & Fonagy, 2006), which was what dramatically occurred on that occasion. Using Ellie's example again, the container (i.e. father) could perhaps not contain his daughters distress, which probably left her feeling even more uncontained than when she took the overdose (Bion, 1962). For many participants feeling uncontained led to a development of a 'false self' (Winnicott, 1960) whereby they 'put on a brave face' (1f) in order to protect themselves and others from the 'unwell self'. For some, experiences of not having been mentalized and contained may have led to the development of an 'alien self' (Bateman & Fonagy, 2006), whereby emotions were internalised which may not have originally belonged to them. Klein (1946) called this projective identification.

Research Question 2: How do adolescents with BPD features experience a therapeutic inpatient service utilising MBT-A?

This question can be answered with reference to the third superordinate theme: 'I'm Not Alone; Feeling Contained & Understood'. Participants talked about feeling contained by the inpatient service as a whole (3a), but particularly in relation to therapy (3b), including individual, group and family therapy. Participants also found the group incredibly valuable and containing as it helped them realise that they were not alone in their experiences and made them feel understood (3c). Therefore the therapeutic milieu as a whole was experienced as containing, but also the therapies and the therapists.   The ability of the unit, the therapies and other adolescents to act

as containers for the distress that adolescents experienced, allowed them to feel contained (Bion, 1962).

This in turn led to a thinking or mentalizing space being created where the adolescents' ability to mentalize was engaged, as became evident in the fourth superordinate theme: 'Developing a Healthier Relationship with Self & Others'. Bateman and Fonagy (2006) suggest that in order for mentalizing to take place the attachment system needs to be activated sufficiently for a person to be physically and emotionally engaged, but not so much that they are overwhelmed. Through a process of gently stimulating their attachment systems in therapy, participants were able to develop new understandings of themselves and others (4a), see themselves as relationally able (4b), and feel able to be their 'real' selves (4c).
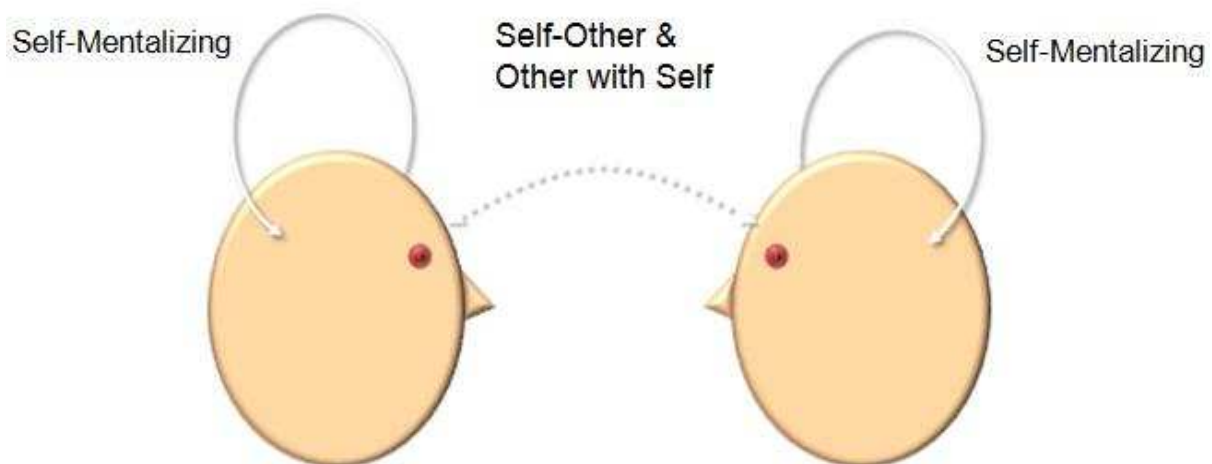
Figure 1. Mentalizing the self and the other.

These changes appeared to have occurred through a process of adolescents reflecting on (i.e. mentalizing) their own past experiences, the way they related to others, how they may have made others feel and why others they may have reacted in certain ways (see Figure 1). For example Ellie was able to reflect that her father must have been terrified when he found her overdosing in his bathroom and that this

may have led to him reacting angrily. The latter theme, 'Being Your Real Self' (4c), suggested that adolescents felt able to nurture their 'true selves' and could set aside their 'false' (Winnicott, 1960) or 'alien selves' (Bateman & Fonagy, 2006). Therefore, in line with the findings of previous research (e.g. Rossouw & Fonagy, 2012; Sharp et al., 2013) adolescents subjectively reported experiencing psychological changes, including improved mentalizing abilities.

Research Question 3: How do adolescents with BPD features receiving MBT-A in an inpatient service experience their recovery process?

This question could best be answered with reference to the fifth superordinate theme: 'Recovery as a Long & Challenging Journey'. Participants expressed hope for their recovery and future (5a). They communicated that the recovery process through therapy was challenging (5b), but also that they felt they had built some resilience through therapy (5c). The latter theme also emerged from other qualitative research studies on patients' experiences of therapies (e.g. Mason & Hargreaves 2001; Perseius et al., 2003).

