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Client and Clinician Experiences of Dialectical Behaviour Therapy

A Discourse Analysis

**A thesis presented in partial fulfilment of the requirements for
the degree of Doctor of Clinical Psychology at Massey
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Abstract

Dialectical Behaviour Therapy (DBT) is recommended as the treatment of choice for people with borderline personality disorder (BPD) in New Zealand. This research presents four studies examining the experience of DBT. Discourse analysis was used to examine 27 clinical journal articles with the aim of identifying discourses about BPD and DBT likely to be read by practising clinicians. A second study examined interview data from five practising DBT clinicians in a New Zealand District Health Board (DHB). The third study looked at interview data from five clients, who were undertaking the DBT programme at the same DHB. A fourth study used three case studies to discuss client changes in mindfulness and quality of life, as they participated in DBT. The discourses associated with BPD were of BPD as an illness, as a stigmatising label with connotations of a difficult client group, as a means of 'making sense' of the clients' experience, and as emotion dysregulation and a skills deficit. DBT was constructed as providing skills which enabled clients (and clinicians) to manage distress in their lives. Clients described themselves as changing in a fundamental way, and assuming new identities, which was a frightening (albeit positive) process. DBT was constructed as well researched and theory based, and as a coherent whole which was also divisible into functional elements. Clients and clinicians were found to utilise different discourses to position themselves and to validate their behaviour in various situations. DBT was constructed as helpful within all the studies, and was promoted as a worthwhile therapy by all participants.

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Preface

This project is an inquiry into the discourses present in client and clinician interviews and in journal articles about borderline personality disorder (BPD) and dialectical behaviour therapy (DBT), a recent development in the treatment of BPD. It aims to increase understanding of BPD and DBT from both clients' and clinicians' perspectives, in a New Zealand setting.

My interest in this area developed through working as a registered nurse in mental health for the previous seven years. In my work I felt particularly challenged, and fascinated by people who had been given the diagnosis of BPD. I was introduced to DBT by one of the psychologists I worked with, and this led to my interest in DBT and choice of this research topic. As I conducted this project, I was enrolled in the Massey University clinical psychology training programme, and was also working part time as a psychiatric nurse in an inpatient psychiatric unit, and then as an intern psychologist.

At university I was introduced to social constructionist ideas. This approach seemed to fit well with my experiences as a clinician because my clients sometimes seemed to interpret language in very different ways. This difficulty with language provided me with the opportunity to reflect on language and its often taken for granted nature as a means to communicate information. My interest in language also extends back to earlier studies including languages and linguistics, and this is likely to have influenced my understanding of language as closely bound to, and in many ways constitutive of, ideas, culture, time, and society. As I write this I believe that clinicians must at least to some degree understand language as an act and a construction of a reality. How else can therapy, which is fundamentally an exchange of words, be effective? This background influenced my choice of methodology. From a social constructionist perspective, experience occurs in language, and through the use of language. In this way language constructs, rather than merely describes experience.

I decided to study the language used by clients and clinicians in talking about BPD and DBT, and to use discourse analysis to identify constructions of BPD and DBT in their talk. In doing so I hoped to gain information about the way in which language constructs experiences of DBT. In addition to this I also conducted a discourse analysis of clinical

literature, likely to have been read by the clinicians I was interviewing. This was to ascertain which discourses were dominant in clinical literature, and whether or not practising clinicians also utilised these. This research also contains a small client outcome measures study (presented as three case studies), utilising measures of mindfulness and quality of life. In conducting four studies in this way, I hoped to gain an understanding of the experience of DBT from several different angles, each of which contributes to a wider understanding of DBT. As with all research - as the design, goals and implementation of the studies were mine - my background and interests influenced every aspect of the study. This includes apparently objective sections, such as the literature review chapters. This influence is discussed in greater detail in Chapter Five, however is introduced here so that the entire thesis can be read with this in mind.

The introductory chapter provides a brief introduction to BPD and DBT. Chapter Two looks at the wider issues of ontology and epistemology when conducting research and will provide an overview of discourse analysis, and my choice of research methodology. Chapter Three will provide an overview of literature around the topic of BPD. The discourses of BPD are intimately related to the development and experience of DBT, because DBT was developed for this client group. Constructions of BPD were therefore an important focus for analysis in addition to a focus on DBT. Chapter Four introduces DBT and provides an overview of the therapy, and literature to date. These introductory chapters set the scene for enquiry into the discourses associated with BPD and DBT. Chapters Five and Six will describe Study One, which examines DBT literature, and will provide context for the following studies. Chapters Seven and Eight will present Study Two, which examines clinicians' talk about BPD and their experiences with DBT. These chapters focus on the language the participants use to talk about their clients, and their experiences of delivering the therapy and constructions of how the therapy has worked for their clients, and for themselves. Chapters Nine and Ten present Study Three, which focuses on clients' talk about BPD and their experiences of DBT. This is followed in Chapter Eleven by Study Four, which is an outcome measures study looking at mindfulness and quality of life, presented as three case studies. The final chapter will provide a discussion of the studies, and associated conclusions and recommendations for further research.

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Chapter 1: Introduction

This thesis aims to examine how clients with Borderline Personality Disorder (BPD) and clinicians in a New Zealand Dialectical Behaviour Therapy programme (DBT, Linehan, 1993) constructed the BPD diagnosis and their experiences with DBT in their talk, and to identify some of the linguistic resources available to them in doing so. Later in the thesis I will also present three case studies, which attempt to bring empirical and social constructionist understandings in discussion with one another. This introductory chapter briefly outlines BPD and DBT so that the following chapters can be read with this understanding. From a social constructionist viewpoint, the construction of diagnoses, act of giving or receiving a diagnosis, location of therapy (in this case DBT) within the mental health system, and the empiricist framework underpinning these processes are important unspoken features of the mental health system which impact on the way in which both the diagnosis and the therapy can be understood (a discussion of underlying epistemological assumptions will be presented in Chapter Two). This section should be read with that understanding in mind.

Borderline Personality Disorder

Psychiatric diagnoses are used within the mental health system to provide labels for different sets of 'symptoms'. In New Zealand, psychiatric disorders are classified using a manual called the Diagnostic and Statistical Manual of Mental Disorders (DSM), which outlines exactly which sets of experiences or symptoms qualify for diagnosis. Borderline Personality Disorder (BPD) is defined in the most recent version of the DSM - 4th ed. Text Revised (DSM-IV-TR), as a "pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following...". The definition then lists nine criteria, which include efforts to avoid abandonment, intense or unstable interpersonal relationships, identity disturbance, impulsivity, recurrent suicidal gestures or self mutilation, affective instability, chronic feelings of emptiness, inappropriate anger, and transient paranoid ideation or dissociative symptoms (American Psychiatric Association, 2000). Personality disorders

(of which BPD is one) are defined as enduring patterns of behaviour, which impact on the person's functioning in a significant way.

BPD is diagnosed in 1-2% of New Zealand adults, and in 15-20% of users of mental health services (Mental Health Foundation of New Zealand, 2005). Approximately 75% of people diagnosed with BPD are women (Krawitz & Watson, 1999). Suicidal behaviour is closely associated with the BPD diagnosis, and suicide attempts occur in up to 75% of people (Blum et al., 2008), with a completed suicide rate of 10% among those presenting for treatment (Krawitz & Watson, 1999; Glaser, van Os, Mengelers & Myin-Germeys, 2008). BPD is described as a chronic condition, however the rates of impulsive behaviours and deliberate self harm may diminish as the person ages (Blum et al., 2008). People meeting the criteria for BPD in New Zealand use mental health services at a higher rate than any other diagnostic group except schizophrenia, which has a similar rate (Krawitz & Watson, 1999).

People with a diagnosis of BPD often exhibit behaviours which are difficult for clinicians to manage, such as suicidal ideation, self harm and repeated crises (Smith & Peck, 2004). This and other meanings associated with the BPD diagnosis will be discussed in Chapter Three. This sense of difficulty working with people with this diagnosis, combined with the high prevalence rates in the psychiatric population, suggest that effective interventions which may reduce the difficulty working with these clients would be helpful to those working in the mental health system.

In the past, mental health services in New Zealand have been poorly equipped to work with people with BPD (Krawitz & Watson, 1999), and the introduction of a new therapy (DBT) has been welcomed. DBT has become the current treatment of choice for BPD in New Zealand, as recommended by the Royal Australian and New Zealand College of Psychiatrists (Boyce, Carter, Penrose-Wall, Wilhelm, & Goldney, 2003). It has a growing research base, which will be discussed in Chapter Four. The next section provides an outline of DBT.

Dialectical Behaviour Therapy

DBT is an adaptation of cognitive behaviour therapy (CBT) specifically designed to treat BPD (Paris, 2005). It was developed by Marsha Linehan as a treatment for chronically

suicidal women with a diagnosis of BPD, and is based on Linehan's biosocial theory of BPD (Linehan, 1993) (Linehan's understanding of BPD will be described in Chapter Three). It is a synthesis of Western (CBT) and Eastern (Zen) psychological practices. Koons (2008) describes DBT as consisting of behaviourism as a "technology of change"; Zen as a "technology of acceptance" and dialectics as a "worldview and a striving for balance between acceptance and change" (p. 112).

Central to DBT is the concept of dialectics, which according to Linehan (1993) has three core ideas about reality. Firstly, reality is based on systems. This means the self is defined in terms of relationships within a system. Secondly, reality is made up of internal, opposite forces ("thesis and antithesis"), which can integrate ("synthesis") to form a temporary stability and then a new set of opposing forces. Finally the continuous tension between thesis and antithesis means that reality is in a constant state of change. The transition to each new synthesis is often experienced as a crisis. Linehan describes this process in therapy as like being on a "teeter-totter" with the client on one end and therapist on the other. The goal is to move toward the middle together (synthesis) so that climbing to the next level (or new "teeter-totter") is possible, while moving back and forth to maintain balance. Movement of either the client or therapist necessitates movement of the other to maintain balance. DBT proposes that a balance between change and acceptance is necessary to facilitate growth. DBT therapists work to validate the client's reality and behaviours as understandable and valuable. At the same time, the therapist works with the assumption that these same behaviours must change. The therapist continuously balances acceptance and change, adapting the level of acceptance vs. change to meet the client's needs at a given time. The client is encouraged to move back and forth on a dialectic (polarity) of acceptance and change (Marra, 2005).

DBT assumes that the core dysfunction in BPD is difficulty regulating affect. DBT combines CBT with Zen meditation practices (McMain, Korman, & Dimeff, 2001). It differs from CBT in that the focus is on self management of affect rather than cognitions. Clients attend individual therapy sessions with a therapist, attend a DBT group, focusing on skill development (core mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness), and can contact their therapist for telephone 'skills

coaching' in times of crisis (Linehan, 1993). DBT has a growing evidence base supporting efficacy and effectiveness for BPD (this will be outlined in Chapter Four).

A typical DBT programme consists approximately one year of weekly individual therapy sessions, a weekly skills training group, and a weekly consultation group for DBT therapists. Individual therapy targets behaviours for change with a focus on skills and generalising these skills across different situations in the client's life. The skills training group (for clients) focuses on skills needed 'to build a life worth living' and contains four modules, covering core mindfulness skills, distress tolerance skills, emotion regulation skills and interpersonal effectiveness skills. Telephone consultation is available with the client's individual DBT therapist for skills coaching, and the client is encouraged to first attempt to use their DBT skills on their own, and then to call for assistance on using the skills prior to engaging in unwanted behaviour (for example self harm). The weekly DBT consultation group (for therapists) is designed for therapists to 'do DBT on themselves', providing support and feedback within a DBT framework (Linehan, 1993).

While BPD and DBT are the target subjects of this research, it should be noted that the research involved a focus on the language used by and available to participants, rather than an attempt to uncover underlying thoughts and beliefs. This reflects an understanding of language as constitutive of thoughts and beliefs (rather than representing underlying thoughts or beliefs). The next chapter presents a discussion of ontology and epistemology in research, because the underlying assumptions about reality fundamentally impact on understandings of how research (or clinical practice) should be carried out, and how research findings should be interpreted.

Chapter 2: Ontology and epistemology in research

This chapter is about the underlying assumptions of research itself. I will outline the broad overarching understandings of objectivism versus constructionism. I will then provide an introduction to discourse analysis and identify why this is an appropriate methodology for this project. This discussion is a necessary introduction to the following sections, including literature review in the areas of BPD and DBT, and ultimately to later chapters outlining my investigation of discourses present in clinical literature, clinician and client interviews.

There is always choice in research about what questions to ask and how to go about answering (Pratto, 2002). In order to investigate or research anything, a researcher begins with a set of assumptions about the nature of reality or object of study. Questioning these underlying assumptions is necessary because research is fundamentally based on how reality is understood. Current psychological thought is based on sets of assumptions at the fundamental or 'metatheory' level (Botella, 1998). These overarching understandings of reality are known as objectivism and constructionism. The core assumption of objectivism is that reality exists independently of the observer, and can be measured accurately if the right methods are used. Constructionists on the other hand understand knowledge as a product of constructions and experienced reality, which can not be conceived as independent from the observer who is situated historically and culturally (Botella, 1998).

An examination of changing ideas promotes the importance of grounding research in a theoretical context. Throughout history, truth has been defined in different ways. In mediaeval times truth was defined by the church (word of God). Gradually, in what is known as the Enlightenment, this was replaced by human intellect as a source of knowledge (Durrheim, 1997). Enlightenment values were those of empiricism and rationalism (Tuffin, 2005). Empiricism is an epistemology which asserts that knowledge is derived from experience (Durrheim, 1997). It assumes that accurate knowledge of the world is attainable. This epistemology is the basis for most psychological research and 20th century science in general. Rationalism holds that truth can be obtained through reasoning rather than experience. Both empiricism and rationalism are examples of objectivist ways of understanding.

Because empiricist researchers believe that knowledge is gained through observations of an existing reality, researchers working from this understanding attempt to gather facts (observations) and then utilise these to create theory, thus theory is driven by observations (Gergen, 2002). Good research corresponds with 'reality' as much as possible, and with as little bias as possible. The researcher's task is to observe these links without bias, and to identify a "value-neutral theory" or hypothesis, that reflects reality, and can be used to predict outcomes in the future (Gergen, 2002, p. 188).

The most highly regarded clinical trials using a randomised controlled design (RCTs) are based on empiricist understanding. As well as RCTs, there are many other empiricist designs used in psychotherapy research. These include experimental (Mitchell & Jolley, 2001) and non-experimental designs (Kerlinger & Lee, 2000). Qualitative designs can also be empiricist in nature, for example the earlier form of Glaser and Strauss's Grounded Theory (Chamberlain, 1999). It is important to acknowledge the empirical foundations of most clinical research, in order that these assumptions are recognised and not taken as the only possible understanding.

There are limitations to empirical research in psychology, and there is a well recognised gap between psychotherapy research and the way psychotherapy is practised in the real world (Goldfried & Wolfe, 1998). Many psychological constructs do not translate easily into observable measures (Durrheim, 1997). This tension is reflected in the gap between the RCT as "gold standard" and the recognition of the importance of individual clinical description in clinical work (Bateman & Margison, 2003). Despite these difficulties there is recognition that research and practice are mutually dependent on one another (Stricker, 1992). Goldfried and Wolfe (1998) identify several areas which compromise the value of clinical research in the real world. These include medicalisation of the research, random assignment of clients rather than choosing treatments targeted for the client, a fixed number of therapy sessions, rigid psychotherapy manuals and use of theoretically pure treatments. These considerations improve the reliability of research however do not often meet the needs of individual therapists looking for the best treatment for a particular client. As Gergen (2006) writes, therapists of many different persuasions are aware of client narratives, acts of defining

problems and how to solve these, metaphor and differing realities; in other words therapists are aware of constructionist ideas.

Postmodern ideas, of which social constructionism is one branch, originated last century with the ideas of Nietzsche, that all knowledge is perspective (Blatner, 1997). Postmodern ideas came to prominence in the 1960s with disillusionment about the modernist idea that the role of science is to produce universal truths. This was related to political and social events occurring at the time, for example the challenge to authority because of the Vietnam war (Blatner, 1997), and the increasing recognition of different ways of thinking that occurred because of technological advances connecting people in a global network (Snyman & Fasser, 2004). Essentially postmodernism promotes the idea of the existence of multiple subjective truths, each with its own validity (Cosgrove, 2003). Recognition of the importance of social aspects of knowledge created an environment for social constructionist ideas to develop. There can be no one true answer because the underlying assumptions that guide knowledge differ for each community, and for different periods in history. In contrast to empiricism (in which observations drive theory), theory provides a lens through which researchers create understandings (Gergen, 2002).

A key tenet of social constructionism is that language is active and is a form of social action (Burr, 1995). Assumptions about the world are acquired as a person develops language, and participating in the use of language also creates shared assumptions in a community. Language is therefore both constructed and constructive (Burr, 1995). Edley (2001) writes that language can be 'onto-formative' (p.439). This means that phenomena are created through language that would otherwise have no existence. These phenomena are just as 'real' as concrete objects, such as trees. Unlike empiricists who pursue a unitary truth, social constructionists both expect and value variation in accounts and plurality of meaning. Durrheim (1997) states that empiricism makes the error of fixing the meaning of words, and assuming that words will be used and understood the same way each time.

Social constructionism does not only question how unbiased our observations of the world are, it also questions the existence of a fixed truth (White, 2004). The nature of research becomes a process of interpretation and generation rather than one of

description (Durrheim, 1997). This is in contrast to empiricism, where the focus is on the nature of people and society rather than process, and the researcher is removed from the object of research. As Durrheim (1997) states, “the aim of investigation cannot be truth” (p.181). Liebrucks (2001) identifies that the discipline of psychology studies phenomena which are inherently dependent on social context. He makes a case for ontological difference between ideas (such as intentional states) studied in psychology, and concepts (such as electrical discharge) studied in physical science.

Within social constructionism there are people who take a realist stance (that an external world exists), and those who take a relativist stance (that accounts cannot be judged to be more accurate than others, because there is no fixed ‘reality’ to gauge accuracy). Although social constructionism argues for a relativist viewpoint, few social constructionists deny reality altogether (Burr, 1995). Harré (2002) reports that social constructionism is not radically relativist. There is room for disagreement among social constructionists as to the degree to which knowledge can be regarded as factual. White (2004) describes a continuum of ‘facticity’, with social constructionists agreeing that some ideas can be described as more factual than others.

The split between objectivism and constructionism might seem impossible to bridge. Crotty (1998, p. 15) states that any attempt to be both objectivist and constructionist is “problematic”. Despite this difficulty several authors have attempted to do just that. Jost and Kruglanski (2002) discuss the idea of truth and report that although social constructionists believe that numerous alternatives are possible, they accept that people choose those alternatives that are (at least subjectively) the most valid; and points out that most experimental social psychologists although believing in the existence of truth agree that they are fallible and can only guess. Pratto (2002) reports that some of the rift between experimental and social constructionist psychology is political and aesthetic rather than epistemological in nature. Gergen (2002) states that neither a foundational position of pure objectivism nor pure constructionism can be justified. He suggests that instead of attempting to identify which is more legitimate; researchers should focus on looking at the relative benefits of each position. Gergen suggests social psychologists from both sides move towards a pragmatic version of truth, one in which the goal is to produce the knowledge which is “best” for a particular group of people.

Fishman (1999) describes his idea of pragmatic psychology as taking a centrist position in psychology's "culture wars" between objectivist and constructionist ideas. Fishman advocates for "neopragmatism", which identifies that the goal of psychology is to achieve goals for a particular social group rather than to uncover general laws of human nature. Truth is related to the usefulness of a particular outcome. Although it is not possible to uncover universal laws (as in empiricism), a goal of research is to identify useful understandings that can solve practical problems for individuals or groups (Birgden & Ward, 2003).

Fishman (1999, 2005) highlights the value of the individual case study, complete with the full context and nuances of the particular case. The case is where practising clinicians begin when examining how best to work with a client. As well as emphasising the value of individual case studies, Fishman advocates for a database of pragmatic case studies producing a more generalisable body of knowledge relevant to clinical practice. In this way a database of example cases is formed, which can be accessed by clinicians and researchers. This is similar to the process used in the justice system, where actual legal cases guide the assessment of current cases (Fishman, 2003). It recognises that clinicians are primarily concerned with the details of an individual case, while academics are generally more interested in general trends, and attempts to recognise the relevance of both positions (Alison, West, & Goodwill, 2004).