Finally, participants explained that they needed time to recover (5d), and could not do so at a pre-prescribed pace set by others. Individuals with BPD (features) possibly requiring a more intensive form of treatment and more time to recover than other presentations has been supported by previous research. In Bateman and Fonagy's (1999) original adult MBT RCT, patients were offered an 18 month intervention, while in Rossouw and Fonagy's (2012) adolescent MBT RCT patients were offered a 12 month intervention. This is probably considerably longer than the average length of psychological treatment for young people in CAMHS. This notion that more time and greater intensity may be required is also supported by the

National Institute for Health and Clinical Excellence (NICE) guidance on BPD which states that brief interventions, defined as three months or less, should generally not be offered to individuals with BPD and that twice-weekly session should be considered (NICE, 2009).

Research Limitations

There are certain limitations to the present study. First, the results cannot be generalised to the population studied as a whole, however they may be transferable to other similar subpopulations of a similar sociocultural background in a similar context. For example the results of the present study could be transferable to other similar inpatient services in the UK or other similar countries, working with mostly female adolescent patients with BPD features including deliberate self-harm and utilising a similar approach to MBT-A.

Second, the author's analysis may have been at least unconsciously biased to a certain extent by previous theoretical understandings (e.g. containment). However, the analysis was explicitly inductive and not deductive, meaning that the author allowed the themes to emerge from the transcripts, rather than trying to fit preconceptions onto the participants' experiences. In IPA it is neither possible nor desirable to eliminate all researcher bias as the researcher is himself the instrument through which the analysis takes place. However, efforts were made to ensure the quality of the analysis using Yardley's (2000) criteria and through attempts at bracketing or setting aside the author's preconceptions. For example, the present author had regular discussions with the research supervisors during the design, data collection and analysis process, which were invaluable in ensuring the research quality. Additionally, one supervisor (TL) listened to an entire interview, and both

supervisors read at least one transcript and spot checked others to check the rigour of the interviews. Coded transcripts were also checked by supervisors to ensure the sensitivity, rigour and transparency of the analysis process. Nonetheless the results are the author's interpretation, of the participants interpretation, of their experiences; Smith et al. (2009) refer to this as a double hermeneutic.

Third, it would have been advantageous if participants had completed their treatment at the time of the interview. This could have allowed for a more complete picture to emerge, but was not possible due to time constraints. Nonetheless, the in vivo exploration of participants' experiences is arguably equally valuable and sufficient sessions had been completed in order for participants' to be able to reflect on their experiences.

Future Research

The evidence base on MBT-A is in its infancy, though there are reasons to believe that it may be a valuable intervention for the treatment of adolescents with BPD features. In order for the efficacy of MBT-A to become more established further quantitative research would be necessary. For example, quasi-experimental research could be conducted examining the effectiveness of MBT-A in an inpatient setting by comparing those adolescents with other adolescents with similar clinical presentations in a different inpatient setting using a different intervention approach. Alternatively, single-case-series design (Barlow, Nock, & Hersen, 2008) or within participant design could be used to compare results within a mental health service using MBT-A. Qualitative research could be conducted retrospectively interviewing participants who have completed MBT-A on their experiences of treatment.

Clinical Implications

Several clinical implications could cautiously be drawn from the present study. It appeared that some adolescents required the level containment and intervention that only an inpatient setting could provide. Anecdotally there can be some stigma in community mental health professionals regarding patients being admitted to inpatient services. However, rather than being a necessary evil or simply a way of managing risk, an inpatient admission in a therapeutic environment may be the best clinical intervention for some adolescents. Furthermore, it seemed imperative to most adolescents that they had multiple therapeutic settings (e.g. individual and group therapy) in which to explore their experiences. For example many adolescents described finding the group very valuable as, among other factors, it helped them realise that they were not alone in their experiences. Mental health services could consider offering multiple interventions to adolescents with BPD features, provided that these are coordinated and complimentary in their approach.

Quantitative research on MBT for adolescents (Rossouw & Fonagy, 2012; Sharp et al., 2013) has yielded positive results thus far and the present study suggests that adolescents interviewed did experience a therapeutic inpatient service utilising MBT-A as beneficial. Therefore, there may be merit in more adolescents with BPD features having access to MBT-A in mental health services, including in therapeutic inpatient settings. Careful attention would also need to be paid to transitions from child and adolescent to adult services, in order for a sense of containment by services to be maintained across services. Transitions from child to adult services can be anxiety provoking for young people and where close attention is not paid to the transition process, including endings, this can lead to an increase in anxiety.

Conclusions

This study broadly aimed to investigate adolescents' experiences of a therapeutic inpatient service utilising MBT-A for BPD features, including deliberate self-harm. The results suggested that participants went through a journey of feeling uncontained in the community, to feeling contained in an inpatient service, developing new insights and resiliences and experiencing changes in their views of self and others. However, adolescents interviewed also recognised the challenges of this process and their recovery journey. Many were hopeful about the future. The results of the present study are limited in their generalisability by methodological issues, though they may be transferable to other similar settings with clients of similar sociocultural backgrounds. Further quantitative and qualitative research is needed into MBT-A in establishing it as an effective intervention for adolescents with BPD features, though the results to date suggest that it is a promising therapeutic intervention.

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Section C: Critical Appraisal Paper

Word Count: 2000

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JULY 2013

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

1. ***What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?***

Prior to conducting the present study I had many and varied experiences of quantitative research. I had studied quantitative methodologies and analyses, reviewed many quantitative papers as part of essays or critical reviews, and conducted two quantitative theses, as part of my undergraduate and postgraduate studies in psychology. However, I had never been exposed to qualitative research prior to undertaking my clinical training; the qualitative research "world" was entirely foreign to me.

I first became acquainted with it through my 'Quality Improvement Project' during my first year of training, when I conducted a thematic analysis (TA) of clinicians' experiences of utilising a certain systemic measure, while loyally following the guidance provided by Braun and Clarke (2006). Though this was a useful introduction to qualitative methods, the analysis lacked depth. This was due to a combination of factors including the subject matter, my novice qualitative research skills, and the way I chose to apply TA by interpreting meanings on a surface level taking a realist epistemological position, which assumes a clear relationship between meaning, experience and language (Braun & Clarke, 2006).

When I first embarked on the present project, it was meant to be a purely quantitative 'single-case series design' (Barlow, Nock, & Hersen, 2008) on 'Mentalization-Based Treatment for Adolescents' (MBT-A; Rossouw & Fonagy, 2012) in an outpatient setting, investigating changes in participants' scores on a variety of measures. It was then decided to add a thematic analysis (Braun & Clarke, 2006) to

the study investigating participants' experiences of treatment at follow-up, thus making it a mixed design. After a lengthy and laborious process of all the relevant approvals (i.e. University, NHS Ethics, NHS R&D) being sought and granted for that project and some data collection had commenced, the project "fell through". It was decided in December 2012 that it was no longer feasible as significant unforeseen participant recruitment difficulties emerged. A contingency plan was available, but was not designed for a scenario as dramatic as the one that we were faced with (i.e. n=0). Therefore, a new plan had to be devised and executed as soon as possible.

Thankfully my external supervisor had good links with an adolescent inpatient service with a well established MBT-A programme, which was willing to assist me in conducting a qualitative project on adolescents' experiences of MBT-A. Nonetheless, the process of seeking approval from all the relevant bodies had to restart, as the change of methodology and research site constituted a major amendment to the research. As this was now a purely qualitative project, 'Interpretative Phenomenological Analysis' (Smith, Flowers, & Larkin, 2009) was chosen in order for the qualitative analysis to have greater depth. All the relevant approvals were eventually granted; data collection started at the end of May 2013 and finished at the beginning of July 2013.

The purpose of describing all of the above was to set the context for the research skills that I have learned and developed. I developed my qualitative research skills substantially from a more novice level to a more intermediate level. I developed skills in single-case design, though I did not fully utilise them as a result of the initial project being cancelled. I developed skills in complex project management, dealing with many changes which had to be responded to swiftly and flexibly, without

protracted mourning for the time and effort spent on developing ideas which never came to fruition. I learned that when it comes to research it is wise to 'hope for the best and expect the worst'. By that I mean that multiple flexible contingency plans need to be considered as so much can go wrong in a research project. Though I developed a sufficient understanding of the underlying philosophy of IPA in order to conduct the analysis, I think that studying the philosophies of phenomenology and hermeneutics (e.g. Husserl) in greater depth in their own right, would add to the depth of the analysis. Unfortunately, this was not possible due to time constraints of the research and other obligations. In future, I would also like to deepen my qualitative research skills by utilising triangulation (i.e. having multiple sources/perspectives) when studying an issue, perhaps using a grounded theory (GT) approach (e.g. Charmaz, 2006).

2. **If you were able to do this project again, what would you do differently and why?**

If I was able to do this project again, I would have liked to have conducted the project which I eventually did conduct, from the beginning of the clinical training, rather than as a contingency plan in the beginning of 2013. In other words, if I had more time, I could have added further elements to the research study, such as triangulation, which may have created a richer description of participants' experiences. For example, I could have added interviews with parents and with therapists, investigating their views on young people's development through treatment. This could have been done utilising the existing methodology of IPA, or GT could have been used instead in order to develop a model of 'MBT-A in an inpatient setting'.

Furthermore, if I had more time I would have perhaps interviewed participants at the end of their treatment, in order to gain a more complete picture of their experiences. However, I believe that there was value in eliciting an in vivo account of participants' experiences, as the issues were very much alive for them, though still considerably more processed than they might have been at the time of their admission. At last, I could also have added participant observation to the research, by for example attending service user meetings (non-therapeutic) for a number of weeks, and creating process notes of my observations (e.g. Crouch & Wright, 2004). This could have enriched the analysis by immersing me in the milieu of the unit and the interactions of young people, thus possibly strengthening the emergent themes.