My approach to research

In the previous section I have attempted to illustrate that understandings of what constitutes reality have not been fixed over the course of history, or understood in the same way by all people at any particular point in time. I have come to think that examining current ideas complete with their history, context and variation, is the most relevant enquiry. It is clear to me that people use language to construct these understandings as they interact with other human beings, be it their friends and family, therapist, client or with a researcher conducting a research interview. In conducting this research I am therefore mainly utilising a social constructionist approach. I am however also presenting a small study, which also uses an empiricist methodology, and will explain why shortly.

Although I am using a social constructionist approach, I am not attempting to reject (or confirm) the existence or otherwise of underlying assumptions and beliefs. I am working with the assumption that understandings are created in a social situation using language however this does not automatically reject the presence of underlying beliefs and assumptions, or biological pathology in the case of the diagnosis of BPD.

Taking the context of research into account I have chosen to use two different methodologies. Discourse analysis (which has social constructionist underpinnings) will be used for three studies, a literature analysis, a clinicians' study, and a clients' study. In a fourth study, three case studies will also be presented, which utilise a pragmatic approach in line with Fishman (1999, 2005). I would like to attempt to reconcile the two approaches by highlighting that they examine different kinds of information. The empiricist elements of the case study design attempts to measure changes in levels of a construct (such as depression) using measurable outcomes (scores on a psychometric measure). The social constructionist discourse analysis highlights difference and contradiction, and is useful for looking at how participants construct their meanings in conversation and language, and identifying linguistic resources, or discourses, evident in language, whether or not these meanings are intended. The use of two methodologies is consistent with the ideas of pragmatic psychology, that psychotherapy research should begin with the case study in all its background and context, and should be judged at least in part by the value or usefulness of the explanations constructed (or discovered) in the research.

Introduction to Discourse Analysis

The studies presented in this research utilise discourse analysis methodology to examine text (published journal articles and interview transcripts). Discourse analysis is not a discrete method, but rather a philosophical approach to language (Reeves, Bowl, Wheeler, & Guthrie, 2004). It is based on social constructionist ontology, and has an understanding that the function of language is to construct versions of the world. From this perspective individual psychological states are created within interactions in context of the particulars of that interaction. From a broader perspective, languages and the resources within them are created in communities, and are historically and culturally bound (Potter & Wetherell, 2001).

Discourse analysis is concerned with talk and texts as social (rather than linguistic) practices. From a discourse analysis perspective, the social world is seen as a 'text', which can be analysed by the researcher (Banister, Burman, Parker, Taylor, & Tindall, 1994). The term 'discourse' is defined by Potter and Wetherell (1987) as 'all forms of spoken interaction, formal and informal, and written texts of all kinds' (p.7). This definition identifies potential sources of data for analysis. Talk and text are examined for their own sake, not as a means to uncover knowledge about things beyond the text (Potter & Wetherell, 1987). It is not necessary to decide whether there is anything 'beyond' the text. This focus on the text itself rather than possible underlying thoughts or structures is what differentiates discourse analysis from qualitative methods aimed at uncovering thoughts or values possibly held by individual participants or groups.

There are two broad versions of discourse analysis which have been influential in social psychology. The two versions complement each other and can be described as 'macro' and 'micro' (Tuffin, 2005). The 'macro' version examines resources which are used to perform action in discourse (Potter & Wetherell, 1994). The 'micro' version of discourse analysis focuses on detailed use of language to construct versions of reality, and examines the detail of everyday examples of talk and text (Potter & Wetherell, 1987). These distinctions are somewhat artificial, and there is considerable overlap between the two.

This research utilises approaches to discourse analysis outlined by Potter and Wetherell (1987) and Ian Parker (2005), and also aspects of work by Michael Billig, Derek Edwards and Ken Gergen. Potter and Wetherell utilise the term 'interpretative repertoire' to refer to systems of terms used to organise patterns in data (talk and text) examining the differences and similarities between accounts, and the function and consequence of these patterns. An example of an interpretative repertoire is an 'empiricist repertoire' identified by Gilbert and Mulkay (1984) as present in many scientific papers. Potter and Wetherell pay attention to the detail of texts as well as identifying interpretative repertoires. Analysis is concerned with the performative aspects of language, including the construction of different viewpoints (Potter & Wetherell, 1994).

Parker (2005) identifies four key ideas in discourse analysis. The first of these is that language has many voices, and research invites examination of this variability rather

than searching for underlying processes. Potter and Wetherell (1994) also note variability in language as a focus of study. From this perspective, an examination of how a word or phrase is different to another in use is the focus of study. Secondly, Parker writes that discourse analysis focuses on 'semiotics', or the way in which ideas are both actively constructed through use of language, and at the same time are constrained by meanings already inherent in available words and phrases. This reflects the idea that language is both constructive and constructed. The third idea, called 'resistance' examines the work done by language, which may or may not be intended by the participants. Maintenance of and challenge to dominant ideologies occurs through language (Parker, 2005). Discourse analysis is concerned with the way in which language is used to promote certain viewpoints (Potter & Wetherell, 1994). It studies how language performs various functions in social and historical context (Potter, 2003).

Finally, Parker (2005) links the ideas of variability, semiotics and resistance and writes that discourse analysis can study 'discourse' as a form of social bond created through the organisation of language. Parker (1990) defines a 'discourse' as a concept created through a system of related statements. 'Discourses' are 'coherent systems of meaning' which are in competition with one another (Tuffin, 2005, p. 82). These definitions present the idea of entities, created through (and constitutive of) language, which can be identified and examined for the role they play in social lives. Each 'discourse' or social bond categorises which kinds of people belong or are excluded. This leads to an examination of how discourses function to maintain or challenge accepted versions of the world. Identification of the discourses and their presentation within language enables the analyst to look at their function. Power is a central idea, and social relations are also power relations. Discourse analysis can have a political aspect to it, because recognition of oppressive discourses can enable resistance to develop, encouraging change (Hammersley, 2003).

In presenting this research, I have chosen to use Parker's term 'discourse' rather than Potter and Wetherell's term 'interpretative repertoire', because Parker's description of 'discourses' as entities, which can include or exclude different groups of people, provides a narrower focus than the broader concept of 'interpretative repertoire' (which refers to systems of terms), and provides perhaps a more useful concept to aid in examination of language categorising those within a mental health system. Therefore I

am defining discourse as a concept created through a system of related statements. This means that language and concepts (discourses) created in language are the focus of study rather than possible underlying thoughts or beliefs held by participants (as would be the case for a thematic analysis).

Within discourse analysis there are a variety of approaches that have been utilised by researchers, who are interested in aspects of discourse and communication. The approaches which I have found useful for this research include rhetorical analysis, examination of emotion language, and construction of self.

The study of attitudes, or opinions, from a discourse analysis perspective, involves examination of discourse, which criticises or justifies an opinion or construction of what is going on (Billig, 2001) . This type of discourse analysis is called 'rhetorical analysis'. It examines how people adapt what they say to fit the moment and situation in which the interaction occurs. Billig writes that the analysis of argument can reveal what is taken as common sense, and can reveal common values, which are regarded as acceptable or understood by all participants. This is because speakers will often appeal to these common values which are understood by all. It can also reveal how such understandings are challenged, and potentially altered over time. In this way analysis goes beyond what is said by individual speakers, and identifies ideological understandings of the time/setting.

Understandings of concepts are not limited to shared cultural values or beliefs. Emotions can also be regarded as constructed, and historically and culturally located (Edwards, 2001). Edwards (2001) writes that emotion resources (discourses) are used to perform rhetorical tasks, such as constructions of events, and the accountability of participants in these events. Edwards writes that emotions are often constructed as different from thoughts, and conceived of as deeper than language. Emotion talk is part of how people construct their experiences. Emotion categories can be used to assign blame, reasons for behaviour, excuses, and accounts of events. Emotion categories are often associated with metaphors, which Edwards describes as 'conceptual resources', providing shared descriptions understood by participants in the conversation.

The construction of self from a discourse analysis perspective is also a process of interaction and dialogue with other people (Gergen, 2001). Gergen writes that constructions of self are created as narratives which link past and present events, and suggest pathways for the future. Success in establishing an identity is dependent on dialogue, and utilising culturally available discourses to construct an acceptable narrative. Narrative validity is dependent on the affirmation of others. In this way presenting a certain narrative works to negate others, and impacts on constructions of reciprocal identities. Davies and Harré (2001) write that the individual emerges through a process of social interaction and is constituted and reconstituted through the process of interaction. In this way the construction of self does not produce a stable end product, but rather the self emerges as a function of a fluid and changing process. Participants in social exchange position themselves as coherent identities within the context of the exchange, creating jointly produced storylines, which are in turn shaped by the discourses available within the context of the interaction. There can be more than one life-story, or construction of life events for each individual as a process of constructing and re-constructing narratives occurs in social interactions.

Discourse analysis recognises that the researcher is necessarily included in this process as a participant rather than a spectator (Hammersley, 2003). Objectivity is neither a goal nor a possibility. The researcher has an ethical obligation to recognise her own position as a constructor of ways of knowing. The construction of a research report is in itself an example of discourse, and could itself be subject to analysis (Potter & Wetherell, 1987). As the researcher of the current study, it is impossible to identify every aspect of my own construction of discourses within the data. It must suffice to make the constructed nature of this document overt. In doing this I do not hope to overcome this subjectivity, but to acknowledge and recognise it as context that will add information to the interpretation of participants' voices. The process of interpretation of the stories of a number of people is described by Burgess-Limerick and Burgess-Limerick (1998, p. 64) as "bringing individuals in conversation with one another through the researcher" to construct useful versions of realities. Although this process is based in participants' stories, it is finally the researcher who brings these voices together and constructs versions of what is occurring, and the researcher influences both what is said and how the talk is interpreted.

The usefulness of discourse analysis for psychotherapy research in general and for this project in particular becomes clear when the nature of psychotherapy itself is considered. Gergen (2006) writes that psychotherapy can be thought of as a process of meaning creation, in discourse between therapist and client(s). Identification of these constructions of meaning and how this occurs provides information about the process of therapy. Discourse analysis provides a useful framework for examining participants' talk in such a way that these constructions are identified. It is my belief that all therapy process involves some kind of meaning generation through language, and discourse analysis is therefore an important methodology for the study of therapy processes. An understanding of reality as socially constructed appears to fit well with psychotherapy and DBT in particular. DBT takes a contextual view of the person, and as a treatment fits well with social constructionist understandings. Linehan states that "Identity itself is relational, and the boundaries between parts are temporary and exist only in relation to the whole; indeed, it is the whole that determines the boundaries" (Linehan, 1993, p. 31). Linehan's approach also adopts the social constructionist viewpoint that there is no fixed or absolute truth. Truth is never absolute, it "evolves, develops, and is constructed over time" (Linehan, 1993, p. 35). Therefore qualitative research from a social constructionist perspective is warranted.

Qualitative research is appropriate for in depth understanding of experience, rather than the statistically based outcome measures provided by much quantitative research (Parnis, Du Mont & Gombay, 2005). Discourse analysis in particular is good for examining the relationship between cultural practices and individual lives (Gilgun, 2005). Participating in therapy, or being a client or clinician within a mental health system can be thought of as cultural as well as clinical practice, when current ways of knowing (and practising) are recognised as transient, and historically and culturally located.

The next chapter examines the BPD concept and development of the diagnosis. This aims to identify meanings associated with BPD and their historical origins.

Chapter 3: Borderline Personality Disorder

In this chapter I will examine current literature around the diagnosis of BPD. I will briefly describe some of the history and ideas behind the development of psychiatry leading to the defining of BPD (including an outline of the current diagnostic criteria), before examining some of the theories of etiology of BPD and the conceptualisation of BPD presented by Linehan (1993), founder of DBT. I will then look at some of the different meanings that have been ascribed to the label BPD, from clinician, client and family perspectives; and feminist critique. The purpose of this chapter is to provide context and background for the following chapter presenting DBT literature, and for the studies that follow, which look at constructions of BPD and DBT. It should be noted that the focus of this research is BPD in context of the introduction of DBT to a mental health service. As such, in this literature review the development of the BPD concept within the field of psychiatry, and the conceptualisation of BPD utilised by DBT theory is privileged over other potential alternative meanings, for example those provided by alternate forms of therapy.

In order to approach the meanings associated with the label BPD, it is useful to briefly examine how mental illness has been written about in the past, and how the concept has developed. The same tension evident in psychotherapy research is also evident in understandings of psychopathology, and how this should be conceptualised and treated or managed. The objectivist understanding is related to an understanding of mental disorder as having an organic cause, which produces symptoms which can be measured, and diagnosis can be given. Treatment is aimed at the cause or etiology of the illness. An alternative, constructionist view of mental disorder is that the creation of disorder occurs through social and personal construction of psychological processes. An examination of the history of the development of psychiatry locates diagnoses as transient entities, liable to change with socially constructed understandings.

History of psychiatry

The discipline of psychiatry, with its intent of treating those experiencing mental illness began in the 18th century with the recognition that confining people to asylums could have a therapeutic and a custodial role (Shorter, 1997). The asylums provided a set of subjects for psychiatry, imposing a sense of unity through the process of incarceration

(Rose, 1996). In 1786 Phillip Rush described those exhibiting 'deviant' behaviours as the subjects of medicine, locating the cause of disturbance in the physical brain (Shorter, 1997). Szasz (1970) identifies this as part of the wider change from medieval 'word of God' to Enlightenment versions of truth.

Early psychiatrists focussed on biology as the likely cause of mental disturbance. Between 1800 and 1900 the focus of psychiatry remained biological. One of the reasons for this was the high rates of neurosyphilis, which was one of the most common psychiatric complaints of the time and with a clear biological cause (Shorter, 1997). In the late 1800s, expansion of psychiatry's scope beyond the asylums was related to a concept of 'degeneracy', in which various ailments were labelled as symptoms of underlying pathology, which would inevitably worsen and be passed on through family lines if not treated (Rose, 1996). The range of ailments increased to include those suffering from 'nerves'. An organic base was supposed for these ailments, although no observable physical changes were noted. The diagnosis of hysteria marked the line where it was not possible to tell "real" or organic disorder from "fake" (non organic disorder) (Orr, 2000).

In the 1890's Freud began his development of psychoanalysis, which originated in attempts to help patients with 'hysterical' symptoms. Freud linked development of symptoms to past events in his patients' lives, identifying symptoms as exaggerations of processes common to everyone. A second key idea of psychoanalysis was that behaviour was controlled by unconscious processes, governed by instinctual drives. Finally, Freud believed that all behaviour is goal directed, and that symptoms fulfilled a purpose. Symptoms revealed specific histories relevant to each person, which could be uncovered by analysis (Brown, 1964). In this way illness could be seen as originating in an interaction of biological drives with a person's early childhood experiences. Psychoanalysis provided tools for the 'mental hygiene' movement of the 1920's and 30's to further expand the scope of psychiatry to include preventative interventions, targeting social inefficiencies or family dynamics (Rose, 1996).

The anti-psychiatry movement in the 1950s and 1960s challenged the notion of mental illness as a biological phenomenon. Szasz (1970) likened mental illness to the earlier concept of witchcraft and writes that mental illness serves a social function in the

modern day that was earlier performed by the notion of witchcraft. Thus for Szasz psychiatry was a system based more on social power than on medicine or scientific theory. Laing, another psychiatrist, suggested that social norms could be experienced as an external entity, creating pressure to behave in certain ways. He noted that language available to him as a psychiatrist placed expectations on the type of interaction that could occur with his patients (Laing, 1965, 1967).

Foucault (1961) wrote of the relational nature of knowledge, and identified that the creation of the difference between reason and non-reason each required the existence of the other concept to exist. This recognises that the creation of a concept also creates boundaries around that which is not included in the concept. The clinical diagnosis performs a function of categorising the person – separating sane from insane, and is a condition of entry into mental health services (Rose, 1996).

The Diagnostic System of the American Psychiatric Association (DSM) was first published in 1952, and represented an attempt to comprehensively categorise mental disorders. There was also a parallel classification system published by the World Health Organisation (WHO) known as the International Classification of Diseases (ICD), first published in 1948. Several versions of the DSM have now been published, in an attempt to encourage consensus, and uniformity in diagnostic practices (Davison & Neale, 1994). It now provides the dominant classification of mental disorders in the United States and many other countries including New Zealand. BPD appeared as a diagnosis for the first time in the DSM-III, in 1980, and has appeared in all editions since this time. The most current version, the DSM-IV-TR was published in 2004 (American Psychiatric Association, 2004).

Etiology of BPD

The DSM-IV-TR classifies diagnoses according to observed symptoms rather than describing an etiology or formulation. As such the DSM-IV-TR diagnosis does not indicate any specific pathology or cause for the observed symptoms, or suggest a particular intervention or treatment. Livesley (2004) writes that the treatment possibilities for BPD are changing as ideas about what BPD is and what causes it also change. Etiology of BPD is complex and multifaceted, and the diagnosis has been explained from differing viewpoints. Initially it was explained in intrapsychic terms, with primary attention

given to family relationships, especially the relationship between the patient and his/her mother. More recently biological precursors for BPD have received more prominence (Freeman, Stone, Martin, & Reinecke, 2005). Social and cultural factors have also been recognised. In the following paragraphs I will outline the key areas of thought behind the causes of BPD. This then leads to a discussion of the different meanings that have been ascribed to the diagnosis. Although the schools of thought are presented in the order in which they were developed, they do not necessarily represent a progression in understanding, and each continues to inform clinical practice today.

The term 'borderline' has its origins in psychodynamic theory (Bradley & Westen, 2005). It originated from an effort by Stern in 1938 to consider patients who could be described as 'neurotic' but who also experienced brief psychotic episodes (Freeman et al., 2005). Psychodynamic theory of BPD focuses on object relations theory (Sadock & Sadock, 2003). From this perspective, cognitive development occurs both in periods of low and high emotional intensity. The development of a child's mind is thought to be closely linked with his or her experiences with caregivers. When the infant experiences high emotional intensity (such as hunger or pain), the response from a caregiver can either respond to the need or not. The young child internalises these two responses separately, including a loved and satisfied self and caring other; and also a suffering and neglected self and corresponding persecutory other. These are known as object relations dyads (Yeomans & Delaney, 2008). In normal human development these perspectives do not remain rigidly divided and are gradually internalised and integrated, so that the child develops a sense of security in the absence of the caregiver (Sadock & Sadock, 2003). A psychodynamic perspective of BPD views a person as unable to integrate these representations of the self and others, as a result of inadequate nurturing responses from caregivers in infancy. This results in a fixation of the split internal world and extreme and polarised views of the self and others (Yeomans, 2004). The person with BPD regards himself and others as either all good or all bad, and can switch from one polarity to the other in response to even minor triggers. Interactions with other people become problematic as a result of rigid, dichotomised thinking. In the mental health setting people with BPD are thought to transfer their internal difficulties onto staff. Clients may idealise some staff, and regard others as all bad, sometimes changing to the opposite in a short period of time. This is called "splitting" and creates a challenging situation for staff who work with these clients (Friedman, 2008).

Attachment theory has its base in psychodynamic theory and emphasises the role of a child's attachment to parental figures on the development of personality characteristics in later life (Holmes, 2003). The type of attachment thought to lead to the development of problems seen in BPD is called disorganised attachment. This is thought to occur when the parental figure is both the source of threat and the source of comfort, and the child is unable to develop a consistent behavioural strategy to manage the threat. The child is caught between wanting to approach and avoid the parental figure, and has no secure base or way to manage threat, either from the environment, or from his or her own emotions. Attachment problems in childhood are thought to lead to hypervigilance to rejection or criticism and a tendency to see others as all good or all bad (Tragesser, Lippman, Trull, & Barrett, 2008), difficulties in social relationships, and dysfunction in romantic relationships in adulthood (Selby, Braithwaite, Joiner, & Fincham, 2008). This etiological link can cause difficulties for families interacting with clinicians who are aware of the possibility that the family environment has contributed to the clients' difficulties (Giffin, 2008). Allen and Farmer (1996) write that these influences are not only important for the young child, but also that family relationships in the present may serve to maintain BPD behaviours in adulthood as well. For example parents or partners may alternate between over-involvement and withdrawal when the adult with BPD is distressed.