3. **_Clinically_, as a consequence of doing this study, would you do anything differently and why?**

I think that conducting this study has changed my attitude towards inpatient services, while also recognising that it is hard to generalise as they are all different. Prior to conducting this study, I held a commonly held belief amongst mental health practitioners that inpatient admissions are themselves traumatic and should only be used as a last resort in an attempt to manage risk which is impossible to manage in the community. While there is still some truth to that in my opinion, I have developed an additional perspective. An inpatient admission to a therapeutic environment can be the best treatment option for some young people, in my opinion. This is an attitude which may inform my thinking as a qualified clinical psychologist, when considering whether a person requires or would benefit from an inpatient admission. It has also opened up the possibility to me of perhaps working in an inpatient service at some point in the future.

Conducting this research has also highlighted to me the amount of input that some young people require in order to change. A therapeutic milieu with twice-weekly individual therapy, twice-weekly group therapy, and weekly family therapy, in addition to other educational and recreational activities, is indeed a very intensive treatment program. However, even under such conditions change can take a relatively long time. I think that clinically, this realisation may impact my view on how much input a young person may require. For example, I may consider offering twice weekly therapy to some young people when I am qualified if the service I am in would support that; this is supported by 'National Institute for Health and Clinical Excellence' (NICE) guidance on 'Borderline Personality Disorder' which states that twice-weekly session should be considered (NICE, 2009).

Finally, this project highlighted to me the importance of transitions and endings, particularly for young people with attachment difficulties. I think I would therefore pay even closer attention to those issues when working with that client group in the future. For example, I may talk to young people more about the ending from very early on in the therapy in order to allow sufficient time for psychological adjustment to take place. With regard to transitions, particularly transitions from 'Child and Adolescent Mental Health Services' (CAMHS) to adult services, I would spend more time with young people and with professional colleagues thinking about those transitions, should a discharge not be in their best interest. Ideally, the adult service would share a similar ethos and model to the CAMHS team, such as MBT (Bateman & Fonagy, 2006), depending on the difficulties that the person presents with, in order for optimal continuity of care to be ensured. Another alternative would be for ageless personality disorder services to be designed using one evidence-based model such as MBT, similar to '*Early Intervention for Psychosis Services' (EIS)*. This could

increase a sense of containment for those young people, though it could also harbour some dangers and disadvantages.

4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

As discussed in Section B, recommendations for future research, quasi-experimental research could be conducted examining the effectiveness of MBT-A in an inpatient setting by comparing those adolescents with other adolescents with similar clinical presentations in a different inpatient setting utilising a different intervention approach (e.g. dialectical behaviour therapy). This would be easier to conduct than an RCT, but could be equally valid. Anecdotally, it appears that inpatient admissions to adolescent units are often random, depending primarily on bed availability provided that two young people present with the same kinds of difficulties (e.g. self-harm).

Alternatively, single-case-series design (Barlow, Nock, & Hersen, 2008) or within participant design could be used to compare results within a mental health service using MBT-A. As previously discussed, the former is what I originally intended to do for the present research project. I could therefore utilise the knowledge gained through preparing to conduct that project, in order to carry out a similar project in the future. The advantages of this approach are that it is very flexible and could provide valuable results with a relatively small number of participants. A disadvantage would be that it would require the young person to fill in many different outcome measures at different treatment points, as well as a brief weekly outcome measure. This could feel like a strain to the young person.

Overall, further quantitative research could strengthen the evidence base for MBT-A in different CAMHS settings, including outpatient, day-patient and inpatient settings.

As previously mentioned, qualitative research could be conducted with adolescents who have completed MBT-A in order to gain a more holistic view of their experience of treatment. This could be done a few days before or after a young person's discharge from a service. Additionally such a project could be conducted in an inpatient or an outpatient service. Young people could also be interviewed at multiple time points, in order to track possible changes in perspectives and experiences. For example, they could be interviewed at assessment, during treatment and at a follow-up. This would perhaps necessitate a smaller number of participants (e.g. four) so that the researcher can manage the amount of data that this kind of study would generate.

Finally, a further interesting possibility would be to conduct a mixed design, similar to the one originally proposed, combining single-case design with qualitative interviews at multiple time points, in order to track participant's experiences of treatment and of change during treatment. Elliot (2002) developed an approach which could cater to this mixed design, called 'Hermeneutic Single-Case Efficacy Design'. This approach can answer three important questions: a) whether a client has changed; b) whether that change was due to therapy; and c) what about therapy led to that change. Thus, it would greatly inform clinicians understandings of both process and outcome in MBT-A.

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Section D: Appendix of Supporting Material

Appendix 1: Literature Search Methodology

Procedure:

The following procedure was employed to identify articles of interest.

1. Searches were performed in OvidSP, APA PsycNet, PsycArticles, SAGE Journals, Wiley Online Library, JSTOR, EBSCOhost, CINAHL, PubMed Central and Biomed Central via the Canterbury Christ Church University e-library online portal. Separate searches were also performed via Google Scholar.

2. Different combinations of the following keywords were used to search for relevant articles:

   - Self-Harm OR Self-Poisoning OR Self-Mutilation

   - Adolescents OR Young-People

   - Interventions / Treatment / Therapy / Psychotherapy

   - Emerging Borderline Personality Disorder

3. The result pages were scanned for relevance in ascending order until the research titles ceased to be relevant.

4. Abstracts of relevant papers were read by the author to check for relevance.

5. References of relevant papers were scanned for other relevant research.

Inclusion Criteria:

- Published original research articles which presented and investigated psychotherapeutic interventions for deliberate self-harm and related emerging borderline personality disorder features in adolescents.

- Reviews on adolescent self harm and related emerging personality disorder features were also included, in order to position the present review in relation to them.

Exclusion Criteria:

- Research articles on interventions for adolescent self-harm related emerging personality disorder features which were not psychotherapeutic (e.g. token economy or medication only).

- Research studies which only investigated self-harm as a concept, but not in relation to interventions, though some may have been included in the introduction.

After accounting for inclusion and exclusion criteria, the literature search resulted in 10 quantitative original research papers; six RCTs, one on MST (Huey et al., 2004), three on DGP (Wood et al., 2001; Hazzell et al., 2009; Green et al., 2011), one on CAT (Channen, et al., 2008), and one on MBT(Rossouw & Fonagy, 2012); two open feasibility studies on CBT-SP (Brent et al., 2009; Stanley et al., 2009); two quasi-experimental studies on DBT (Rathus & Miller, 2002; Katz et al., 2004).

Relevant reviews of research on interventions for adolescent self-harm were also included, in order for the present review to be positioned in relation to them.

Appendix 2

<div align="center">

Interview Schedule

</div>

Provisional Interview Questions and Follow-Up Questions:
General Prompts / Probes: Can you tell me more about that? / What do you mean by X? / Examples?

1. Can you tell me a little about what your life was like before you came to [Service Name]?

    a. How were things at Home?

    b. How were things at School?

    c. What was your relationship with classmates and friends like?

2. If I met you before you came to [Service Name] what would you have been like?

    a. How would you describe yourself?

    b. What sort of things did you struggle with?

3. Can you tell me what happened for you to come to [Service Name]?

    a. How is it that you came here?

    b. What did you think about coming to [Service Name]?

4. How are you finding the therapy at [Service Name] (Generally)?

    a. How are you finding the individual sessions?

    b. How are you finding the group sessions?

    c. How are you finding the family sessions?

    d. How are you finding having all three of these together?

5. If you ever had therapy before, how was that compared to therapy at [Service Name]?

    a. How was it similar or different?

6. What have you been like since coming [Service Name]?

    a. What, if any, changes have you noticed in yourself?

7. What have your relationships with other people been like since coming to [Service Name]?

    a. What, if any, changes have you noticed in your relationships?

8. How, if at all, do you think therapy at [Service Name] has contributed to how you see yourself and your other people now?

    a. Is there anything about therapy has made the way you see yourself different?

    b. Is there anything about therapy that has made the way you see other people different?

9. How do you see your future after [Service Name]?

    a. How do you see yourself being in the future?

    b. How do you see your relationships being in the future?

Appendix 3

<u>**- Research Information Sheet –**</u>

Version 1.4 – Anonymised Version

<u>**Part 1**</u>

Research Title:

Experiences of Therapy at [Adolescent Unit] for Adolescents with Mood and Relationship *Difficulties.*

We are asking if you would join in a research project to find the answer to the question:

How do adolescents with mood and relationship difficulties experience therapy at [Adolescent Unit]?

Before you decide if you want to join in, it's important to understand why the research is being done and what it will involve for you. So please consider this leaflet carefully. Talk to your family, friends, doctor or nurse if you want to.

Why are we doing this research?

Some people find relationships very hard and have difficulties with their mood. For example they may feel very strong emotions or they may feel emotionally empty sometimes. Emotions and relationships can be hard to handle and may overwhelm us at times.

Recent research suggests that therapy at [Adolescent Unit] is helpful for adolescents. However, we would like to hear from adolescents themselves about how they experience therapy at [Adolescent Unit].

This research forms part of Pavlos Rossolymos Doctorate in Clinical Psychology, at Canterbury Christ Church University.

Why have I been invited to take part?

You have been invited to take part in this study because you are a patient of the [Adolescent Unit] Adolescent Service, and people in the team felt that you may benefit from therapy. Everybody who is receiving therapy at [Adolescent Unit] has been invited to take part.

Do I have to take part?

No. It is up to you. We will ask for your consent and then ask if you would sign a form. We will give you a copy of this information sheet and your signed form to keep. You are free to stop taking part <u>at any time during the research</u> without giving a reason. *If you decide to stop, this will not affect the care you receive.* You can take part in therapy at [Adolescent Unit], without taking part in the research.

What will I be asked to do?

As part of the research study, you will be asked to fill in a brief Background Information Form, and I will invite you for an interview at [Adolescent Unit]. The interview will be recorded using audio recording equipment. The purpose of the interview will be for me to find out what the therapy at [Adolescent Unit] is like for you. How you are finding it.