Biological factors are thought to be important in the development of BPD. Distel et al. (2008) examined heritability of BPD in three countries using twin samples. They found that genetic influences could explain 42% of the variation in BPD, and that this rate was similar for men and women and for all three countries surveyed. People with BPD are reported by some authors to have cognitive deficits (Gunderson et al., 2008). Meekings and O'Brien (2004) write that although there are no distinctive biological markers for BPD, there is evidence for subtle neurological deficits, especially frontal lobe deficits, as evidenced by impulsivity, poor self monitoring and cognitive inflexibility. Deficits in neurobiological mechanisms have been identified in people with BPD. In particular serotonergic functioning has been identified in brain imagery studies to be reduced in people with BPD and suicidality (James & Taylor, 2008). Areas of the brain most affected are the amygdala and prefrontal cortex. Heightened emotional sensitivity and intensity is linked to hyperactivity in the amygdala, while hypoactivity of the prefrontal

cortex is linked to difficulties in regulating emotional responsivity (Goodman, Triebwasser, & New, 2008). Trauma such as sexual abuse has been linked with biological changes in the brain, particularly when the trauma occurs in early childhood (Teicher, 2002).

Social and cultural factors are thought to influence expression of BPD. Selby and Joiner (2008) examined differences in BPD symptoms among three different ethnic groups, Caucasian, Hispanic and African American groups from Florida, USA. They hypothesised that some symptoms may be more tolerated – and thus perceived as less problematic - in some ethnic groups compared to others. They identified a four-factor structure for each ethnic group, containing elements of affective dysregulation, cognitive dysregulation, disturbed relatedness, and behavioural dysregulation. In general the same factors were found across the cultures examined. There were differences in how the factors related to one another, with one difference being that affective and behavioural dysregulation were more highly correlated in Caucasians compared to other groups. The authors hypothesised that this could reflect cultural differences in the way emotions are expressed, and that suicidal behaviour may be more accepted in Caucasian compared to Hispanic or African American cultures.

How DBT defines BPD.

It is important to consider how the developers of a treatment model think about the disorder it is designed to treat. This understanding of disorder (or lack of disorder) is fundamental to the theory behind every intervention within the treatment. In order to be able to examine the impact of DBT on clients' language, and constructions of the world, it is necessary to examine how DBT conceptualises their difficulties. Linehan (1993) proposes a biosocial theory of BPD, which sees the development of BPD as occurring through the interaction of biological and social learning influences. She focuses on a subgroup of people with BPD with chronic self harm or suicidality.

Linehan (1993) organises the DSM-IV-TR criteria into five key areas of dysregulation: emotional, interpersonal, behavioural, cognitive, and self-dysregulation. She is careful to note that her description of BPD is a reorganisation but not a redefinition of the DSM-IV-TR criteria. She notes the overlap between BPD and individuals who are chronically parasuicidal, who are the focus of DBT treatment. Linehan defines 'borderline'

dysfunctional behaviours as 'normal' responses to dysfunctional biological, psychological and environmental events. The principles influencing behaviour are effective in all individuals, including people with BPD and also their therapists. Although Linehan recognises the central place of environment in the development and maintenance of dysfunctional behaviours, the therapy is focussed on individuals and their interaction with the environment. In this way, systemic dysfunction is recognised, however the individual is the target of change.

Dysfunctional behaviours are viewed as a result of 'dialectical failures' (Linehan, 1993, p. 35). This means that people with BPD often switch between opposing viewpoints, and are unable to move to an integration or synthesis of these viewpoints. Reality is viewed in terms of polarities, and there is great difficulty in recognising the possibility of change or transition. The most fundamental of these opposing viewpoints is the wish to either live or die. A person with BPD is unable to recognise the possibility of having the wish to live and the wish to die at the same time, so switches back and forth between these two opposites. From a dialectical perspective, this conflict is resolved when the person is able to recognise the paradox of truth in both of these opposites. A level of integration can occur that recognises the existence and validity of both positions.

DBT assumes that emotions are the underlying cause of difficulties people with BPD experience. Faulty cognitions develop in response to difficult emotions rather than the other way around (as in CBT), as people look for reasons for feeling emotion. Attachment theory is important in DBT theory, and DBT acknowledges the role of attachment figures and environment in development of difficulties, utilising the concept of an invalidating environment to refer to a lack of consistent nurturing or response to a child's emotions. Neurobiological explanations are included in DBT theory, with the suggestion that once neural pathways involved in emotional pain are activated (such as during childhood), then future activation of these pathways becomes more likely. People with BPD experience ongoing activation of these pathways, and their response (of avoidance or escape of emotion) is therefore understandable (Marra, 2005).

The concept of emotion dysregulation has become central in the understanding of BPD. This is described in DBT as difficulty responding to emotional distress in an effective manner, leading to avoidance and unwillingness to experience distress; lack of ability to

modulate the intensity of distress; difficulties in controlling behavioural responses to distress; and lack of awareness of emotion and inability to use emotions accurately as information (Bornovalova et al., 2008). A skills deficit is central to this formulation (Linehan, 1993).

Meanings of BPD

Regardless of the etiology of BPD, the term has come to carry different meanings in addition to a disorder as defined by the DSM-IV-TR. These meanings vary depending on the context in which the label is used. In this section, some of the meanings identified by clinicians, clients, and families which are presented in the literature are discussed. Feminist thought about the diagnosis will be briefly discussed, as will one study which reports on discourses present in the DSM-IV.

BPD and clinicians' meanings

It is clear the term BPD carries many more meanings than a simple diagnosis of a disorder. Freeman et al. (2005) report that it is used among clinicians to refer to “a syndrome, a level of functioning, a dynamic constellation, a prognostic statement, and an insult and accusation” (p.1). Allen (2004) identifies two uses of the BPD label by mental health clinicians interviewed. One was the DSM criteria applied to a group of service users; the other was a group of (usually) female, non-compliant, self-harming service users who were ‘trouble’ (p.135). The tensions between meanings of BPD are evident in these uses of the term.

Woolasten and Hixenbaugh (2008) studied nurses' perceptions of patients with BPD using qualitative interviews and thematic analysis. The core theme identified was called “destructive whirlwind” because of the sense of clients as being an unstoppable force. This study also found themes that nurses felt that they were either idealised or demonised by clients; felt manipulated and used by clients; felt threatened by clients – particularly threats of suicide if certain demands were not met; and also a felt unable to help these clients. This last theme was related to nurses' perceptions that they did not have the skills to effectively work with people with BPD. They had entered nursing as a profession in order to help people, and with this client group felt unable to do so. Hersh (2008) writes that for many clinicians, the BPD diagnosis elicits strong negative

emotions which are greater than those associated with clients with other diagnoses who have similar problematic behaviours.

The idea of BPD being difficult to treat is common to much research in the literature. Health professionals frequently report difficulty managing people with BPD, and this has resulted in the diagnosis being used to describe a client who is 'difficult' (Fraser & Gallop, 1993, Palmer, 2002). Freeman et al. (2005) open their chapter about BPD with a comment about this meaning the term has come to carry since its introduction. "Merely mentioning to a fellow clinician that your new patient is a *borderline* virtually guarantees a sigh of knowing sympathy, even absent any additional details" (p.1). The authors also note that the diagnosis can also be used as an excuse for therapeutic failure. Commons Treloar and Lewis (2008) consider that the diagnosis can lead to a focus on the label rather than the person, and less effort is made to identify reasons behind self harm. Clinicians may avoid telling a client about a diagnosis of BPD, because the diagnosis is recognised as having negative connotations. This can lead to a lack of attention paid to difficulties related to BPD (Hersh, 2008).

Perhaps related to the perceived ineffectiveness of clinicians is the idea that people with BPD are not unwell, and that BPD is not an illness. People with BPD are sometimes described as 'not sick, manipulative, and non-compliant' (Nehls, 2000, p. 62). Clients themselves identify that they feel misunderstood by health professionals who regard self harm (which is one of the criteria leading to a diagnosis of BPD) as manipulative attention seeking (Nehls, 1999). There is tension between the idea of BPD being an illness, which mental health services should then treat; and BPD being a name given to a group of dysfunctional, yet wilful behaviours, and therefore not the health professional's responsibility to treat.

Clinicians working in different settings have been found to have varying attitudes towards working with people with BPD. Commons Treloar and Lewis (2008) compared attitudes towards self harming clients with BPD between mental health and emergency department practitioners in one New Zealand and two Australian health services. They found that mental health clinicians were more likely to consider working with these clients worthwhile. Krawitz and Jackson (2008) evaluated a training programme provided to 412 mental health and substance use clinicians in seven New Zealand cities,

which included a consumer perspective. They report that the benefit of having a consumer perspective included the recognition of the “humanity” of the person with BPD. Ratings given by participants were higher than those provided for earlier, clinician-only run training courses.

Clients’ and families’ meanings

The term BPD has different meanings for clients and families however there is relatively little research in this area. Clients may sense derogatory attitudes towards them associated with the diagnosis, possibly leading to further self harm or suicidal behaviours (Commons Treloar & Lewis, 2008). Van Gelder (2008) writes of her own experience with BPD. She describes trepidation about disclosing her diagnosis for fear of the impact this could have on others’ attitudes towards her, including potential employers or partners. Despite this awareness of stigma, Van Gelder describes receiving the BPD diagnosis 20 years after her first suicide attempt, and feeling relief that she had a name for the difficulties she experienced. The diagnosis gave her a sense of control, an explanation for what the difficulties were, and a means to research possible solutions. For her this recognition allowed some distance and an ability to observe her own difficulties, and begin to change her responses. In this case, the diagnosis was received as a positive experience, with positive meaning.

Families can come up against negative clinician attitudes, and experience problems accessing help for their family members. Buteau, Dawkins and Hoffman (2008) conducted a qualitative study of family members’ experiences and found families had difficulties with clinician attitudes. Little information was provided by clinicians, leaving family members feeling there was no hope for their relative with BPD. One participant in this study described attempting to contact over 200 therapists for her daughter, only to be told the therapists had no availability once she mentioned that her daughter was self harming. The diagnosis was linked with a sense of hopelessness for family members, who were not able to access treatment. One participant even described the diagnosis as a death sentence “it would be like saying you’ve got AIDS. There is nothing you can do, really.” (p. 210). Giffin (2008) conducted a qualitative study of families’ experiences of BPD, using qualitative interviews and Grounded Theory. Family members reported chronic stress and strained relationships both with their family member with BPD and with the mental health system. In particular the family members faced a dilemma about

wanting to care, and believing they should stand back. They reported a sense of helplessness similar to that described by clinicians.

Feminist critique

BPD is largely a women's issue, which is a point not made obvious in the DSM-IV-TR classification. Approximately 75% of people diagnosed with BPD are women (Krawitz & Watson, 1999). One explanation for this is that a history of abuse or trauma is often implicated in the development of emotional dysregulation. Approximately 70% of people meeting diagnostic criteria for BPD have a history of sexual abuse during childhood and similar percentages have a history of physical abuse (Linehan, 1993; Bandelow, Krause, Wedekind, Brooks, Hajak & Ruther, 2003).

Feminist writers have examined the construction of mental illness as a particular concern of women, and here the diagnosis of BPD assumes increased significance. In particular the construction of 'selfhood' is relevant, as BPD is constructed as a disorder of selfhood, fragmentation and lack of stability. In the words of psychiatric language, the DSM-IV-TR describes those with BPD as having difficulties (among others) with "identity disturbance", "intense or unstable interpersonal relationships" and "chronic feelings of emptiness" (APA, 2000). Gottshalk (2000) describes the 'self' not as a stable state, but as an ongoing and changing process, created through relationships with others and through the communication between people. Gottshalk states that people with a BPD diagnosis could be seen as in tune with a changeable postmodern world. Gergen (2000) too, notes that it is not possible to separate the self from power/knowledge relations, and language, and describes this construction of self as happening continuously, and changing depending on the situation of the moment. Wirth-Cauchon (2000) writes that the diagnosis of borderline personality disorder constructs the person as on the border of 'selfhood'. The normal self is then defined in psychiatry as ahistorical and decontextualised being, and the experience of the 'borderline' woman in this context must be seen as pathological. Wirth-Cauchon focuses on the gendered nature of the diagnosis, and presents the borderline woman as expressing the effects of the construction of self.

Shaw and Procter (2005) discuss the social construction of BPD as an historical attempt to explain strategies used by women to resist oppression and abuse. They note the

importance of the diagnosis 'hysteria' in the history of women's madness, and argue that this diagnosis, as well as the more modern BPD, function to locate difficult or deviant behaviours as individual pathology, obscuring social context, and in particular gendered power differences that also explain these behaviours. BPD is thus constructed as a deviation, in particular from individualism and rationality. Shaw and Procter argue that psychiatry has an inherent gendered value system. They refer to the concept of a 'double-bind' for women, who are pathologised both for conforming to expectations and for failing to conform. For example women who display anger and aggression are pathologised for failing to conform to the expectation of feminine passivity. Women who conform 'too strongly' and internalize behaviour, directing it to the self through means such as self injury, are also pathologised.

There is recognition of the need to somehow work within the current mental health system, despite difficulties with the BPD diagnosis. Allen (2004) expresses discomfort at the use of diagnostic terminology. She identifies a dilemma between wanting to avoid the diagnosis, with its pejorative connotations, and recognising the need to work within a diagnostically based mental health system. The term 'trauma syndrome' is preferred by Allen; however she recognises that this does not fit comfortably with the many people with BPD who do not have a trauma history. Allen notes that avoiding the term BPD with clients can result in excluding the person from access to notes written about them (that use the term). Using the diagnosis however can have the effect of pathologising the individual rather than recognising systemic dysfunction within the family context.

Allen (2004) conducted a discourse analysis of the DSM-IV description of BPD. She describes four discourses: a discourse about selfhood, adulthood, gender, and a professionalised discourse about good and bad patients. In the discourse about selfhood, Allen states that the text portrays the person with BPD as insufficiently autonomous, and very sensitive to environmental circumstances: 'a pervasive pattern of instability' is 'the essential feature' of BPD (p.132). The person with BPD is described as overly dependent on relationships with inadequate self control and goal orientation.

Referring to a discourse about adulthood, Allen states that the compilers of DSM can be assumed to be 'successful selves' in that they have achieved adult status as defined by a culturally prescribed route including persistence and goal directed behaviour.

According to Allen, a theme in the DSM is of the person with BPD failing to grow up. This is done with use of words 'easily bored', 'frantic' if left alone, 'may feel more secure with transitional objects' (teddy bears). Self destructive acts are described as occurring when the person is given an expectation of responsibility. The sentence 'similar features, if seen transiently in adolescence, 'misleadingly give the impression of Borderline Personality Disorder' likens adults with BPD to behaving like unhappy adolescents.

The third discourse identified by Allen is a gender discourse. The text (DSM IV) states that most people diagnosed with BPD are women. Allen argues that the discourse of an autonomous self is itself gendered, and that women may define themselves more through relationships than men, and have more blurred boundaries with others and a less distinct sense of self. From this viewpoint, the diagnosis of BPD may be seen as representing the 'failures of women'.

Finally, Allen identifies a professional discourse about good and bad patients. The DSM-IV has been developed as a professional tool, and has assumed professional legitimacy as a result of this. Allen reads this as an expression of the physician's outrage at an ungrateful patient who doesn't play by the rules.

Summary

BPD carries many sometimes contradictory meanings. It is a diagnostic label, an indicator that treatment will be difficult, a name meaning bad behaviour, a person who will not accept help and who sabotages treatment, a diagnosis to be hidden from the client, a means to locate social problems in an individual, and a means to label women's experience as pathological. The behaviours associated with BPD can be seen as a result of individual pathology, as a normal response to abnormal situations, or even as normal responses that have been constructed as abnormal by a gendered value system of psychiatry. One of the tasks of DBT then (or any therapy), is to clearly articulate how BPD (or behaviours and experiences targeted by the therapy) is conceptualised by the therapy and its practitioners, and how the therapy is designed to assist with the problems identified in this conceptualisation.

A review of the literature around the meaning of BPD, the behaviours associated with this diagnosis, and especially the difficulty in treating clients with BPD assists in the understanding of why DBT, with its promise of effective treatment, has become so popular in a short space of time. It also provides context for investigation into the meanings of behaviours and therapy experiences, including identification of discourses of BPD and how these impact on the development and experience of DBT. The current research was planned to go some way towards articulating some of the meanings of BPD in a New Zealand setting.

Current research about DBT will be outlined in the next chapter, providing some of the context necessary for my own studies. This review of literature includes both empirical and social constructionist research. Both are important and provide different information and ideas relevant to this study.

Chapter 4: Dialectical Behaviour Therapy

In this chapter I will outline the key research studies that have led to the enthusiasm around introducing DBT. These studies can be read both as evidence for a therapy that has been effective in the past and warrants further use and study, and as providing background and context for the current experience of clients and clinicians working with DBT.

Outcome Studies

There have been several studies of the effectiveness of DBT for BPD since the first published study in 1991. Linehan, Armstrong, Suarez, Allmon and Heard (1991) compared DBT with treatment as usual in the community (TAU), with 22 participants in each treatment condition. Results were that the participants who received DBT had significantly reduced frequency and medical risk of parasuicidal behaviour, remained in therapy longer, and had fewer psychiatric inpatient days compared to those who received TAU. However the participant group included people with severely dysfunctional parasuicidal behaviour, which may mean the results are not applicable to people with less severe difficulties.

Since then there have been RCT studies evaluating effectiveness of DBT compared to TAU for women veterans with BPD (Koons et al., 2001), and BPD plus substance use disorder (Van den Bosch, Koeter, Stijnen, Verheul, & Van den Brink, 2005; Verheul et al., 2003). All three studies reported positive results for DBT with greater retention in therapy, reduction in self-mutilating and other self-damaging behaviours, and reduction in alcohol consumption compared to TAU. There were also decreases in suicidal ideation, hopelessness, depression and anger expression reported. In the most recent study, Carter, Willcox, Lewin, Conrad and Bendit (2010) conducted an RCT comparing DBT with TAU plus waitlist for DBT with 73 female participants meeting criteria for BPD. They found that both groups showed a reduction in deliberate self harm and hospitalisation, with no significant difference. DBT showed superior outcomes for secondary targets of disability (measured by days spent in bed) and quality of life. These studies examined DBT compared with TAU however a difficulty with this type of study is the uncertainty around what TAU means. In particular most TAU conditions contained far less therapist-client contact compared to DBT.

The next group of studies compared DBT with another established or well defined therapy. Linehan et al (2006) conducted a two year RCT and follow-up of DBT vs. therapy by experts for suicidal behaviours and BPD (community treatment by experts, CTBE). The study consisted of a one year RCT, and one year of follow up. Women with recent suicidal and self harming behaviour, and meeting DSM-IV criteria for BPD (n=100) were randomly assigned to the treatment conditions. Results were that although no participant in either group committed suicide, the DBT group had half as many attempts as the CTBE group (23.1% vs. 46%). The DBT group used crisis services less than CTBE, and had fewer visits to the emergency department. Fewer DBT participants dropped out of therapy (19.2% vs. 42.9%). Both groups showed improved quality of life scores. There were no differences between groups in the incidence of non-suicidal self-injury. This study is important because it provided a control group in which participants received equal quantity of time compared to the DBT group (once individual, group, day treatment and inpatient treatment were included), therefore amount of therapeutic contact alone does not explain the differences in outcome between the two groups. The major limitation was the high dropout rate of the CTBE group, making comparison more difficult. The authors called for further dismantling studies of DBT, and further research into CTBE, which provided participants with improved quality of life and reduced self harm as effectively as DBT.

DBT has been compared with Comprehensive Validation Therapy with 12-Step (CVT + 12S) for heroin dependent women with BPD (Linehan et al., 2002), and Client-Centred Therapy (CCP) for people with BPD (Turner, 2000) using an RCT design. Both studies reported comparatively greater improvements for people in the DBT condition, although comparison treatments were also effective. These studies suggest that DBT compares favourably with other treatments shown to be effective for people with BPD.