What are the possible benefits of taking part?

We cannot promise the study will help you, but the information we get might help treat adolescents with difficulties in dealing with feelings and relationships in the future. You will also be helping improve the service by taking part. When the study is finished, you will get written feedback with the results of the research study.

Contact Details

Please contact me, Mr Pavlos Rossolymos, on pavlos.rossolymos@nhs.net should you have any further questions. You can also leave me a phone message on:
- 01892 507673

Thank you for reading so far – if you are still interested, please go to Part 2:

Part 2

More detail – information you need to know if you want to take part.

Will anyone else know I'm doing this?

We will keep your information in confidence. This means we will only tell those who have a need or right to know. Your parents will be told you are taking part in the study, but we will NOT tell them your responses to the interview questions. Your parents will also have to sign a form (Consent Form) agreeing to you taking part if you are under 16 years old.

What will happen to the interview when it is finished?

The interview recording will be transcribed and analysed to find out how you, and the other teenagers taking part in therapy at [Adolescent Unit], have experienced it. Your data will be kept confidential and anonymous. That means that no one will know what you have answered to the questions. The only exception is if during the interview you tell me that you are at serious risk of hurting yourself or others. In that case Dr Trudie Rossouw, Consultant Psychiatrist at the [Adolescent Unit] Adolescent Service, will be notified.

[Name of Local Collaborator] or another team member will then try to talk to you about it. The interview transcripts will be kept in a secure (NHS issued, encrypted and password protected) USB in a locked cabinet.

Who is organising and funding the research?

This research is organised by Mr Pavlos Rossolymos, Trainee Clinical Psychologist and is funded by Canterbury Christ Church University. It is part of Pavlos Doctorate in Clinical Psychology at the University.

Who has reviewed the study?

Before any research goes ahead it has to be checked by a Research Ethics Committee. They make sure that the research is fair. This project has been checked by the Kent Research Ethics Committee. The study has also been reviewed by a panel of psychologists, at the Department of Applied Psychology, Canterbury Christ

Church University. Finally, the research has also been approved by the Research and Development (R&D) Department at [Name of NHS Trust].

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher, Mr Pavlos Rossolymos, who will do his best to address your concerns.

You can reach Pavlos Rossolymos by e-mailing pavlos.rossolymos@nhs.net or by calling 01892 507673 (Research Answer Phone) and he will get back to you.

Alternatively you could write to him at the following address:

Mr Pavlos Rossolymos
Trainee Clinical Psychologist
Department of Applied Psychology
Canterbury Christ Church University
Salomons Campus
Broomhill Road
Tunbridge Wells
Kent
TN3 0TG

If you remain unhappy and wish to complain formally, you can do this by following the [Name of NHS Trust] Complaints Information. Further details are attached.

Thank you for reading this – please ask any questions if you need to.

[Name of NHS Trust] Complaints

You can make a complaint, and this must be followed up. At first, if you are upset about something, try to talk to the person involved: perhaps the situation can be resolved. If not, speak to the nurse in charge of the shift or a senior nurse (Clinical Practice Leader). If you are still unsatisfied, write a complaint and send it to:

COMPLAINTS MANAGER
[Name of NHS Trust], [NHS Trust Address]

Tell us:

  - What happened.

  - When it happened.

  - Who was involved.

  - Where it happened.

Telephone: -------------------------

You can also contact the Patient Advice and Liaison Service (PALS) on ---------------(Email: PALS@-------.nhs.uk). They can help you with making a complaint.

What will happen if I complain?

On receipt of your complaint letter the Complaints Department will send you an acknowledgment letter and further information on the complaints process within three working days. We take all complaints seriously and we endeavour to work in partnership with you to resolve your concerns. We operate within a 'Being Open and Honest' policy; this means we will keep you informed about the progress of your complaint at every stage.

Appendix 4

<center>Research Consent Form
(Over 16 Young Person's Version 1.4)</center>

Participant ID #:_____Participant Age:_____ (>16) Participant

Gender:_____

<u>Project Title:</u> *Adolescents' Experiences of Therapy at [Name of Inpatient Unit]*

<u>Name of Researcher:</u> Pavlos Rossolymos   Please

Initial Box

1. I confirm that I have read and understand the Information Sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my psychological care or legal rights being affected.

3. I agree to take part in a recorded interview with you about my experience of therapy at [Name of Inpatient Unit]. I understand I can stop the interview at any time without giving reason.

4. I agree to my interview quotes being published anonymously.

5. I agree to the researcher asking [Name of Inpatient Unit] when my treatment started and how much of it I have had. I understand that you will NOT be asking *[Name of Inpatient Unit]* about the content of my sessions.

6. I agree to take part in the above study.

_____   _____   _____
Patient Name (PRINT)   Date   Signature

<center>92</center>

Appendix 5

Research Assent Form
(Under 16's Young Persons Version 1.4)

Participant ID #:_____Participant Age:_____(<16) Participant

Gender:_____

Project Title: *Adolescents' Experiences of Therapy at [Name of Inpatient Unit]*

Name of Researcher: Pavlos Rossolymos   Please

Initial Box

1. I confirm that I have read and understand the Information Sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my psychological care or legal rights being affected.