Although DBT was originally developed for use in community settings, several studies have looked at the adaptation of DBT for inpatient settings (Bohus et al., 2004; Kröger et al., 2006; Low, Jones, & Duggan, 2001). These studies all reported improvement in measures of psychopathology and provide preliminary evidence supporting the use of DBT in an institutional setting. The studies were limited by a high rate of co-morbidity (being an inpatient sample), lack of a control group, and the fact that interviewers were

aware of the treatment. Another study examined the efficacy of DBT plus olanzapine vs. DBT without olanzapine for BPD (Soler et al., 2005). This study found improvements in both groups, with participants who received olanzapine and DBT exhibiting greater reduction in impulsivity and aggressive behaviour, anxiety and depression compared to the placebo group.

Initial attempts to examine components of DBT have been published. DBT skills-training (DBT-ST) was compared to standard group therapy for BPD in an attempt to isolate effective components of DBT (Soler et al., 2009). DBT-ST was found to produce positive results, and could be implemented relatively easily in mental health settings, not requiring the level of resources needed for standard DBT. One study utilised a video to teach DBT skills (Waltz et al., 2009). This study randomly allocated participants to a DBT skills video group or a control video group. Those in the DBT video group showed a significant increase in the skill taught compared to the control group. The authors concluded that video may be a feasible way to present DBT skills.

Several studies have reported favourable outcomes for DBT, or DBT-based therapy for people with disorders other than BPD, including comorbid eating disorder and BPD (Ben-Porath, Wisniewski, & Warren, 2009; Palmer et al., 2003), comorbid axis one disorders and BPD (Harned, Banawan, & Lynch, 2006), major depressive disorder (Feldman, Harley, Kerrigan, Jacobo, & Fava, 2009), women who have experienced domestic abuse (Iverson, Shenk, & Fruzzetti, 2009), and family members of suicide attempters (Rajalin, Wickholm-Pethrus, Hursti, & Jokinen, 2009).

In summary, the above studies have consistently found that DBT reduced self-harming behaviours, impulsiveness and parasuicidal behaviours. Most studies have also found improved scores on measures of psychopathology following DBT. No studies found that DBT had a negative impact on clients' wellbeing. DBT is a comprehensive therapy programme, involving individual therapy, group therapy, telephone skills coaching, and consultation to a DBT group (for therapists). It is inevitable that some studies have adapted the therapy to fit the situation required, for example DBT was developed as an outpatient treatment, yet three of the studies cited involved inpatient participant groups. The outcome literature to date supports the effectiveness of DBT.

DBT in New Zealand

In 2005 there were five District Health Boards (DHB's) (Northland, Waitemata, Auckland, Counties-Manukau and Waikato) offering a full DBT programme (Batchelor, 2005). Te Whare Mahana was a rural non-governmental organisation (NGO) residential service offering DBT. The Auckland DHB Balance programme is the most established DBT programme in New Zealand, beginning in 1998. This programme runs across four community mental health centres, with three consult teams, up to four skills groups at a time, and about 30 BPD clients at a time. Batchelor (2005) draws on his own experience using DBT with the Auckland Balance programme, to recommend further implementation of DBT, and further research into DBT in New Zealand.

A DHB-based National Personality Disorder Advisory Group, involving almost all New Zealand DHBs, has been involved in looking at ways to promote effective and compassionate care for people with personality disorders (Batchelor, 2005). DBT training in New Zealand has been developed by Te Pou o Te Whakaaro Nui (National Centre of Mental Health Research). Two days of training were held for 170 people in 2005. In 2006 a DBT intensive training course attracted 70 participants. In 2006 DBT teams were established in four Central regional DHBs. In 2009, there were eight DHBs offering a specialist DBT service for clients with BPD (Te Pou, 2009). Barriers to the implementation of DBT have been lack of access to expensive US based DBT training, and lack of Ministry purchasing for this client group, who have typically been regarded as ineligible for treatment (Te Pou, 2006).

New Zealand research into DBT is still at an early stage, with only small scale studies completed so far, and only one published outcome study. Brassington and Krawitz (2006) conducted an outcome study of DBT for a group of 10 people with BPD, using the Millon Clinical Multiaxial Inventory, 3rd edition (MCMI-III) and the Symptom Checklist 90 Revised (SCL-90-R) as well as qualitative interviews and hospital stay data. The sample was drawn from those already receiving 'treatment as usual'. Treatment was standard DBT of 60-90 minutes of individual therapy per week, group skills training (2 hrs per week), telephone calls and therapist consultation meetings (90 minutes per week). Treatment providers were three psychologists, two social workers, two alcohol and drug counsellors, one nurse, one psychiatrist and one psychology intern. Unlike the original version of DBT, therapists were not available to take calls out of regular hours.

These were taken by the mental health service crisis line. Medication use continued as usual during treatment. Results indicated that improvements in functioning were found on 10 of the 24 scales of the MCMI-III. The pre-treatment mean score on the MCMI-III BPD scale was 90.5 (severe), improving to 67.6 (not clinically significant). Only five of the participants completed both pre and post treatment SCLR-90-R scales. Statistically significant reductions in symptomology were found for the Global Severity Index (GSI) and 10 of the 12 subscales. The inpatient bed usage decreased from a mean of 0.57 days per patient per month to 0.2 days per patient per month. All 10 participants reported satisfaction with their experience in the qualitative interviews. This study, although small, provides evidence that DBT can be effective in a New Zealand setting.

In a small unpublished study, Gregory (2004) examined the effectiveness of a DBT programme in a New Zealand setting using hospital records, psychological test scores, and a feedback sheet with four women with BPD. Several adaptations to the original DBT format were made to accommodate the local environment. There were several gaps in the data, when participants had not provided data. Participants improved on several measures following DBT. The small sample size and missing data means that these results should be interpreted with caution, however they indicate that DBT was helpful for these women.

It is important to note that although DBT is the most recommended therapy for BPD in New Zealand, it is not the only possible treatment and other treatments have also been shown to be effective in some studies. These therapies include Systems Training for Emotional Predictability and Skills Training (STEPPS) (Blum & Black, 2008; Silk, 2008); Mentalization-based treatment (Bateman & Fonagy, 2008); Transference-Focussed Psychotherapy (TFP) (Yeomans & Delaney, 2008); Psychodynamic therapy (Gregory et.al, 2008); and Conversational Model (CM) (Gerull, Meares, Stevenson, Korner, & Newman, 2008). Only DBT has been discussed here.

In summary, New Zealand research on DBT is encouraging, although limited in scope. The studies that have been conducted have found a decrease in hospital inpatient days following DBT and improvements in psychopathology scales. There have been no New Zealand RCTs or large scale outcome measurement studies, and limited research into client experience. There is no published research on clinician experience of using DBT.

Adaptations have been made to DBT to fit the context of the mental health system in New Zealand, for example the studies have examined DBT programmes, which utilise crisis services rather than provide the ability for clients to contact their own therapist out of hours. New Zealand research is important to identify any local factors which impact on the way DBT is delivered or experienced, and whether or not DBT is able to meet the needs of clients and clinicians. Also important in evaluating DBT is to look at client and clinician experiences with DBT.

Experience of DBT

Although several studies overseas and a few New Zealand studies have examined the effectiveness of DBT, few studies have researched the experience of people undergoing the therapy. Cunningham, Wolbert and Lillie (2004) conducted a qualitative study with the goal of understanding the client's perspective of what was effective about DBT. They interviewed 14 clients, who were involved in the same DBT treatment programme. In general, all participants said that DBT had been positive for them, and described DBT as a life changing therapy. DBT was described as giving the women tools to manage their BPD, or to manage when feelings become overwhelming. Participants identified that the most important qualities in the therapist were to be non judgmental and validating. They also spoke of the importance of the therapist pushing them. Skills training was described as most effective when the participants were encouraged to relate the skills back to their daily lives and the groups themselves were described as providing support from others, and benefit of seeing how others managed to use the skills. Participants agreed DBT had helped them with relationships including family, friends and everyday encounters. They were more in control of boundaries and able to be appropriately assertive. DBT was described as having given them greater control of emotions.

One New Zealand study examined client ratings of DBT skills (Dewe & Krawitz, 2007). Participants (n=19) who had completed a 25 week DBT programme were asked to rate 27 skills in terms of their usefulness. The results indicated which skills were most valued by participants soon after completing therapy. The authors note that this may vary depending on how skills are taught, and the recency of the teaching session as well as the time the person has been able to practise the skill. Skills were reported as useful in participants' lives.

One study reported on community mental health administrators' perspectives of DBT, using interviews with 13 participants (Herschell, Kogan, Celedonia, Gavin, & Stein, 2009). Generally the participants were positive about DBT, however there were also concerns about some aspects of DBT such as clinicians being available to be contacted at home. There were concerns about resources and funding because of the commitment required for DBT. They talked of selecting clinicians for DBT training who had shown some commitment to the company, and were thought to be less likely to leave. Finally the administrators expressed concern that there would not be enough client referrals to make DBT a viable (economic) option. These resource management concerns are important because they ultimately determine access to DBT in any particular service.

Summary

As the above studies have suggested, DBT has a small but rapidly expanding research base including studies conducted in different countries, all of which report favourable outcomes. In New Zealand, this is a time of new development and growth in the services available to people with BPD, with the introduction of DBT training and new regional DBT teams. There is interest in DBT and whether DBT will help New Zealand clinicians work successfully with people with BPD. Most of the DBT research published to date was conducted in the United States or Europe, and consists of outcome measurement studies based on quantitative methodologies. This suggests a need for qualitative studies of DBT from both client and clinician perspectives, and in particular from the point of view of New Zealand services – studies of local experience. As I will explain in the following paragraphs, research from a social constructionist perspective is also needed.

In Chapter Two, aspects of the development of the BPD concept were outlined. These included its place located within psychiatry, which was itself located fairly recently in context of changing social conventions over time and changing understandings of the nature of reality. This location of the diagnosis within a wider context highlights the transient and socially defined nature of meanings assigned to it. This understanding allows for the identification of some of the socially defined meanings which have been attributed to the BPD diagnosis over time, and also to the potentially transient nature of

current psychological theories of BPD. Some of the meanings assigned to the BPD diagnosis include biological, psychodynamic, attachment and social/cultural theories of etiology; and biological, psychodynamic, antipsychiatry and feminist understandings of the nature of BPD. The behaviours associated with BPD can be seen as a result of individual pathology, as a normal response to abnormal situations, or even as normal responses that have been constructed as abnormal by a gendered value system of psychiatry. All of these offer potential contributions or frameworks from which BPD can be understood. Linehan (1992) also contributed a particular understanding of BPD – which is utilised in DBT theory. Although DBT offers a conceptualisation of BPD, this is only one of the possible formulations available to clinicians, and is itself situated within ever-changing clinical understandings.

Most research (including qualitative research) has been conducted utilising empiricist epistemology. This is despite recognition that clinicians place importance on meaning and context, and are aware of information carried within labels such as BPD. As discussed in Chapter Two, the usefulness of discourse analysis for psychotherapy becomes clear when the nature of psychotherapy is understood as a process of meaning creation, with acknowledgement of changing socially constructed meanings. Research from a social constructionist perspective is needed to identify important meanings carried in language of BPD and DBT. This research will attempt to begin to address this need.

In the next chapters I introduce my own research. In Chapters Five and Six I will present Study One, which is a discourse analysis of clinical literature. This is followed by Study Two, a discourse analysis of clinician interviews in Chapters Seven and Eight; Study Three, a discourse analysis of client interviews in Chapters Nine and Ten; and Study Four, a client outcome measure study in Chapter Eleven.

Chapter 5: Study One: Discourse analysis of literature

The previous three chapters have discussed underlying assumptions of research, including an introduction to discourse analysis, and presented literature on the topic of BPD and DBT. As noted, most clinical research in this area has been conducted from an empiricist perspective, and although empirical research provides important information (within an empiricist framework), research from a social constructionist perspective has the capacity to identify multiple or contradicting meanings carried within language. These meanings have the capacity to influence communication, an important consideration when the central role of meaning creation in psychotherapy is acknowledged.

In the first part of this study, constructions of BPD within a set of clinical journal articles about DBT will be discussed. The second part will then examine discourses of DBT in the same data set.

Aim

The aim of this study was to identify the discourses present in current research literature about DBT that could be read by practising clinicians. This is because research literature is one of the sources of information and ideas available to clinicians, and is likely to be a source of discourses of BPD and DBT. In one discourse analysis study, Allen (2004) describes four discourses in her analysis of the DSM-IV (outlined in Chapter Two): a discourse about selfhood, adulthood, gender, and a professionalised discourse about good and bad patients. The DSM-IV is likely to differ from DBT literature, in that it provides the definition of BPD within psychiatry, applied in different streams of thought (not just that provided by DBT), however the pivotal role of the DSM-IV in creating the BPD label cannot be underestimated. The contribution of research articles to available meanings of BPD is potentially also significant. The research question for this study was: What are the discourses of BPD and DBT present in the DBT literature?

Method

There is a large amount of literature available on the topic of DBT and it was necessary to limit the number of articles to a manageable number. It was important for the selection of articles to be conducted in such a way that I was not choosing those articles

which contained particular discourse or constructions of DBT. This was because my selection of articles could have differed in some important way from those read by practising clinicians. The sample was limited using a particular online database, and date of publication.

I conducted a PsycInfo database search on 5 August 2007, using the search terms 'dialectical behaviour therapy' and 'dialectical behavior therapy' ensuring that my search included both British and American English spelling of the word 'behaviour'. The search was limited to journal articles published in 2006 or 2007, written in the English language, and book reviews were removed. The dates were chosen to correspond to the most recent articles likely to be read by the clinicians I was interviewing for Study Two. Of course literature is being added to the database continuously, and it is likely that as DBT becomes more researched, new discourses and ideas will be added. Earlier DBT studies, representing the initial presentation of DBT to the research and clinical communities, would also have been important in providing a foundation of understanding and establishing those discourses available for use in the DBT field.

This search resulted in 27 journal articles, which became the database for this study (see appendix A for list of articles). The articles included four RCTs; nine studies which looked at treatment outcomes of various implementations of DBT without control groups; two case studies; one qualitative study of staff experiences; one evaluation of a personality assessment measure; one discussion of research methodology using DBT as an example; one study that examined rates of trainees using DBT; and seven theoretical articles. The search did not identify articles containing qualitative client experience of DBT. The discourses that would be present in client contributions are therefore largely missing from this database.

The data was analysed using discourse analysis techniques (Potter & Wetherell, 1987). Potter and Wetherell provide an outline of the steps involved in conducting analysis, however they acknowledge difficulty in providing a stepwise 'how to' guide, due to the subjective nature of the task, with analysis occurring at each level of the process. The next step after collecting my data was a process of coding. I read through the entire data set several times to get a general idea of what it contained. I then worked through each article selecting those quotes which constructed BPD or DBT, and created a data

set for each of these two areas. This step involved reading through each of the data sets, and identifying discourses within these.

The next step was the most difficult. It involved reading through each of the discourses, and checking to see if they were well supported by the data. This was at times confusing, as the same piece of data could sometimes be read in several different ways. This step included an examination of the work done within the language contained in the articles, including what knowledge was 'taken for granted', and analysis of the use of various discourses to promote subject positions or arguments. This process necessarily involves the researcher developing theories to be revised as the analysis proceeds (Potter & Wetherell, 1994).

Reflexivity

As the researcher my own ideas and background can not be removed from the research as I could not be an impartial observer, but rather an active participant in creation of, and reading of the data. In this literature study, my influence included choosing clinical journals and the dates of those journals as my data set, the use of PsycInfo database and particular search terms to locate the data, first coding and then analysing the data within that set of journals, and then translating that analysis into this report. In all of the studies my background as a clinician – especially my previous experiences within the mental health system, my interest in languages and culture, my position as a graduate student within the clinical psychology programme, my ethnicity, age and gender, and my expectations for the research influenced my choosing of and reading of data.

It should be noted that in addition to the above influences, the selection of clinical articles with DBT as focus is likely to have excluded studies with alternate conceptualisations of BPD (for example those using a psychodynamic approach), and alternative media sources could have included websites, books, films, radio and television media. The study was therefore narrowly focussed on DBT clinical journals, a necessary limitation given time constraints. This does not invalidate the data however, because discourse analysis notes that meaning is always created in context. It must suffice to make this context as overt as possible, so that the analysis can be read with this understanding.

Because of the large amount of data present in the articles, the study will be discussed in two chapters. The discourses of BPD, client behaviours and presentations of who DBT was supposed to be for, will be discussed in this chapter. The constructions of DBT itself in the journal articles will be examined in Chapter Six.

Study One part one: Constructions of BPD

This study presents discourses of BPD identified in the set of journal articles about DBT. A dominant discourse, unsurprisingly given that this was a clinical journal set, constructed BPD as an illness. The clinical focus of the journals was also reflected in a discourse of clients with BPD as 'difficult' for clinicians to manage. A discourse of BPD as emotion dysregulation was also present, and closely connected to the discussions of DBT and the conceptualisation of BPD offered by DBT.

An illness discourse

The idea that BPD is an illness was dominant with all articles constructing BPD as a difficulty experienced by the individual, and locating the problems in the individual. The following extracts illustrate this discourse in use.

1. *BPD is a highly prevalent, chronic, and debilitating psychiatric problem. (Levy, Meehan, Clarkin, Kernberg, Kelly, Reynoso & Weber, 2006, p. 1028)*

Extract 1 is typical of the descriptions of BPD in the articles, and presents BPD in terms of prevalence, chronicity and severity as an illness. BPD is therefore constructed as a medical (psychiatric) condition worthy of attention and resources (including the publishing of research).

2. *Each participant completed the SCID-II personality questionnaire to identify potential personality disorders and then the diagnosis was confirmed or disconfirmed using the SCID-II interview. (Bray, Barrowclough & Lobban, 2007, p.1412)*

BPD was presented as a diagnostic entity or illness that exists and can be measured and diagnosed using a variety of measurement tools. Although the clinical presentation can vary there remains an underlying 'BPD' entity that can be identified accurately given

the right tools and experience, albeit with difficulty in some cases. Extract 2 constructs the diagnosis as clinically relevant and accurately diagnosed in this study, by describing the use of a diagnostic questionnaire followed by the interview tool (the SCID-II). This double “measurement” of disorder increases the perception that diagnosis is of an underlying pathological entity, and that can be made accurately. The next extract describes the development of the diagnosis across editions of the DSM.

3. *The successive revisions of the DSM have improved both the clarity and reliability of this disorder (Blais, Hilsenroth & Castlebury, 1997; Blais, Hilsenroth & Fowler, 1999; Blais, Kelley Holdwick & Hilsenroth, 2001). Nevertheless, the current diagnostic algorithm produces over 200 variations, making BPD, as defined by the DSM-IV, a broad and heterogenous disorder. This extensive diagnostic variability can make rapid and accurate identification of patients with BPD difficult, even for experienced clinicians (Jacobo, Blais, Baity & Harley, 2007, p. 74)*

The BPD concept was described as evolving, and becoming more refined over time. Extract 3 suggests this development over time with a reference to improved clarity and reliability of the “disorder”. The discussion of the wide range of possible combinations of elements of the diagnosis seems at first glance to negate the idea of a singular underlying disorder, to the extent that the diagnosis seems meaningless with over 200 possible variations. However this variation is then discussed in terms of increasing the difficulty in diagnosis of the underlying (singular) entity of BPD. The function of this is to construct the variable presentation of each client as a manifestation of the same underlying illness. In the following extract the construction of underlying illness is also separated from outward appearances.

4. *Fruzzetti and Iverson (2004) present a thoughtful discussion of the use of validation, mindfulness, and acceptance strategies to treat individual psychopathology and problematic partner responses, such that both can be ameliorated. (Kirby & Baucomp, 2007, p.377)*

Extract 4 locates pathology within the individual diagnosed with BPD. In this way a partner’s problematic behaviours are not presented as evidence of disorder and the

location of “disorder” is deeper than observable behaviours. Although only the person with BPD is constructed as disordered, the partner’s “responses” are also a target for treatment. This suggests a possibility that although treatment is targeted at people who are ‘unwell’, it is also useful for others. In the next extract, the extent of disorder is highlighted.

5. *BPD is rarely the sole diagnosis and sufferers generally meet criteria for at least one axis I disorder and other personality disorders (Bray, Barrow, Barrowclough, & Lobban, 2007, p. 1410).*

People with BPD were described as having multiple problems in addition to the diagnosis of BPD itself. This serves to include these other diagnoses in the meaning of BPD. Therefore a diagnosis of BPD carries a meaning of greater pathology in the language used by clinicians, than would be thought from the diagnosis as defined in the DSM-IV-TR. Extract 5 is an example of this, linking a minimum of one ‘axis 1’ disorder and additional ‘personality disorders’ to BPD. Not only can the disorder present in multiple forms (as in extract 3), but it also carries additional illness along with it. This is constructed as increasing disability, as the next extract illustrates.

6. *It has been said that the extent of disability associated with the disorder ‘involves a terrible way to experience life’ (Hazelton et al., 2006, p. 121).*

BPD was connected with a high level of impairment for the person with the diagnosis. The word ‘disability’ presents the person with BPD as impaired, and without control or choice over the influence of the disorder. It is not just one aspect of experience that is disabling, but the experience of life itself. This is congruent with the construction of BPD including multiple diagnoses, in that increased number or severity of disorders is logically associated with greater disability (see also extract 5).

These extracts illustrate how the journal articles present BPD as an illness or disorder, located in an individual person, whether or not signs of this disorder are apparent at any given moment. The illness is a singular entity despite the wide range of different presentations it can exhibit. This illness discourse is inherently present in all discussions about BPD, and is drawn upon whenever the term ‘BPD’ or ‘borderline personality

disorder' is used. The act of naming and categorising disorder creates the existence of this disorder and pathology category; and any attempt at introducing alternative constructions of behaviour, thoughts or emotions using the naming word must first recognise this link.

The illness discourse functions to maintain the client in a role of being 'disordered', and to mandate the role of mental health services in treating the client. Any behaviours exhibited by the client can be labelled as symptoms of disorder when seen through the lens provided by this discourse. This discourse is perhaps reflected in Allen's (2004) 'professional discourse' which notes that the DSM was developed as a professional tool and gained professional legitimacy because of this. In this way the creation of the diagnosis by professionals, automatically functions to maintain those who are given the diagnosis in an illness role. In the context of clinical journal articles, use of the illness discourse can also be seen to promote a reason for therapy and research to take place, in order to obtain appropriate means to help people with the 'disorder'. This works to validate the importance of the research studies in this sample, and to validate their position within a clinical domain.

Difficult client group

The definition of BPD in the DSM-IV-TR does not state that difficulty for clinicians working with people with BPD is part of the diagnosis. The construction of the difficult client was however reasonably dominant throughout the journal articles. People with a diagnosis of BPD were described as difficult and challenging, sometimes with no further elaboration as to how or why they might be difficult. This discourse differed from the illness discourse, in that clients did not comfortably fill the role of passive sufferer of 'illness'. People with BPD were constructed as choosing to behave in a difficult manner. They were difficult because clinicians experienced them as difficult to like as people, and finally they were difficult because they did not respond to treatment and improve. The following extracts reflect these constructions.

- 7. individuals meeting criteria for this diagnosis are generally viewed as among the most challenging for clinicians to treat. (Harned, Banawan, & Lynch, 2006, p. 67).*

In extract 7, working with a client with BPD is not only challenging, but the 'most' challenging work a clinician could do, elevating the level of difficulty beyond that of working with other client groups. The idea of BPD as an illness remains, in the reference to 'treatment, however here the focus is on clinician experience. This construction is also apparent in the next extract.

8. *Frequent team meetings focussing on both problematic behaviours and patients can decrease staff stress and increase group cohesiveness (Vitacco & Van Rybroek, 2006, p. 10).*

The focus here was on the impact of the behaviours on clinicians. Extract 8 indicates that staff members require support, in the form of team meetings, to reduce stress associated with 'problematic' behaviours. Such meetings are required 'frequently', presumably because of the extent of staff stress. The effect of this is to construct the extent of difficulty associated with working with BPD as extreme, and as extending to all staff within the service. In the following extract this construction of difficulty is extended to include other 'patients'.

9. *They have a way of...getting under the skin of other patients...And it is also difficult for all of the staff to stay united...in dealing with them. (Focus Group 1) (Hazelton et al., 2006, p. 126).*

People with BPD were also described as creating problems for other people receiving treatment from a service. Extract 9 presents them as annoying to others, and creating friction between staff. The difficulty is extended to include a wider range of people, including other clients. The clients are positioned as causing the difficulty, because they have to be "dealt" with or managed by staff. The next extract presents a range of difficulties related to BPD.

10. *Not surprisingly, patients with BPD are notoriously difficult to treat. Patients with BPD use higher levels of services in emergency rooms, day hospital and partial hospitalization programs, and outpatient clinics and inpatient units, and these are often used in chaotic ways with repeated patterns of dropout,*

erratic psychotherapy attendance, refusal to take medications as prescribed, and pervasive non-compliance (Levy et al., 2006, p. 1028).

Extract 10 summarises the difficulties described in the articles with the greatest concern being difficulty in treating these clients. People with BPD are described as using 'higher' levels of services however the comparison group is not described. This has the effect of making it difficult to disagree that 'higher' level of services are used. Adjectives that increase the perception of ongoing disorganisation are 'chaotic', 'repeated' and 'erratic'. The construction of deliberate choice in these negative behaviours is created using the words 'refusal' and 'pervasive non-compliance', presenting the therapist as knowing the correct way to behave, and the client refusing to comply. The word 'pervasive' indicates this non-compliance is covering the whole range of options offered to clients.

The function of this difficult client discourse is to place responsibility for treatment failure on the client rather than clinician or treatment programme. This maintains the client group in a role of needing extra resources (improved treatment modalities, further research) and again validates the importance of the research presented in the journal articles. This discourse also maintains the position of clinicians as important in attempting to overcome 'difficulty', an important consideration given clinicians are the target audience for these journal articles. It is noted in Allen's (2004) study of the DSM-IV as an aspect of the 'professional' discourse of 'good and bad' patients, with Allen reading the DSM-IV as physician anger at a patient who does not play by the rules. The next section discusses the construction of this 'not playing by the rules' as deliberate choice.

Deliberate choice

The construction of non-compliance or deliberate choice was associated with lack of actual illness. This created a counter-argument in response to the illness discourse. People with BPD were described as choosing not to work on their recovery, and therefore as partly responsible for their lack of progress.

11. Personality disordered patients present formidable treatment challenges as they are often noncompliant with treatment and disruptive to the hospital milieu (Tardiff, 2001). For instance Ireland (2004) found personality

disordered patients frequently bully or pressure more compromised patients towards their own ends. (Vitacco & Van Rybroek, 2006, p. 3)

In extract 11 the authors compare people with a diagnosis of BPD to “more compromised” patients, which works to construct the other patients as more unwell, and the person with BPD as exploiting this. The idea of difficulty (‘formidable treatment challenge’) is linked with the word ‘noncompliant’, indicating that the person has chosen not to participate in treatment. The word ‘noncompliant’ also indicates an attitude that the therapist knows best and positive client behaviour should comply with therapist expectations.

This example hints at unspoken discourses of the expected client role being one of compliance, and of making progress; and the clinician role as healer – with associated expert status. The presentation of clients as responsible for lack of progress works to defend the assumed role of clinician as ‘healer’, despite the lack of improvement or response to treatment. A comparable finding was noted by Woolasten and Hixenbaugh (2008) in their study of nurses, who reported that participants felt unable to fulfil their role as nurses when confronted with clients with BPD who did not improve, indicating that client improvement is important for the maintenance of professional identity. In the following extract, the construction of deliberate choice is made overt.

12. in some sections of the interviews participants implied that this client population may purposefully set out to discomfort and cause friction between staff (Hazelton et al., 2006, p. 122).

Extract 12 identifies that staff spoke of this purposeful disruption on the part of clients with BPD, going further than clients disrupting their own therapy to include deliberate disruption for others within the hospital environment. This adds a malicious flavour to the behaviour, which is presented as aimed at causing staff distress.

13. treating a group of patients who have often demoralized prior generations of clinicians’ (Swenson 2000: 87) (Hazelton, Rossiter, & Milner, 2006, p. 121).

The articles reported that clinicians experience negative emotions when working with people with BPD. In particular the Hazelton, Rossiter and Milner (2006) article does this, which is to be expected given that it is the only qualitative study among the sample, and it examines clinician experience. The word ‘demoralising’ has a strong negative meaning associated with oppression and hopelessness (extract 13). It seems the clinicians can not escape, and also cannot fulfil their expected ‘healer’ role. This presentation of difficulty over time also works to predict ongoing difficulty for clinicians in the future, presumably for ‘generations’ to come.

The construction of deliberate choice functions to place blame and responsibility for behaviour onto clients’ shoulders. This works to negate any blame clinicians may have in failing to manage the hospital environment for people with BPD. Although this appears to allocate some degree of power and control to clients – it should be noted that only negative behaviours are ascribed client responsibility. Implicit in this is the idea that good clients should be compliant – and get better – and that people with BPD do not fit this mould. This construction of clients with BPD as being deliberately difficult for clinicians to manage is perhaps linked to their construction as unlikeable clients as well. This is discussed next.

Disliked (stigmatised) client group

An important aspect of the construction of difficulty working with clients with BPD is that they are difficult to like. Clients with BPD were constructed as unlikeable, meaning that the difficulty in working with them is something more than simple frustration at a difficult to treat condition. The next extracts illustrate this.

14. In some instances the extent of staff dislike for having to deal with consumers with BPD was all too clearly expressed, indicating intense frustration and bewilderment, even torment (Hazelton et al., 2006, p. 126).

Extract 14 explicitly mentions clinician’s negative emotions toward people with BPD. This constructs them as difficult to like as people, which positions the negativity on the person rather than the disorder. The extent of the staff dislike and distress associated with clients with BPD is emphasised using extreme language not usually associated with

a client group: 'intense frustration', 'bewilderment', 'even torment', clearly placing the level of distress outside the boundaries of normality.

The level of staff dislike is also commented on negatively in this extract, in which the authors report that staff dislike is "all too clearly expressed", indicating that staff attitudes are possibly problematic in themselves, or at least should be kept hidden. This implies a parallel discourse of a stigmatised group of clients, perhaps unfairly represented as difficult by staff.

15. Punitive attitudes and pessimistic belief systems seemed endemic, even amongst recently recruited staff and students on clinical placement (Hazelton et al., 2006, p. 122).

The idea that people with BPD are disliked is sometimes constructed, as indicated in extract 14 above, as a fault on the part of the clinician. In this example staff members rapidly adopt negative attitudes regarding clients with BPD regardless of the length of exposure to these clients. This construction occurs through use of the words 'punitive' and 'pessimistic' to describe clinician attitudes in extract 15. This negative attitude is portrayed as pervasive, and part of a 'meaning system' of the workplace rather than only relevant to a few clinicians.

In context of clinical journal articles, this construction of clients with BPD as disliked may function to promote research as balanced and valid, in that it acknowledges fault on the part of the clinician. It is also likely to function to validate research promoting staff education, or therapy modalities which alter clinicians' attitudes.

A final construction within the 'difficult client' discourse appears to lay less blame, and simply to present BPD as an untreatable disorder.

Untreatable clients

Sometimes people with a diagnosis of BPD were described as difficult not so much because of themselves, but because of inadequate or inappropriate treatments. BPD was constructed as treatment resistant, with all attempts at treatment unlikely to

succeed. The next extract refers to 'pre-training focus groups' in context of a training programme aimed at providing clinician education about BPD.

16. In general, participants in all three of the pre-training stage focus groups held out little hope for successful treatment. Indeed all treatment options were likely to fail (Hazelton et al., 2006, p. 127).

In extract 16 clinicians describe all treatment options as likely to fail. This includes all treatments in the past and probably future attempts by these clinicians to treat BPD. In this extract the reason for this could be either client or treatment related. The following extract refers to client reaction to the 'untreatable' meaning attached to the diagnosis.

17. Notes of those significantly improved. From individual therapy notes. "Disagreed with previous diagnosis of BPD, thinks is post-traumatic stress" (McFetridge et al., 2006, p. 186).

Occasionally this use of the diagnosis meaning something untreatable is constructed as being also utilised by clients with the diagnosis, as in extract 17. Here a connection is made between those clients who 'significantly improved' and client rejection of the diagnosis of BPD. In this case post-traumatic stress is seen as a more acceptable diagnosis by the client. This indicates that in the case of clients who do improve, the diagnosis may be revised to one which contains the possibility of improvement. This is likely to perpetuate the construction of BPD as untreatable, as if the client is successfully treated, he or she did not have BPD. This extract also hints at client recognition of the negative aspects of the BPD diagnosis, and the hopelessness contained within it.

18. they often return for services not long after a successful "closure" (Sussman, personal communication, August 2001) (Koons et al., 2006, p. 146)

Even if treatment is initially effective, there is expectation that people with BPD will not maintain gains. Clients with BPD were described as likely to lose any benefits of treatment that may have occurred, so even if the treatment was initially successful, the improvement was unlikely to last. Extract 18 is an example of this.

The next set of extracts link the construction of BPD as 'untreatable' to a lack of treatment options. This lends importance to the research contained in the articles which discuss a potential new treatment.

19. In spite of this high prevalence among inpatients and their severe symptoms, few options for inpatient treatments are currently available (Kröger et al., 2006, p. 1211).

Services are seen as inadequate and unavailable, with the implication that perhaps if appropriate services could be provided, the difficulty in treating people with BPD could be overcome. This moves some of the responsibility for treatment failure onto the services provided rather than the people with BPD. Extract 19 implies that the existence of a large number of people with severe difficulties should lead to more options for treatment. That 'few' options are available maintains the lack of improvement expected for this client group.

20. Limited access to DBT treatment for community patients with borderline personality disorder is a significant concern, as this form of psychotherapy has shown the greatest efficacy in treating some manifestations of the condition (Sharma, Dunlop, Ninan & Bradley, 2007, p.218).

The idea of untreatable clients is presented in these articles in conjunction with the introduction of DBT as a potentially effective treatment. The idea here is that although people with BPD have become recognised as difficult to treat, new treatment modalities may eventually change that. This elevates the importance of DBT. This enthusiasm is qualified in extract 20, which limits this success to "some manifestations of the condition". The limited access to DBT is presented as of great concern given that DBT is likely to be the most effective treatment for these clients. The proponents of DBT again present this viewpoint as valid, based on evidence. This is achieved through the use of the word "efficacy", implying that measurement of success compared to that of other possible treatment options has taken place.

The difficult client discourse contained several strands, linked by the idea of difficulty for the treating clinician. Difficulty was created by deliberate choice of clients not to

participate in treatment or to behave in unhelpful ways, difficulty liking people with BPD as a group, and the untreatable nature of BPD as a disorder. These meanings contribute to the stigma associated with BPD.

The function of the construction of clients as untreatable removes responsibility for treatment failure from the clinician or service. This maintains the person with this diagnosis in a state of hopelessness and powerlessness. An additional function of this discourse in this context is to promote the importance of research into the area of BPD aimed at improving the situation – namely the research articles comprising the data set.

With the label 'BPD' identified as containing illness and difficult client discourses, which function to maintain the person with the BPD diagnosis as disordered, unlikely to improve, and difficult to work with; an alternative discourse is needed if a more hopeful construction of the person's difficulties is required. This was identified as a discourse of emotion dysregulation. This will be discussed in the next section.

Emotion Dysregulation

The formulation of clients' difficulties being as a result of 'emotion dysregulation' was used almost as a euphemism for BPD, and was clearly linked to the BPD diagnosis (although a wider concept than BPD) in that the articles all used the label BPD, however most then reported that BPD can be thought of as problems with the 'emotion regulation system'. The 'emotion regulation system' was constructed as a mechanistic entity, involved in a process of 'regulation'. The 'emotion regulation system', could moderate emotional intensity when working correctly, and malfunctioned in the case of BPD. The system was constructed as having components, which may malfunction and cause the system to become 'dysregulated'. There are other 'systems' in place for other areas of a person's functioning – cognition and behaviour. Aspects of the individual's environment were linked as causative factors in the malfunction of this system. The next set of extracts illustrates the emotion dysregulation discourse identified in the DBT journal data.

21. BPD is fundamentally a disorder of one or more components of the emotion regulation system (Harned, Banawan & Lynch, 2006, p.68)

In extract 21, the use of the word “fundamentally” presents the explanation that BPD is a disorder of an emotion regulation system as the essential feature of the diagnosis, perhaps removing unnecessary elements. This emotion regulation system is presented as consisting of several components, each interacting with the other so that failure of one or more leads to BPD. This is elaborated on in the next extract.

22. leads to dysregulation across the individual's emotional system, characterised broadly by difficulty in up- and down-regulating physiological arousal as well as difficulty in turning attention away from emotional stimuli (Lynch, Chapman, Rosenthal, Kuo & Linehan, 2006, p. 462)

Extract 22 describes this emotion dysregulation in terms of physiological arousal, constructing this as something which can be turned up or down. The reference to the physical world continues with the use of the word “stimuli” to refer to potentially emotionally upsetting experiences. In the following extract the link to the BPD diagnosis is made.

23. and that problems of dysregulation are associated with some forms of psychopathology, including BPD (McFetridge, Morton & Berg, 2006, p. 183)

In the above extracts the inability to “regulate” was described as problematic. Emotions were constructed as pathological if they are not contained within a range. Extract 23 uses the word “psychopathology” to make this distinction clear, and to link “emotion dysregulation” with pathology. The word “pathology” here means an illness, or medical disorder, the addition of the prefix “psycho-” linking this medical definition to psychological experiences. Here the construct of emotion dysregulation is closely linked although not synonymous with the diagnosis of BPD, which is presented as one of several diagnoses linked with emotion dysregulation.

This ‘emotion dysregulation’ discourse distances BPD from the person or behaviours, and instead constructs it in terms of an underlying mechanism. This functions to provide an explanation for behaviours. It functions to include etiological factors into the meaning of BPD in order to formulate how the underlying mechanism was disrupted. The causes of the ‘emotion dysregulation’ were constructed as originating in the person’s childhood

environment, with both biological and environmental factors relevant. The next extract illustrates this.

24. The borderline individual's intense emotional reactions elicit invalidating behaviour of caregivers, which then elicits further emotional dysregulation, and vice versa. This transaction between an emotionally vulnerable individual and an invalidating rearing environment leads to dysregulation across the individual's emotional system (Lynch, Chapman, Rosenthal, Kuo & Linehan, 2006, p. 462)

Extract 24 refers to the behaviour of “caregivers” as invalidating. This works to create an image of circularity, with the person with BPD and other people (such as parents) influencing one another to perpetuate difficulties. Although this scenario is constructed as leading to emotion dysregulation over time, the origin of the circularity seems to be in the individual (who experiences intense emotions).

25. one partner (the DBT graduate) had experienced significant emotion dysregulation difficulties, but who was now functioning in a more regulated manner and was therefore a better candidate for a couple intervention (Kirby & Baucom, 2007, p.378)

The construction of difficulties being linked to “emotion dysregulation” hints at potential possibilities to help people. The goal of therapy is therefore to improve the ability to “regulate” emotions. This is described in extract 25 which presents the client as having made progress on improving emotion regulation skills, and improving functioning. This progress is described as now enabling the person to make progress on couples’ therapy, which presumably would not have been manageable earlier. The construction of BPD as an illness and emotion dysregulation as a core difficulty provides a description of the target of DBT.

The function of the emotion dysregulation discourse appeared to be to provide a formulation or model for BPD, while avoiding the more punitive or hopeless meanings associated with BPD, such as the idea that the ‘disorder’ is untreatable (e.g. extracts 16-18). It also provides a theoretical framework of what is happening for the person, which in turn provides theoretical background for therapy development. In this set of journal

articles the transition from the use of the term BPD to the term 'emotion dysregulation' was linked to introduction of or discussion of DBT, and functioned to construct DBT as a non-stigmatising therapy.

Summary

This chapter has examined constructions of BPD present in a set of journal articles. BPD was constructed as an illness, located within the individual. It was described as a complex diagnosis, and likely to include co-morbid diagnoses alongside it. This understanding makes sense when considering clinical focus of the articles.