3. I agree to take part in a recorded interview with you about my experience of therapy at *[Name of Inpatient Unit]*. I understand I can stop the interview at any time without giving reason.

4. I agree to my interview quotes being published anonymously.

5. I agree to the researcher asking *[Name of Inpatient Unit]* when my treatment started and how much of it I have had. I understand that you will NOT be asking *[Name of Inpatient Unit]* about the content of my sessions.

6. I agree to take part in the above study.

As you are under the age of 16 your parents will need to sign a separate consent form.

_____   _____   _____
Participant Name (PRINT)   Date   Signature

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Appendix 6

Research Consent Form
(Under 16's Parent Version 1.4)

Participant ID #:_____ Participant Age:_____ (>16) Participant

Gender:_____

Project Title: *Adolescents' Experiences of Therapy at [Name of Inpatient Unit]*

Name of Researcher: Pavlos Rossolymos   Please

Initial Box

1. I confirm that I have read and understand the Information Sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my child's participation is voluntary and that my child is free to withdraw at any time without giving any reason, without his/her psychological care or legal rights being affected.

3. I agree to my child participating in a recorded interview about his/her experience of treatment. I understand that my child can refuse without giving a reason.

4. I agree to my child's interview quotes being published anonymously.

5. I agree to the researcher asking [Name of Inpatient Unit] when my child's treatment started and how much of it she/he has had. I understand that the researcher will NOT be asking *[Name of Inpatient Unit]* about the content of my child's sessions.

6. I agree to my child taking part in the above study.

Childs Name (PRINT):_____

Person Consenting (Circle One): Mother / Father/ Legal Guardian

_____   _____   _____
Guardian / Parent Name (PRINT)   Date   Signature

Appendix 7 (N.B. Format has been amended to fit page)

BACKGROUND INFORMATION FORM (V1.4)   ID: ....

Please answer the questions below by circling the appropriate answer or filling in your answer.

How old are you? _____ years

Are you: Male   Female

Which hand do you write with? Right   Left

What is your diagnosis?

……..……………..………   None   Don't know

How many siblings do you have?

*When did you receive your diagnosis (if known)?*_____

Approximately how long have you been at [Name of Adolescent Unit]? _____

To which ethnic group do you belong? (E.g. Black, Asian, White) _____

Do you have any diagnosed learning difficulty such as dyslexia, attention deficit hyperactivity disorder (ADHD) or dyspraxia?   Yes   No

   If yes, please give details.

What kind of school did you attend before coming to [Name of Adolescent Unit]?

   Secondary Modern   Comprehensive school   Grammar school

   High school   None   Other:......………………..…

Did you work before coming to [Name of Adolescent Unit]?   Full-time   Part-time   No

   If yes, what is your job? ……………………..………………………………..…

Where did you live before coming to [Name of Adolescent Unit]?

   With your parents   With your foster parents   Alone

   In a hostel   With friends   Other:…..………………………..

Do you take any medication? Yes   No

   If yes, please give details:...

Have you received psychological treatment / psychotherapy in the past? Yes   No

   If yes, please give details:...

Could you tell us what your parents'/legal guardians highest educational achievement was?

   Secondary School (e.g. GCSE)   Undergraduate University/Polytechnic Degree (e.g. BSc)

   Postgraduate University/Polytechnic Degree (e.g. MSc)   Other:..........................

       Don't Know

Could you tell us what your parents /legal guardians did/do as their job?

   Father: …………………..…………..………   Mother: …………..……..…………………

THANK YOU VERY MUCH FOR YOUR HELP.

Appendix 8: Interview transcript with left and right hand margins, displaying codes and emergent themes respectively.

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Appendix 9 - Example of Emergent to Superordinate Theme Development across six

cases. Superordinate Theme 1 'Feeling Uncontained, Uncontainable & Misunderstood'