A discourse of difficulty associated with the diagnosis of BPD was present in all the articles. Clients with BPD were described as exhibiting difficult behaviours, which impacted on staff and others around them. The diagnosis was associated with a sense that the clients were difficult to like, and often deliberately choose to behave in an oppositional or non-compliant manner, increasing difficulty for staff and others. The sense of difficulty was increased by a lack of available effective treatments for a disorder constructed by some as untreatable.

BPD was presented as a difficulty with emotion regulation in the articles when discussing DBT. This constructed the problems experienced by clients in such a way that DBT could be presented as based on a theory of emotion dysregulation. Utilising a construction of emotion dysregulation rather than BPD also facilitated a focus on treatment, while acknowledging other understandings associated with the term BPD – in particular the understanding that these clients are difficult.

DBT was introduced in these articles as a promising treatment that was beginning to change attitudes towards BPD, and particularly to introduce the idea that there may be effective treatment options available. The move back to using the term BPD rather than 'emotion regulation' in making these claims constructs DBT as possibly effective in this way. The constructions of DBT itself in the article set will be the focus of the next chapter.

Chapter 6: Study One part two: Constructions of DBT

This chapter examines constructions of DBT in a set of journal articles (described in Chapter Five). The articles contained constructions of DBT which reflected empirical and clinical psychology based understandings of the world, and the range was relatively narrow, as would be expected from such a defined and specific source. These assumptions have not been spelled out by the authors, as they are expected to be recognised and acknowledged as fact by readers. In the whole, the articles focussed on validating DBT and in particular DBT research as meeting the needs of the intended audience, and on presenting their research findings as clinically and empirically valid. It is likely that alternative constructions of DBT could be found in texts such as newspapers, popular media, writings about personal experience, or other texts. This study is by no means intended as an exhaustive examination of what has been written about DBT.

There were three key discourses of DBT identified in the journal article set. The first of these constructed DBT as well researched and empirically sound. The second constructed DBT as based on theory, and therefore with a logical base to interventions. Both of these are unsurprising given the clinical nature of the data set. The final discourse moved away from the 'scientific' discourses, and constructed DBT as a positive experience for clients and clinicians.

Well researched therapy

A prominent discourse was that DBT was presented as well researched and empirically sound, with all articles in the set referring to research supporting DBT. The following extracts illustrate this.

26. Empirically supported treatments that help individuals with chronic difficulties in emotion regulation are few in number, with the most well-researched intervention being dialectical behavior therapy (DBT) (Kirby & Baucom, 2007, p.375)

Extract 26 is typical in the assertion that DBT is the most researched treatment for BPD/emotion dysregulation. Use of the word 'most' constructs DBT as superior to all other

treatments for emotion regulation difficulties and presents DBT as having a good research base. The author does not have to outline the extent of the DBT research base, because it has been presented as the ‘best’ compared to other options. Use of this discourse also constructs the authors as making use of available research and their report as scientifically sound and unbiased.

27. Dialectical behaviour therapy (DBT) can be considered a well-established treatment for borderline personality disorder (BPD) as evidenced by seven well-controlled randomized clinical trials across four independent research teams (Lynch, Chapman, Rosenthal, Kuo & Linehan, 2006, p. 459)

Extract 27 presents the accepted criteria for definition of a good research base, including a number of studies utilising the most accepted research methodology of randomised controlled trials; and conducted by independent research teams. This constructs good research as containing as little subjective influence as possible. The authors’ statement is validated by their use of the word ‘evidenced’, ensuring that their evaluation of DBT is presented as based on objective ‘evidence’ rather than personal opinion or experience. In this extract the BPD diagnosis is presented unproblematically utilising the illness discourse (see also extracts 1-3 in Chapter Five). This ensures the appropriateness of researching DBT as a ‘treatment’ is not questioned.

In the following extracts, the construction of DBT as having a good research base is linked to clinical practice, appealing to the target audience of clinicians and researchers.

28. First, we calculated the effect sizes for changes in depression, anxiety, and anger. As shown in Table 2, a large effect size was obtained for decreasing depression in DBT graduates from pre-test to post-test ($d = -0.86$). To further understand this notable finding, we assessed whether this change was clinically significant (Kirby & Baucom, 2007, p. 383-385)

Extract 28 links findings from the study to clinical practice, noting that the change was assessed for “clinical significance”. The importance of this finding is emphasised using the word “notable”. This linking of the research to practice constructs the research as having potential use or importance in the clinical setting, and the researchers as aware of practical uses for research findings.

29. One of the most researched therapies for BPD is dialectical behavioural therapy (DBT). Randomised controlled trials have found this therapy to be more effective than treatment-as-usual at reducing parasuicidal behaviours, decreasing service usage and improving interpersonal functioning for women who engage in acts of parasuicide and who meet diagnostic criteria for BPD (Linehan, 1991; Linehan, Tutek, Heard, & Armstrong, 1994) (Bray, Barrowclough & Lobban, 2007, p. 1410)

Extract 29 similarly attempts to link research to practice. It constructs DBT as effective in producing improvements to 'real life' concepts such as "improving interpersonal functioning" rather than abstract scores on a measure. Again the type of research thought to be most important is the randomised controlled trial, and other possible types of research are not included in the evaluation of DBT. In addition to the use of RCTs, the subject group is defined in a careful manner – as 'women who engage in acts of parasuicide and meet diagnostic criteria for BPD'. The research is therefore presented as fulfilling the requirements for both research and practice. The work done here to bridge a gap between clinical and research understandings indicates that such a gap is implicit in understandings of what is occurring. The construction of research as contributing to and advancing clinical practice promotes the importance of research of particular design (RCT's in the above extract). The following extract is an example of this construction.

30. However, the development of DBT is an important advancement in the search for an effective therapy for BPD, as it is one of the few therapies for BPD that has been subjected to a controlled evaluation of its effectiveness. (Bray, Barrowclough & Lobban, 2007, p. 1410)

DBT is described as 'advancement' in treatment of BPD because it has been evaluated for effectiveness. This is interesting because this statement does not state that DBT is more effective than other therapies, but rather that it has been subject to controlled evaluation. This constructs the evaluation itself as contributing to the effectiveness of the therapy.

The next extracts expand the discussion of DBT as well researched, and describe the research as having moved forward from initial outcome studies to include component studies.

31. Now that DBT has garnered empirical support in treating BPD, researchers have begun to turn their attention to the mechanisms of change associated with DBT (Lynch, Chapman, Rosenthal, Kuo & Linehan, 2006, p. 460)

Extract 31 presents the first step in evaluating therapy as conducting empirical studies which support the therapy, before examining the therapy to identify which is the active component. This constructs therapy in a mechanistic way, consisting of components which can be isolated and examined separately. There is an assumption that therapy will have several 'mechanisms' which are active components of treatment, still to be discovered and categorised. An established pathway for evaluation of new therapy modalities is constructed– and DBT research is presented as having followed the appropriate pathway without missing any steps. This construction of evaluation process is continued in the following extract.

32. DBT comprises at least a year of individual therapy, group skills training, telephone consultation and a staff consultation group. Research has begun to show therapeutic impact for combinations of some but not all components (e.g. Davidson and Tyrer, 1996). (Sambrook, Abba & Chadwick, 2006, p. 241)

DBT is described as an entity, which is in some way mysterious and needs to be taken to pieces in order to understand it. This constructs DBT both as a whole, and as divisible into component parts, each of which address different aspects of the client's difficulties. Extract 32 constructs these components as individually distinct, and each capable of being researched independently. This ability to regard each component as a separate entity is presented as valid, because it is backed up by 'research', which has examined individual components. The construction of process of evaluating therapy is evident in expectation that research "has begun" to show therapeutic impact for combinations of elements of the therapy. There is an expectation that further component research will continue this process of refinement.

There is a circular logic, when the next section (presenting DBT as based in underlying theory) is considered. Extracts 31 and 32 reflect the underlying empirical assumptions of the research that truth is out there to be uncovered. For example component research may find that a particular component of DBT is effective on its own for treating target behaviour. However in the next section it becomes evident that DBT (and its component parts) is also constructed as having been created, or based on an underlying theory – itself based on a research or observation process. This is an example of rationalism and empiricism interacting in a self-perpetuating cycle. From this perspective, ongoing research and refinement should lead closer to an existing truth.

Based on theory

DBT is presented as specifically designed for people with BPD and suicidality and based on underlying theory of what is occurring for people with BPD. The concept of an emotion regulation system is important, because this describes a mechanism behind the behaviours, and therefore provides a theoretical base for a therapy targeting these behaviours. The use of the ‘emotion dysregulation’ discourse (see Chapter Five) allows for theory to be developed, without the need for it to address the wide variety of meanings associated with the BPD label – for example that the client is ‘difficult’. The following extracts provide examples of this discourse in use.

33. DBT understands problem behaviours in terms of the biosocial theory. The central idea is that people with significant difficulties including self-destructive behaviours, control of emotions, depression, aggression, substance abuse, and other impulsive behaviours often have problems with their emotion regulation system. (Lew, Matta, Tripp-Tebo, & Watts, 2006, p. 1).

Extract 33 constructs DBT as firmly based on a specific theory (biosocial theory) which is then further outlined. The phrase “DBT understands problem behaviours as...” gives DBT itself the status of a thinking entity, entitled to its own understanding of what is happening and reacting in response to this understanding. “Biosocial theory” is narrowed down to the specific theory behind problem behaviours, which is the construction of an emotion regulation system (and associated difficulties if this system malfunctions). The following extract continues the construction of DBT as theory based, adding the concept of progress in theory development.

34. Dialectical behaviour therapy (DBT; Linehan, 1993a, 1993b) and mindfulness-based cognitive therapy (MBCT; Segal, Williams & Teasdale, 2002) both belong to the recently described expansion of the cognitive-behavioral tradition known as third wave (Hayes, 2004; Hayes, Follette & Linehan, 2004), after traditional behaviour therapy and cognitive therapy. Third wave treatments generally include concepts such as mindfulness, acceptance, and dialectics and address the relationship between acceptance and change, often through training in mindfulness skills (Huss & Baer, 2007, p. 17)

The construction of DBT as theory based is enhanced by reference to existing well accepted therapies which have provided the base for DBT. Extract 34 refers to an “expansion” of the cognitive behavioural tradition, implying that this is an advance on earlier models. This progression of advancement began with traditional behaviour therapy, moved on to cognitive therapy, and now the ‘third wave’ includes DBT. DBT is presented as one of several such therapies, which have certain elements in common. This again works to construct DBT as based on sound theory, which other new therapies have also utilised. The commonalities between some of these new therapies are outlined, enhancing the presentation of these therapies as based on common understandings of what is occurring. This listing of common elements is congruent with the idea that DBT consists of components, which are active in some way in treating clients, and based on theory. The next extract refers to one such component of DBT – telephone consultation.

35. DBT telephone consultation capitalizes on many of the operant principles of generalization delineated by Skinner (Lynch, Chapman, Rosenthal, Kuo & Linehan, 2006, p. 471)

Examples of specific elements of DBT that are derived from theories describe these elements as evidence based, because they have grown out of well researched theory. Extract 35 refers to operant conditioning, one of the underlying concepts of behaviourism, and so well established as to be regarded as fact. Few psychologists would question the existence of principles of operant conditioning. The next extract identifies theories behind the conceptualisation of DBT.

36. *In DBT, dialectical philosophy contributes to the conceptualization of the treatment network as a holistic system, involving a dynamic interplay or transaction among the therapist, the patient, and other treatment providers. Behaviorally, the therapist is just as prone to the influence of behavioural principles of reinforcement and punishment as is the patient. With challenging patients, the patient and therapist may transact in such a manner that the patient effectively punishes effective treatment and reinforces iatrogenic behaviour or behaves in a way that directly elicits defensiveness or hostility on the therapist (Lynch, Chapman, Rosenthal, Kuo & Linehan, 2006, p. 474)*

The construction of DBT as impacting on clinicians as well as clients is congruent with constructions of DBT as working holistically, taking into account the whole system surrounding a client. Extract 36 outlines this, and notes particularly that according to behavioural theory, therapists are subject to the same influences as clients. This link to theory validates the statement that therapists may be reacting to client behaviours rather than the reverse. The following extract constructs links between theory and clinical practice.

37. *Understanding dialectical theory is essential to the proposed view of BPD as a disorder of emotion regulation and its treatment as an emotion-focused one. According to the Encyclopedia of Marxism, “dialectics is the method of reasoning which aims to understand things concretely in all their movement, change and interconnection, with their opposite and contradictory sides in unity.” From this brief definition one can see the importance of asking “what’s missing?” in treatment (Harned, Banawan & Lynch, 2006, p. 68).*

In addition to this foundation of behaviourism, dialectical theory is presented as guiding therapy, and is also linked to the understanding of the BPD diagnosis (extract 37). Mentioning Marxism takes the base of DBT beyond psychology to include elements of history and philosophy. This presents DBT as holistic, in that it takes into account the person’s environment and multiple connections and viewpoints, and also recognises these as dynamic across time. This compares with the importance of separating out component parts of DBT for analysis presented in other extracts (for example see extract 32). In itself this comparison is dialectical, in that DBT is presented as holistic

and compartmentalised at the same time, with both aspects having validity, and both based on theory. The construction of theory as vital to clinical practice is continued in the following extract.

38. DBT is a principle-driven as opposed to a protocol-driven treatment. Consequently, a comprehensive understanding of the theoretical foundation of treatment is necessary to ensure both effective and adherent treatment delivery (Harned, Banawan & Lynch, 2006, p. 68)

Extract 38 overtly links the base of DBT to theory, and describes it as based on a “comprehensive understanding of theoretical foundation”. This presents DBT as a therapy provided by skilled therapists, and not simply a set of tasks which could be assigned by someone without the requisite understanding. The theory is therefore important for treatment delivery as well as treatment development. The idea that DBT is based on principles rather than protocol fits with the idea of component parts having been developed to fulfil purposes determined by theory, and also with the existence of an overall theory of how the components work together. This produces a scenario by which a therapist is presented as requiring knowledge, which can be utilised both to adapt and vary the treatment – and to remain true to the treatment.

39. Based on dialectical thinking, DBT involves a synthesis of formalistic universalistic thinking (there is absolute truth) and relativistic thinking (there are many truths; Basseches, 1984) – there is both absolute truth and truth is contextual and always evolving (Lynch, Chapman, Rosenthal, Kuo & Linehan, 2006, p. 474)

Extract 39 refers back to dialectical theory, linking philosophy to the understandings of DBT. This constructs DBT as taking the dialectical theory to the deepest level, including fundamental understandings about existence and truth. This construction links objectivist and constructionist thinking. It challenges the reader to see the truth in different explanations of things, a process which in itself constructs the theory as both valid and relevant to many different situations and people.

The construction of DBT as theory based was not confined to the existence of theoretical background to DBT as a whole, and to its component parts. This discourse also included

a theoretical background to the sequencing and combining of these component parts of DBT in practice.

Sequential and coherent

The next selection of extracts illustrates the construction of DBT theory as applicable to practice. This works in a similar manner to the earlier linking of research and practice within the discourse of DBT as well researched (see extract 29).

40. The pre-treatment stage involves orienting the client to the therapy and obtaining a commitment agreement for therapy. Stage one focuses specifically on reducing NSSI or suicidal behavior and maintaining therapy compliance, as well as reducing distress associated with Axis I disorders. Once the self-destructive behaviors are under control, stage two addresses ways of processing and dealing with traumatic experiences and invalidating environments. Stage three emphasizes developing and maintaining self-respect while synthesizing the skills learned (Muehlenkamp, 2006, p. 171)

DBT consists of several component parts as has been discussed. These are presented as linking with one another in a coherent plan, with a sequence of treatment goals for the client to move through. Extract 40 outlines these stages, which present DBT as comprehensively addressing a wide range of potential difficulties in a client's life. There is a wide overall theory and plan behind DBT in addition to its individual research-based components. The presentation of the therapy in stages promotes the idea of client progress, as each stage is reached, and links to a discourse of the client role being one of progress and improvement in treatment (see also Chapter Seven, extract 49). The following extract provides an example of a treatment programme.

41. In 1999, a 3-month inpatient treatment for BPD was conceptualized according to the guidelines of DBT. A weekly 1-h session of individual therapy integrated validation (acceptance, empathy) and problem-orientated techniques (skill training, cognitive modification, contingency management, exposure to emotional cues). The problem focus of each individual session was determined by a target hierarchy and the patient's behaviour in the target domains. (Schweiger, Sipos, Arnold, Khal, Schunert, Rudolf & Reinecker, 2006, p. 1213).

The sequential and planned nature of DBT interventions constructs DBT as based on theory and also that it is adaptable to fit current clinical needs as long as clinicians have a good understanding of the principles of the therapy. Extract 41 describes an example of DBT being adapted from the original to fit the clinical situation. The therapy is described as “conceptualised according to the guidelines of DBT”, which constructs it as based on a deep understanding of principles, rather than an unplanned use of DBT resources. This treatment also describes a treatment hierarchy, and specific techniques used, again linked to observations of what behaviours the client had engaged in within those domains. The following extracts provide examples of specific DBT interventions within the wider theoretical framework of DBT.

42. DBT skills are taught in four modules. Mindfulness is a core module that cuts across many of the other skill modules and is repeatedly revisited throughout the course of the skills training group. Mindfulness in DBT broadly involves helping the client learn to be fully awake and present to his or her experience of the present moment, participating in the current moment from an open, nonjudgmental perspective, with a focus on effective behavior (“effectiveness”) and on doing one thing at a time (“one-mindfully”). (Koons, Chapman, Betts, O’Rourke, Morse & Robins, 2006, p.147)

Extract 42 describes the content of the ‘mindfulness’ module offered by DBT. Mindfulness is constructed as central to the treatment. This is accomplished by reference to the use of mindfulness within each component of DBT. The description of what is meant by mindfulness attempts to isolate components of mindfulness. This then provides theory and evidence for the likely effectiveness of skills taught to clients.

43. DBT assumes that attention must be paid to effective treatment provider behaviour (Lew, Matta, Tripp-Tebo, & Watts, 2006, p.2)

In addition to mindfulness, other components of therapy are described and linked to theory and practice. The construction of DBT as a holistic therapy is enhanced by the presentation of attention to different areas in the client’s life and includes the environment in which the therapy occurs, taking note of clinician contributions to the interaction. Extract 43 describes clinicians’ behaviour as responding to the same principles as clients’, by treating clinician behaviour as a potential target for attention.

This constructs DBT as taking notice of all potential elements contributing to a given situation or interaction.

44. DBT emphasizes teaching individuals to solve their own problems and navigate skilfully within their own environments. In other words, DBT teaches individuals to do for themselves, rather than have others do for them (Lew, Matta, Tripp-Tebo, & Watts, 2006, p.2)

Extract 44 constructs DBT as a future oriented and client focussed therapy, which will result in autonomy for the client. This last sentence seems to indicate that clients coming to DBT have previously relied on others to assist them, rather than having skills to manage their own difficulties. The word 'navigate' in particular creates an image where the client is now in charge of the direction he or she wishes to go. Using the word 'environment' ensures that the client is not viewed in isolation.

The above extracts have examined the presentation of DBT as a well researched therapy based on accepted theories, which have been integrated into a coherent whole. DBT is constructed as both solidly based on empiricism and at the same time taking account of context and change with the use of dialectical theory. It is presented as both compartmentalised and sequential, and at the same time holistic and adaptable. The two discourses – of DBT as well researched, and DBT as based on theory, created a circularity in which one logically feeds in to the other. Both originate from underlying empiricist assumptions and a relatively unproblematic construction of BPD as an illness and as emotion dysregulation. These discourses function to promote the dominance of medical understandings and the importance of empirical research in understanding BPD and DBT. Use of these discourses effectively silences alternative constructions, for example feminist meanings of BPD or of the role of mental health services. They work to validate the idea of BPD as an illness, the importance of providing adequate treatment, and the elevation of empirical research (and particularly RCT's) in evaluating treatment.

The following section examines a discourse of DBT as a positive experience for clinicians working with DBT. These constructions were less apparent than the presentation of DBT as well researched and theory based. The construction of DBT as

a potentially effective, well researched therapy in itself does contain the assumption that it would therefore be a positive experience for client and clinician.

Positive client and clinician experience

This discourse provided a more human face to the discussion of DBT, although it was not prominent in the sample of journal articles. The following extracts contain examples where DBT is constructed as providing a potential human benefit (in addition to improvement on clinical scales or research measures).

45. All 10 patients reported significant consumer satisfaction with their experience of the programme. Common themes to emerge during follow-up interviews with participants included comments on the utility of treatment (n=8), alternative skilful responses learned to deal with target problems (n=8), achievement of long-term goals (n=5), development of a sense of responsibility for one's own recovery (n=3) and hope and happiness (n=3). (Brassington & Krawitz, 2006, p. 314)

Throughout the articles DBT is constructed as providing positive outcomes for clients however their qualitative experiences are not noted. This reflects clinical psychology's inherent valuing of statistical outcome measurement and empirical design. There were a couple of studies which reported briefly on client feedback. Extract 45 reports on client interviews, and translates these interviews into measurable information as warranted by the empirical design. The number of participants reporting a particular experience is reported. This constructs the experience as divisible into those themes, and measurable in terms of number of people. Despite this quantification of responses, the article reports that all 'patients' reported satisfaction, and constructs the experience of DBT as a positive one. The next extract provides an example from a study using qualitative methodology (focus groups).

46. An unexpected finding of the study was the extent to which the lessons of DBT training had had an impact on participants' personal lives. In particular a number of those involved spoke of how mindfulness training had become important, not only in their clinical work, but also in their daily lives (Hazelton, Rossiter & Milner, 2006,p. 128)

The only qualitative study in the sample presented clinicians' viewpoints about DBT. Extract 46 notes that clinicians reported a large impact on their own lives brought about through their use of DBT. The assumption that a treatment impacts on clients and not clinicians becomes apparent in that surprise is expressed, alerting the reader to the expectation that clinicians would be immune to such effects.

This discourse functioned to promote DBT as worthwhile from a human perspective as well as from empirical or theoretical perspectives. This works to construct the research as valid in addressing potential concerns held by the readers (clinicians) of the articles.

Summary

This chapter has looked at constructions of DBT present in a sample of journal articles. Prominent constructions were that DBT was a well researched therapy, with strong empirical underpinnings. It was presented as based on theory, and as a principle-based therapy which could be adapted to fit different situations while maintaining theoretical and empirical validity. It was described as empirically sound, and also sensitive to context and meaning, recognising the truth in many understandings. It was presented comprised of component parts, each resulting from specific theory, and targeting specific deficits thought to impact on clients, and effective in improving underlying deficits. At the same time it was described as holistic. The use of a dialectical stance to reflect on DBT itself allows for these seemingly contradictory constructions. In this way DBT was constructed as fundamentally pragmatic in orientation, accepting of a variety of ways of knowing.

Although limited constructions of clinician and client experience were noted in the literature, this reflected the empirical or theoretical design of most of the articles. This focus is to be expected in this clinical sample because these values guide admission of research into many of the most prominent clinical journals.

The next chapter will examine clinicians' constructions of BPD, obtained through a series of interviews with practising DBT clinicians. These clinicians are likely to have read literature similar to the sample discussed in this and the previous chapter. In addition to this they draw on their clinical experience as well as other available sources, both clinical

and otherwise and it is expected that the range of discourses utilised may be greater than found in clinical literature.

Chapter 7: Introduction to interview studies and Study Two part one: Clinicians' talk about BPD

This chapter and the following three will report on clinicians' and clients' talk about BPD and DBT. The research question for these studies was the following: What are the discourses of BPD and DBT present in clinicians'/clients' talk?

The research process was essentially the same for clinician and client participants, and will be described here. First I will introduce the participants, describe process issues and ethical issues of the research, and outline how the research evolved. Following this I will describe Study Two part one, which examines clinicians' constructions of BPD, and their conceptualisations of their clients with this diagnosis. Study Two part two - describing clinicians' talk about DBT - will be discussed in Chapter Eight. Study Three, examining clients' talk about BPD and DBT will be presented in chapters nine and ten.

Research Process

This section outlines how this research was conducted, including changes that were made as the research progressed. The undertaking of this research project has spanned four years, and for a variety of reasons the project has changed over this time. Copies of the information sheet, consent form, letter accompanying transcripts, interview schedules and participant feedback sheet are included in Appendices B - H.

When I began this research, my initial goal was to examine language used by clients as they talked about themselves and their experiences of DBT. In addition to this, I intended to collect psychometric information, which would provide measurable evidence as to the effectiveness of the new DBT programme in improving specific aspects of clients' lives. My original proposal therefore, was client based and did not include clinician or literature studies. Difficulties in recruiting client participants (my first approach did not result in any participants) then led me to question the practicality of this design, and to look for complementary studies which would enhance the original client study. I remained determined to attempt to talk to clients as well, because this was a therapy specifically designed for them, and I considered their voices to be extremely important. I decided to approach the clinicians involved in the programme, and to

include their talk about their clients' experiences and their own experiences with DBT. I also decided that a study of discourses present in current psychotherapy literature would provide insight into resources available to practising clinicians.

The DBT Programme

The DBT programme which was the focus of this research is located in a provincial New Zealand city, and is run through the local District Health Board (DHB) mental health service. The DHB serves a population of about 160,000 people. Clinicians involved in the programme took part in intensive DBT training in 2005 and 2006 and have been running the programme since this time. Both adult and adolescent DBT programmes are run, however this research focused only on the adult programme.

The programme closely follows that outlined by Linehan (1993) with some differences reflecting the local situation. The therapy programme consists of weekly individual therapy sessions with a DBT trained therapist, a weekly skills training group run by two DBT trained therapists, and a weekly consultation group in which the DBT therapists meet to discuss their work and provide support and feedback to one another using a DBT framework. Telephone consultation was available to clients with their DBT therapist during work hours and after hours the mental health emergency team (MHET) is available to clients. This is the biggest departure from Linehan's model (which included telephone access to the client's individual therapist after hours), as New Zealand mental health service clinicians are not available for calls out of hours. For a client to complete the entire programme takes approximately one year.

The individual therapy sessions begin with the development of a therapy contract with each client that outlines goals and responsibilities for both client and clinician. Therapy then targets behaviours for change with a focus on skills and generalising these skills across different situations in the client's life. Diary cards are used to record behaviours and skills used. Functional analyses of behaviours occur during sessions to assist clients in identifying links leading up to behaviours. The skills training group focuses on skills needed 'to build a life worth living' and closely follows Linehan's (1993) model. There are four modules, each 6-8 weeks in duration, covering core mindfulness skills, distress tolerance skills, emotion regulation skills and interpersonal effectiveness skills. Two therapists facilitate the group, which is a closed mixed gender group of

approximately eight participants. The weekly DBT consultation group for therapists provides an arena for clinicians to examine their own practice, and to ensure their practice remains true to DBT principals.

The participants

Clinicians were invited to participate in this study if they were involved in the DBT programme (described above) for at least one year. An information sheet (see Appendix B) was mailed to each potential participant, and five clinicians consented to participate. The professional training of each clinician and his or her place of work is not reported in order to protect confidentiality, however they were drawn from a cohort of eight DBT clinicians including clinical psychologists, social workers and nurses. Participants were employed at different services in the DHB including adult mental health, child adolescent and family mental health services and alcohol and other drug services.

Clinicians participating in DBT represent a small number of the clinicians who work in mental health services, and who may have contact with clients with a BPD diagnosis. The clinicians who agreed to participate in this research may have done so for many reasons, including a wish to promote DBT, a wish to assist me in my training, and valuing of research.

Clients were invited to participate in this study if they were participating in the DBT programme described above. The participants were given an information sheet (see Appendix C) about the study by the DBT group facilitators. Two clients consented to participate, one who had completed the first group, and one who was undertaking the second group. Three further participants who participated in a third group also agreed to participate, bringing the total number of client participants to five. In order to protect confidentiality, no further information will be given, other than that the cohort from which the clients were drawn consisted mainly of women, however there were also male participants, with a diagnosis of BPD. Clients accessed the group via their community mental health keyworkers, and all had undergone a psychological assessment determining eligibility for the programme.

Clients who agreed to participate in research are likely to represent those who felt confident in talking about their experiences, and possibly excluded those who may have

identified less positive experiences, who did not value research, or who did not have time available to participate. Those who were offered DBT and declined, were not offered DBT, or those who did not continue with DBT were also excluded.

For ease of comparison between clinician and client participants, I have used the word 'client' to refer to participants in these studies, however it should be noted that this refers to 'client of the DBT programme', and should not suggest a client relationship to myself as researcher.

Informed consent

All participants were fully informed about the study and their rights, both orally and in writing and were provided with the opportunity to raise questions with the researcher. Consent forms were signed by each participant. Participants were informed of the right to withdraw from the study at any time without penalty.

Confidentiality

All materials produced in the course of the research (observations, tapes, transcripts) were kept in a safe confidential place. All of the transcribing was completed by the researcher and names were replaced with pseudonyms. In doing so, the gender of each clinician participant was decided by coin toss and does not necessarily reflect actual gender. Client participants were given female pseudonyms because the overwhelming majority of the group members were female. Lists linking codes to real names were stored separately from the research materials and are accessible only to the researcher. Some details that could identify the individuals have been changed, however the words are those of the participants themselves. This level of confidentiality was required given the small number of participants and the fact that participants were known to one another, therefore additional details (for example clients' histories with the mental health service) were not included.

Transcription

All transcription was carried out by myself and then sent to participants to review. The following transcription notation was used: Pauses were indicated with two brackets (). A short pause was represented as (.) and longer pauses had the time in seconds noted inside the bracket, e.g. a three second pause was written as (3). Overlapping speech

was written inside square brackets [...]. Words with distinct emphasis were underlined. I did not include any other notation in order to preserve the readability of the transcripts.

Potential distress to participants

I was aware that participants in the DBT group are a group of people who are at high risk for emotional distress. Although the potential for distress is always present when conducting interviews, research in this area has not noted significant risks associated with research interviews with chronically suicidal clients. In fact some participants rated reduced levels of distress following interview (Reynolds, Lindenboim, Comtois, Murray, & Linehan, 2006). In order to maintain participant safety the following measures were used:

- A) A protocol for risk assessment was used.
- B) Interviews were conducted by the researcher, who had experience working as a psychiatric nurse, and was undertaking training as a clinical psychologist.
- C) Interviews occurred in a building known to participants, and an experienced clinical psychologist, or the participant's own therapist, was available to participants should they experience distress as a result of the interview.
- D) The focus of the interview was the DBT therapy and the behaviours which led the participant to the therapy. Participants were not asked to discuss topics they wished to avoid.

Sharing of information

Each participant was provided with a transcript of their interview, and given the opportunity to edit this before analysis. At the end of the research participants were provided with a summary of the research findings (see Appendix H). Participants were offered the opportunity to discuss this with the researcher.

Use of information

Participants were informed that results from the study may be published in a relevant journal, and may be used to develop understandings of DBT and BPD.

Ethical approval

The client and clinician studies were approved by the Central Regional Ethics Committee in June 2006, and February 2007, respectively.

Reflexivity

As discussed in Chapter Five, discourse analysis and social constructionist research in general necessarily includes the researcher as a participant rather than an observer of events. In the following clinician and client studies I was present as a participant in the interviews, creating and guiding the questions, and interpreting the responses. My influence included creation of data (in the form of interviews) as well as coding and analysis. It is likely that responses from participants, as well as my own contributions, were influenced by the factors described in Chapter Five, as well as the clinical setting in which interviews were conducted, and the likely desire of participants to present themselves and the DBT programme in a positive light and to assist me with my research goals. Selection of interview participants was likely to include bias towards clinicians and clients with favourable experiences of DBT, and in the case of clients – those who felt comfortable enough to participate in a research interview. There are likely to be many alternative discourses not utilised by participants in these studies. As discussed in Chapter Five discourse analysis notes that meaning is always created in context. The following analysis should be read with this context in mind.

Study Two part one: Clinicians constructions of BPD

This section presents analysis of clinicians' talk about BPD. The clinicians utilised three main discourses in talking about BPD. The initial reaction to the label was a negative one, utilising a 'stigma' discourse. Clinicians constructed themselves as aware of negativity associated with the diagnosis. Secondly, they utilised a 'making sense' discourse, which presented BPD as a useful means of conceptualising their clients' difficulties. Thirdly, and similarly to Study One, was the discourse of 'emotion dysregulation', which was preferred over the BPD label.

Stigma

The 'stigma' discourse contained constructions of BPD as carrying negative connotations. The clinicians talked about punitive or otherwise negative meanings

attached to the diagnosis of BPD, however located themselves as now not accepting of these meanings, although they may have done in the past. The discourse continued to function as an expected or commonly understood set of meanings attached to BPD. The following extracts illustrate this discourse.

47. Alan: you know like it's all very well saying "let's not (.) give labels let's not pathologise" (.) but in the meantime what do we do (.) what and I guess what I see among those who present with borderline personality disorder perhaps more than the other ones (.) is such distress such huge levels of distress and like a (.) a um sort of like an urgent imploring "help me"

In extract 47 Alan notes problematic use of the BPD label, identifying an awareness of an associated – and unwanted - stigma discourse. In this example he articulates a difficulty of how to categorise a group of people (those with BPD) without resorting to the stigma discourse inherent in the label. He notes that although the label carries unwanted meanings, his experience highlights a need to categorise this group of people somehow so that appropriate help can be offered. This need to provide help is highlighted through the portrayal of distressed clients begging for help.

In order for these ideas to be presented, Alan illustrates his claim with extracts from others' talk in a process of 'active voicing' (Wooffitt, 1992). This means that the speech of others is reported as if heard at the time, which demonstrates that the ideas Alan is putting forward are not his alone and he is basing his statement on evidence provided by others. The effect of active voicing is to present the kinds of things others (clinicians or clients) typically say, and brings a 'typical' clinician or client into mind, rather than citing a specific instance. It produces a sense of consensus, because others are reported as having made similar comments. This makes the statement difficult to refute and works to construct events as typical or routine. In this example a typical clinician is presented as advocating avoidance of the label BPD. Alan locates himself as observing the stigma discourse from a distance, however aware of its presence, and potential influence on clients. This recognition of negative meaning is also apparent in the next extract.

48. Tony: It's a scary diagnosis I wouldn't like to be diagnosed with it ((laugh)) I've had changing attitudes during this course

In extract 48 Tony's description of the diagnosis as "scary" connects the diagnosis with the emotion of fear. The reflection that his attitudes have changed during the DBT training suggests that he now constructs himself as thinking differently about the diagnosis than previously, however his acknowledgement of 'fear' connected to the BPD label suggests that it continues to carry negative connotations. Perhaps the current fear relates to his knowledge that the stigma discourse exists and can impact on those receiving the diagnosis.

In the previous two extracts, the clinicians spoke of the stigma discourse from a distance, however in the following extract, Tony speaks about his past negative experience, and presents this as fact (as experienced by him at the time).

49. *Mel: so you were getting this client ringing up all hours of the day*
Tony: yep oh yeah lots of crisis (1) just a real mess and not getting better
Mel: yeah
Tony: just way too much contact for one clinician to manage
Mel: mm
Tony: yeah (.) quite demoralising as well

In extract 49 Tony relates his past negative ideas about BPD to a difficult experience working with a client. He links his distress to the perception that the client was not getting better. Using the word "demoralising" he describes the experience as impacting on his sense of control over what was happening, and therefore reducing his sense of efficacy as a clinician. He uses this example to categorise his experience working with clients with BPD. In this way the negativity associated with BPD is extended to include Tony's experience working with these clients. He distances himself from current alignment with the stigma discourse, by virtue of the account being about past and not current experience.

Billig (2001) writes that analysis of what is challenged or presented as common sense can provide clues as to what is considered to be universally accepted. Here Tony alludes to an expectation that his role as clinician involves healing, while the position of

client involves being healed, or “getting better”. Tony draws on a discourse of clinicians as healers, which is threatened by clients with BPD who do not fulfil the expected client role (compare Chapter Five, extract 11; Chapter Six, extract 40). These discourses are not discussed here, due to the narrow focus of this thesis on discourses of BPD and DBT, however there was an unspoken agreement that the role of clinician involved healing, and that of client included improving with treatment. This was threatened by the behaviour of people with BPD. The following extract links the pejorative use of the BPD diagnosis to the ability to provide treatment.

50. Mike: where (1) earlier earlier (.) in my work at this hospital when we didn't (.) have so much ability to offer appropriate treatment for (.) those clients (.) it was a diagnosis that seemed to get used pejoratively a lot of the time

Mel: mm

Mike: and (.) it would also be used to deny treatment to clients (.) for example that well this is a personality disorder and we don't treat personality disorder or personality disorder can't be treated

In extract 50 Mike talks about his experience of the diagnosis before the introduction of DBT, and links the lack of ability to provide treatment to the pejorative use of the diagnosis. This again alludes to an unspoken discourse of therapists as healers. Without the ability to fulfil the healing role – the act of giving the diagnosis has no use other than to label a difficult client group, and exclude them from treatment. This extract indirectly promotes DBT, which now seems able to offer something to a group of people previously excluded from treatment. Mike's talk is an example of how language can contain almost contradictory ideas in the same section of conversation – he notes that there was no ability to provide treatment and at the same time his use of the word 'deny' implies that the clients were being deliberately refused something which they should have received. This construction of deliberate refusal contradicts the 'common sense' understanding of clinicians as healers, and as serving the client group.

Mike also distances himself from current alignment with the stigma discourse by placing the description of negative meanings associated with the BPD diagnosis in the past tense. In doing so he positions himself as aware of the existence of the discourse, and

past impact of it. Clinicians also constructed clients as aware of the stigma discourse, as the following extract illustrates.

51. Rachel: it can (.) also put some clients kind of (.) you know right offside (.) if you try and diagnose them with it

Mel: mm

Rachel: um given their host of negative experiences with that particular diagnosis within [the mental health system]

In extract 51 Rachel constructs clients as recognising the stigma discourse associated with BPD. She elaborates by stating that clients can become upset and angry when given this diagnosis because previous experience with mental health services has caused them to link the diagnosis with negative treatment. This reaction suggests some resistance to the negativity of the label.

The stigma discourse contained elements of negativity directed at people with BPD. The diagnosis was described as frightening and demoralising for clinicians, and unacceptable to clients. In addition to this, clients with BPD were presented as unlikely to improve – and probably untreatable. Associated with this were references to BPD as a challenge to unstated assumptions about the roles of clinicians as healers, and clients as being healed. This discourse bears similarity to the ‘difficult client’ discourse identified in Study One, however in clinicians’ talk the emphasis was on their individual (emotional) experiences working with clients, and discussion of how this was experienced by clients, compared to the journal articles, which presented the difficulty in a more detached manner.

The stigma discourse functioned to validate clinicians’ difficulty working with clients diagnosed with BPD – and to normalise this discomfort. Clinicians distanced themselves from the stigma discourse, by presenting themselves as aware of it rather than in agreement with it, and by utilising past rather than current accounts of difficult interactions with clients. Clinicians associated this distancing of themselves from this discourse with their training and experience with DBT. This had the effect of promoting the importance of DBT and also constructing themselves as having more understanding of their clients than they previously had (and than other clinicians continue to have). In

describing themselves as having moved from previous beliefs through training, they also constructed these previous beliefs as understandable at the time. This functioned to place the blame for stigmatising beliefs on the context, rather than the clinicians (including current non-DBT trained clinicians) expressing them, and constructed these beliefs as changeable.

Despite the recognised existence of the stigma discourse, the clinicians also spoke of the BPD diagnosis as useful in making sense of what is going on for clients. This will be discussed in the next section. In extract 47 (earlier in this section) as well as noting the presence of a stigma discourse Alan speaks of the need to diagnose because of the distress he observed in clients with BPD. In doing so he implies that by giving a diagnosis he will be more able to reduce that distress. He alludes to a discourse of sense making - that giving a diagnosis can assist in understanding the client's situation and lead to effective treatment. This acknowledgement of two opposing discourses was common in the clinicians' talk.

Making sense

The 'making sense' discourse was identified as the ability of the diagnosis to provide a formulation about what is occurring for the client, which could assist in providing appropriate help for that person. The making sense discourse constructs the BPD diagnosis as providing a framework of understanding for both clinician and client. This could have both positive and negative effects. The next set of extracts illustrates the construction of the BPD diagnosis as helpful in making sense of client difficulties.