P1	P2	P3	P4	P5	P6
• Complete Freak Out (Pressure Burst)	• Self as Unwell	• Self as Unwell – Past	• Self as Unwell; Feeling like a Freak	• Self as Unwell	• Self as Unwell
• Putting on a Brave Face	• Self as Uncontainable	• Overwhelming Pressure- School	• Overwhelming Pressure.	• Feeling Overwhelmed	• The Uncontainment of Others Knowing (Re: Self-Harm) – *Self/Parents/Friends/Patients/Staff*
• Fear of Inpatient Service	• Social Withdrawal	• Social Withdrawal	• Feeling Uncontained – *School, Home, CAMHS*	• Home as Unsafe	
• Social Withdrawal	• Home as Unsafe	• Home as Unsafe	• Feeling Alone & Misunderstood – Teachers, Peers, Home	• Putting on a Brave Face	• Self as a Failure – *I'm a Fuck Up – An Embarrassment*
• Self as Uncontainable	• Feeling Overwhelmed	• Negative Social Comparison – Peers	• Putting on a Brave Face – Past	• Self as Uncontainable *(Angry/Hostile/Aggressive/Danger to Self)*	• Social Withdrawal
• Emotions as Difficult	• Feeling Confused	• Feeling Disconnected	• Feeling Unsafe – Home, School	• Protecting Parents from Dark Side of Self	• Feeling Overwhelmed – *Socially*
• Pressure Burst	• Ambivalence about being Safe.		• Social Withdrawal	• Difficulties with Relationships (*Testing Others – Push & Pull – "I hate you, don't leave me"*)	• Difficulty Mentalizing Self & Others
• Self as Patient	• Social Comparisons – Peers		• Feeling Uncontainable	• Social Comparisons – Peers	• Feeling Hopeless about Future
• Talking to Strangers (Community CAMHS)	• Not Being Understood		• Feeling Overwhelmed	• Social Withdrawal	• Fear of Adult Services
• Lack of Direction	• Feeling Rejected Peers, Family & Services		• Pressure Burst	• Home as Unsafe	• Feeling Unsafe in Community
• Overwhelming Pressure	• Superficial Self			• Feeling Disconnected	• Protecting Parents from the Unwell Self
• Being Overwhelmed by Therapy	• Dark Side of Self			• Feeling Uncontained in Community - CAMHS	• GT as Uncontaining
• Feeling Different/ Trying to be Normal/Introverted Self					
• Fear of Abandonment					

The initial emergent themes of this superordinate theme, displayed in the table above, were grouped together into the following six subthemes. This was done through a process of looking for similarities across themes and grouping those together, as well as discarding some miscellaneous emergent themes, as recommended by Smith et al. (2009).

1. **Self as Unwell; Feeling like a Freak - Past & Present**
   a. **Feeling Disconnected**
   b. **Feeling Alone**
   c. **Self as Failure**

2. **Feeling Overwhelmed; School, Socially, Home, Therapy**
   a. **Feeling Confused**

3. **Self as Uncontainable – Angry/Hostile/Aggressive/Danger to Self**
   a. **Pressure Burst**

4. **Social Withdrawal**

5. **Feeling Unsafe (in the Community) – Home, School, CAMHS**

6. **Putting on a Brave Face**
   a. **Protecting Others from the Unwell Self (Dark Side)**

Appendix 10: Additional Participant Quotes by Themes

Self as Unwell

Sophie reported (p.7, l.26):

> ...so many things had happened to me that it was just this one big
> like lump in my throat...

Feeling Overwhelmed

Emily said (p.1, l.26):

> Just like, my head wasn't in a good place really. I just found that
> school was really a struggle for me. I couldn't really – it was like
> being in my own world really, I couldn't process anything to be
> honest.

Self as Uncontainable

Katie said (p.12, l.19):

> I just was so angry at them because they had nice lives, if you get
> what I mean; they were happy; they were content and I didn't like
> that because I wanted to be happy, but I couldn't be, so I was just
> like so like malicious and rude.

I'm Not Alone; Feeling Contained & Understood by other Patients

Anna described this when talking about her experience in group therapy (p.12, l.5):

> Well there are some things that you can relate to... and I guess that's
> helpful in a way. And other people can relate to you, so you don't
> feel like you're the only one (....) going through this thing.

Developing New Understandings through Therapy

Anna reflected on the impact of therapy on her understandings (p.18, l.30):

I think it's just made me think about stuff... and figure them out (....) I kind of... it's sort of made me more understanding...

Jessica talked about a change in the way she viewed things and about the positive impact this has had on her mood (p.6, l.39):

I'm learning how to look at things in a different way, where before I would have always gone to the negative, now I'm learning it might not be negative and it helps me not feel so down about things.

Putting on a Brave Face

Sam spoke about not wanting his friends to know how unwell he was feeling and pretending that everything was fine (p.6, l.13):

I think they might have seen a slightly different [Sam] because I didn't want them to feel like I was really struggling and I wanted them to think that I was happy with how I was doing and stuff like that. Although I wasn't, but I wanted them to not worry about me and don't give me sympathy and stuff like that.

Feeling Contained & Understood in Therapy

Jessica said (p.6, l.34):

My therapist understands me and I feel very comfortable to talk to him about anything, so I don't really hold back and it's helpful.

Hope for the Future & Recovery

Sophie talked about her hopes in relation to a college course she was due to start following her discharge (p.21, l.8):

I hope to see myself feel like at the end of this college course I'm going to be able to live a life and do things like an adult.

Appendix 11 – Ethical Approval Letter (Some parts have been anonymised to maintain confidentiality)

This has been removed from the electronic copy.

Appendix 12 – R & D Approval Letter (Anonymised)

This has been removed from the electronic copy.

Appendix 13 – SAGE UK Style Guide adopted by 'Clinical Child Psychology & Psychiatry'

This has been removed from the electronic copy.

Appendix 14 End of Study Letter with Research Summary sent to the NHS Research Ethics Committee and the NHS Trust Research and Development Department

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Appendix 15 - Research Diary [Abridged Version]

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