52. Mike: it's useful to be able to give a diagnosis to help you think about what it is that you're working with

Mel: mm

Mike: and I probably (.) now that I'm working in a DBT framework and that we are able to offer the group and individual therapy so able to offer (2) you know a pretty much a full DBT programme then I find it useful to be able to give that diagnosis and to organise my thinking about the client and around treatment for the client

In extract 52 Mike presents the diagnosis as helpful in thinking about the client's difficulties, because included in the meaning of BPD is a formulation of what is likely to be happening for the client. He then explicitly links this usefulness to the ability to provide treatment for problems conceptualised in this way. This compares to previously (before DBT) when the diagnosis may have been less useful because it would not have suggested a treatment option. The validity in providing a diagnosis is directly related to the ability for that diagnosis to suggest effective treatment.

53. Rachel: what had happened is at one point (.) or at various points she had been diagnosed with (.) borderline personality disorder (.) um (.) and (1) she had done some kind of reading (.) and (.) thought that (.) DBT as a treatment could be an effective kind of thing for her to to receive (.) and I'm not sure if that was kind of of her own initiative

In extract 53 Rachel describes how the labelling of experience as BPD had prompted one client to take action to find a solution for her difficulties. In this way receiving the diagnosis is seen as a catalyst for positive change, because it can now be linked to a specific treatment. This client's use of the diagnosis to 'make sense' of her experience and to seek help based on this new understanding is an example of the potential usefulness of the diagnosis. The understanding of the 'therapist as healer' and 'client as being healed' is maintained in this example.

Although the making sense discourse was presented as assisting both clinicians and clients to access appropriate treatment, clinicians also constructed this aspect of the diagnosis as potentially damaging. In doing so they presented the diagnosis as both helpful and harmful. The following extracts provide examples of this.

54. Alan: the other thing I've noticed is that (.) it's not new but I just notice it directly in my work with clients (.) is for some clients (.) it becomes almost like a relief (.) to know that there is something that they can look at (.) and attribute a cause to (.) that's both a good thing and not such a good thing because I know we live in a society where we seek causes to things (1) even if those causes are unknowable (.) sometimes yeah we we we're satisfied when we come up with what might seem to be (.) an acceptable explanation

for our behaviour (.) and it may or may not be true it's like that reified it's turned into something real and it may or may not be true

In extract 54 Alan observes a sense of relief in his clients who have been given the diagnosis, and describes this as giving the clients an explanation for their experiences. He then takes a dialectical stance, looking at both the good and the bad aspects of this sense of relief. Alan's statement is an example of 'dilemmatic' talk, which contains contradictory ideas, presented as two reasonable sides to an argument (Billig, 2001). This presentation of being able to see the validity in both sides of an argument is in line with the philosophy of dialectics inherent in DBT itself. In doing so Alan also does work towards constructing himself as able to examine the validity in different arguments, and presents himself as a reflective practitioner. The client's relief is presented as positive because of the associated reduction in distress. On the other hand Alan discusses the possibility of the client's use of the diagnosis almost as an excuse for behaviour, or as a reason for behaviour. In this way the diagnosis can create pathology by suggesting a cause and negating other potential explanations for behaviour.

Alan's comments present him as aware of the power of language to create meanings, and at the same time he describes this as potentially unhelpful if the created meanings do not match what is 'true'. This creates some ambiguity around 'truth' created in discourse, and a parallel 'truth' which may or may not coincide. His final sentence '*turned into something real and it may or may not be true*' in particular works to validate both social constructionist and empiricist understandings, as it is possible for things to be both 'real' and 'not true'. In the following extract, Anne also utilises a making sense discourse as she describes how utilising a diagnostic label can impact the person accepting that label.

55. Anne:... *and (.) you know if you think about I don't know how familiar you are with the ACT acceptance and commitment therapy stuff if you think about what they say about clients we need to go through sort of like the de-literalisation process so if a person says (.) instead of saying um I've got clinical depression they say I'm a person who has*

Mel: *ok*

Anne: depression or depressed mood or whatever (.) she's into the whole (.) the opposite of that where it's you know I've got an eating disorder and I've got this and I've got that and

Mel: so you kind of become those things really

Anne: yeah they are really reified and of course when you do that none of it's your responsibility

In extract 55, Anne refers to another therapy modality, Acceptance and Commitment Therapy (ACT) to highlight the ability of labels to create entities, which might otherwise not exist. She notes a potential for the use of language to create 'realities' for clients, which can influence behaviour and clinical presentation in a negative way. Here the use of a diagnostic label is described as suppressing alternative (non-medical) explanations for experience. This has the effect of creating an illness identity, which in turn enables the client to avoid responsibility. From an ACT perspective, a goal of therapy is to try to separate language from experience, so that the client can notice her own experience rather than take up the position suggested by the diagnosis (with associated behaviours). In referring to ACT rather than presenting this as her own opinion, Anne is positioned as basing her discussion on theory, which has the effect of presenting her as professional and aware of different psychological theories.

The 'making sense' discourse contained the idea that the diagnosis could assist clinicians to conceptualise their clients' difficulties helpfully. Clients could experience relief at an explanation that fitted their experience. A sense of having an explanation could however prevent clients from accessing alternative possibilities to help themselves.

Contradiction was a prominent feature of the meanings attached to BPD. Clinicians often utilised the stigma and making sense discourses in the same section of talk. The following example illustrates this point.

56. Mel: what do you think about the diagnosis of borderline personality disorder?

Alan: I think it's (.) ridiculous

Mel: yeah

Alan: but probably necessary

The clinicians described the BPD label as containing contradictions, including positive and negative aspects. Extract 56 illustrates this contradiction as Alan uses the word “ridiculous” to indicate negativity associated with the diagnosis, however then immediately qualifies this with the idea that it is necessary. His initial statement ‘ridiculous’ presents an emotive judgement of the label, his ‘gut reaction’ to it – that the whole diagnosis is somehow flawed – and links to his awareness of the stigma discourse. This is followed by the opposite idea – of usefulness, and filling some kind of necessary role. In doing so he alludes to the existence of contradictory discourses of BPD (see also extract 47).

One of the potential negative aspects of ‘making sense’ through receiving a diagnosis – is that clients may assume the associated illness role (and possibly take on expected illness behaviours). The responses of mental health services were constructed by clinicians as potentially playing a significant role in causing pathology. This presentation of mental health services and other influences in peoples’ lives as potentially worsening difficulties will be discussed in the next section.

BPD as environmental response.

Several clinicians constructed BPD as at least partially a consequence of the interaction between client and the clinical environment - indicating that treatment provided could worsen symptoms and behaviours rather than improving them. This discourse also formulated the understanding and expression of BPD as strongly influenced by other societal factors such as cultural expectations. The following extracts illustrate the construction of the mental health system as potentially contributing to development and expression of BPD.

57. Rachel: I also kind of have some theories about some of the iatrogenic aspects of our

Mel: aha

Rachel : hospital environment and what that does to a lot of people (.) um (.) to (.) increase the degree of kind of presenting problems that they demonstrate when they kind of been referred for DBT (.) um you know things

like (.) um inappropriate diagnosis kind of in the early (.) early stages or inappropriate kind of assessment of their (.) constellation of difficulties

Mel: so what would [what]

Rachel: [umm]

Mel: would be an example of an inappropriate diagnosis

Rachel: well you know clear (.) clearly lots of people have come into the service with high levels of emotional disturbance

Mel: yeah

Rachel : they might be (.) typically they'll be diagnosed with (.) um major depression (.) um and they will be promised a cure

Mel: mm

Rachel: they're given an antidepressant (.) the antidepressant doesn't work (.) they're given

Mel: another one

Rachel: another one and multiple medications then their diagnosis might kind of change from depression to bipolar disorder because of their level of emotional dysregulation (.) um then they'll go down all of the medications for bipolar disorder

Mel: yep

Rachel: promised that (.) none of them work and (.) then at the end of that course of broken promises (.) we end up with a client with kind of quite severe (.) levels of self injury

Rachel describes a scenario in which clients receive “inappropriate diagnoses” and indicates these provide the client with false expectation that medications will provide a cure. This ‘promise’ of a cure is important in the exacerbation of distress because it links with an illness discourse, and effectively removes alternative explanations which could have potentially suggested more effective responses. The evidence that none of the medications work indicates that this presentation of ‘illness’ was ultimately incorrect.

Rachel links the experience of broken promises to “high levels of self injury” constructing the client experience of mental health services as causative of self injurious behaviour. Her description of a ‘typical’ scenario presents the idea that this process is occurring repeatedly, as clients come in contact with mental health services and work their way

through a process of becoming labelled with BPD; in the process the client is described as exhibiting more distressing behaviours in response to mental health intervention. The series of diagnoses received – depression, bipolar and eventually BPD - are linked to emotion dysregulation, creating a scenario that the clues were there all along that the client's difficulty would be best described as BPD (here the diagnostic label most synonymous with emotion dysregulation – the emotion dysregulation discourse in clinicians' talk will be discussed next). This account of a typical journey occurring as a result of contact with mental health services places accountability for pathology on the shoulders of the mental health service. The following extract occurred later in the same section of talk.

58. *Mel:* mm so they're kind of been taught to be (.) unwell?
Rachel: well I'm not sure if they're taught to be unwell um (3) or maybe the environment becomes kind of invalidating in some way for them
Mel: because of the continuous broken promise
Rachel: the continuous broken promises and um possible what it also does is (.) what does it do it (1) umm (1) it actually tells them that the cure or the solution to their problems lies outside of them
Mel: right
Rachel: and so they're always kind of externalising (1) the source or the answer to their difficulties outside of them selves and they're not able to kind of dig deep enough to find (.) any solutions kind of from the inside really (.) yeah

In extract 58 Rachel uses the word “invalidating” - also used when describing the impact of early childhood experiences to elaborate on her statement that interaction with mental health services can create problems. According to this construction, the framing of the client as unwell prevents him or her from accessing alternative explanations for what is happening, and therefore from accessing inner resources to manage difficulties. This is congruent with Anne's comments about how an illness label can allow the client to avoid taking responsibility, or perhaps maintains the client in a dependent state (extract 55).

The above extracts have outlined the clinicians' constructions of the how diagnostic labelling and/or engagement with the mental health service can impact on client

presentation, including potentially worsening the situation for clients. The potential for diagnostic labels to have an active role in pathology, including influencing the development and maintenance of difficulties, is recognised by clinicians. In doing so the clinicians construct themselves as in tune with their clients' realities, and reflective in their practice. The mental health service can be seen as a subset of wider societal understandings, and expectations for behaviour (including illness behaviour).

In addition to the impact of the mental health service environment, some of the clinicians mentioned the influence of social and cultural norms on the understanding of behaviours. This broadens the discourse of BPD as environmental response to include environments outside that of the mental health system. The next extracts provide examples of this, and illustrate clinicians' constructions of how understanding and expression of behaviour can be influenced by context and environment. They note cultural influence on how behaviours are understood and interpreted. In doing so they construct themselves as aware of meanings as changeable and context specific.

59. Alan: who determines when emotions are getting out of hand is very culture bound (1) and even down to being family bound

Alan's statement that when emotions are "getting out of hand" is "culture bound" works to construct boundaries between behaviour defined as normal and abnormal as fluid and context bound. In the following extract, he refers to generic 'societal messages'.

60. Alan: so either they're wanting to um (.) they're not wanting to be the way they are (1) because all the feedback is "you're no good the way you are" (.) subtle or otherwise

In extract 60 Alan describes clients as wanting to change because of feedback from others. In this description the client is compelled to seek treatment because of societal labelling of their experience or behaviour as pathological. He presents this societal evaluation as sometimes hidden, with his comment 'subtle or otherwise'. He uses the first person to describe the message the clients hear, which increases the extent to which the listener can empathise with the client, and is an example of active voicing - presenting what a 'typical' client might hear. This presentation of "all" feedback received

by a typical client being negative constructs the social environment as responsible for promoting pathology. The following extract provides a construction of how behavioural expression can be influenced by social expectations.

61. Anne: over time these clients behaviour has changed and once upon a time they might pretty much only self harm whereas now (1) there's a lot of violence and our society generally has a lot more toleration of violence so we can expect many mental health clients and general side clients to be more violent so we need to have that catered for

In extract 61 Anne constructs societal values as impacting on clients' behaviour. She includes "general side clients" – referring to clients of medical or surgical services - to comment that violent behaviour is not limited to mental health clients. Society's tolerance of violence is portrayed as leading to an increase in this behaviour, whereas "once upon a time" society did not condone violence and (as a result) clients did not present with the same level of violent behaviour. This constructs society as prescribing rules of acceptable behaviour, which influences expression of distress. It also constructs these societal rules as changeable over time.

62. Anne: and they're still and I think this comes back to that phenomenological empathy place (.) there needs to be that understanding about (.) um (1) if people are emotionally dysregulated and they live in a certain kind of society then they often are violent not just suicidal

In extract 62 Anne links the expression of "emotion dysregulation" to societal expectations (the 'emotion dysregulation discourse will be discussed next). She suggests here that societal values can influence a person with emotion regulation problems to behave violently (as she also does in extract 61). Societal values are presented as both influencing the meaning of behaviours (as in Alan's comments, see extract 59) and also impacting on the behavioural expression of emotional distress.

Although the clinicians used the 'making sense' discourse associated with the BPD label to assist in case conceptualisation, they were aware of the inevitable intrusion of the stigma discourse when using the term 'BPD', and described a potential risk that 'making

they have the high reactivity and then the vulnerability also means they go straight up whereas we might (.) have a stimulus and go up to a four they'll be up to a ten

Mel: mm

Anne: and then the dysregulation means they can't regulate themselves down

Mel: so they stay at ten for longer

Anne: yep so that's when they go into that pendulum and try to avoid emotion become quite emotion phobic

In extract 63 Anne is asked to elaborate on her use of the term emotion dysregulation. She describes emotion in terms of a thermostat, creating a link with physical properties (such as heat). This is an example of a metaphor providing a shared understanding of emotion (Edwards, 2001). A mechanistic entity of an 'emotion regulation system' is constructed, which includes a trigger, high reactivity to the trigger, and a long period of time at '10' on the (measurable) reactivity scale. Anne uses multiple references to physical sciences in her explanation, for example 'thermostat', 'stimulus', and 'pendulum'. 'Emotion dysregulation' is presented as emotions being at the extreme ends of the thermostat or pendulum, while more 'regulated' emotion might be measured in the mid range of the thermostat, or a more gentle swing of the pendulum.

Although Anne does not overtly state that the experience of dysregulation is abnormal, she uses the word 'they' to refer to people who experience this kind of difficulty, and compares them to 'we' referring to current (presumably normal) participants in the conversation. Although in doing so Anne separates the clients from 'normal' people, she also links them, with the idea that the reactivity and emotional arousal occur for all, but occur to a greater degree and for longer in 'dysregulated' people.

The term emotion dysregulation was used to present the idea of emotion as desirable to be experienced in moderate levels (or regulated levels) only. In describing emotion in this way, the experience of unregulated emotion is constructed as disturbing and frightening. There is fear associated with excesses of emotion, hence the need to regulate. This fear of emotion is described as extreme, to the point where clients will avoid all experiencing of emotion, creating an all or nothing scenario (pendulum). The

clients seek to avoid emotion to the point of “phobia”. The following extract provides a conceptualisation of how such an emotion fear, and emotion dysregulation could come about.

64. Anne: and you see the baby (.) learning to regulate through the mother as external mother as external regulator and you see the mother sort of still frames (.) the mother smiles and you see people doing it and how they do these exaggerated smiles and then they (.) reduce them (.) but it's all so quick you don't see it if you didn't see it in these still frames (.) and baby's learning that oh I have an emotion (.) and I let it get a bit more and then it goes down so the baby's imitating that (.) but if babies don't have good attachment relationships or if they're disrupted by trauma (.) they don't (.) watch those skills and learn them and um (.) I mean some of it's about modelling and some of it's (.) about that getting a response when (.) when they're starting to dysregulate

Mel: mm

Anne: so then the infant can get dysregulated it's just not attended to (.) and then that's another really powerful way of learning at a pre-cognitive level that emotions are scary 'cause (.) you're on your own and it's like this big black hole

In extract 64 Anne explicitly links early childhood experiences to development of emotion dysregulation. She presents a scenario where a baby learns emotion regulation skills by observing the mother's responses. She links this behavioural learning perspective to the development of emotion dysregulation problems, stating that if the baby does not receive a response he or she learns that “emotions are scary”. The use of first person in describing the baby's experience personalises the more clinical description she begins with, and her language becomes more descriptive and emotive as she describes the experience from the baby's perspective, noting especially a link between emotion and fear. Her explanation draws on attachment and behavioural understandings of parent-child interactions, rather than biological or socio-cultural explanations. In this extract Anne also constructs emotion dysregulation as a skills deficit, which is congruent with DBT theory and will be discussed in the next chapter.

Emotion dysregulation experienced by all.

The construction of BPD as emotion dysregulation provided the opportunity for clients with the BPD diagnosis to reject the illness discourse. The emotion dysregulation discourse provides an explanation for difficulties, without creating the split between normal and abnormal present in the illness discourse. 'Emotion dysregulation' is constructed as experienced by all, not only by those with BPD. The idea of 'normality' relates to social norms, and clinicians presented their clients' behaviour as understandable given these expectations, rather than discussing them in terms of biological illness.

Clinicians defended against possible intrusion of the illness discourse by noting commonalities between clients' experiences and their own. The following extracts are examples of positioning against this counter position (of illness), through promoting the idea of common humanity, or shared, non-pathological experience. Billig (2001) notes that statements often carry a rhetorical meaning (here the need to defend against the illness discourse), which can be accessed by examining the context of the conversation, here a discussion of emotion dysregulation problems.

65. Alan: *um (1) there's such (.) um (1) emotionality and being human go together*

66. Alan: *I look at some of my own reactions to things in my own life (.) and I because of my interest in mindfulness (1) I really think humans are basically all the same (1) and when a client comes in and says to me something like (.) I lost it last night (1) I can relate to that maybe a different context maybe less extreme (.) I know what it's like to feel so suddenly surprised by something and or angry (.) that my mind goes blank*

In extract 65 Alan links emotions to being human. In doing so he presents the experience of extreme emotion as common to all humans, not just those with BPD. This is validated by his identification of similar experience in his own life, where he describes humans as 'basically the same'. The difference between the client's experience and his own is one of degree, rather than a difference in type of experience (extract 66). The

following extract notes that clinicians can also experience problems in tolerating their clients' emotional responses, again constructing emotion as a common experience.

67. Alan: *Marsha Linehan um demonstrates a lack of fear (.) regarding human emotion (.) human emotion in in sometimes is in it's um (1) most horrific form (.) like how bad must things be when someone goes away and harms themselves*

In extract 67 Alan also talks about Marsha Linehan as recognising common humanity, using the words 'human emotion' but then goes on to talk about this emotion at its most extreme. There is a construction of clinician empathy, and attempt to understand how a self harming or suicidal client may feel. This construction of understanding is continued in the following extract.

68. Anne: *that's why that's why their emotions are so unpleasant for them because (.) if you think about times when you might have got really really incredibly angry*

Mel: *mm*

Anne: *or really sad maybe somebody's died or (.) lost a relationship or something if you think about how bad that feels that's what it's like for them when they have an emotion (.) but they're like that with*

Mel: *any*

Anne: *any emotion with any kind of trigger*

Anne's comments link people with BPD to 'normal' people, while at the same time maintaining a distinction between the two groups (as also occurs in extract 63). She creates a scenario in which she talks about events which are very distressing emotionally, and for which an extreme emotional response is constructed as 'normal' and not necessarily a problem with emotion dysregulation. She mentions death and loss of relationship as examples where extreme emotions would be warranted and normal. She ensures that the strength of the emotion is described as extreme, using the words 'incredibly angry' and 'really sad'. She then distances the client population from 'normals' by stating that all emotions are experienced by 'them' at that level of intensity, regardless of the significance of the trigger. So although the experience of emotion is

common, in the case of the client with emotion regulation problems, this intense experience occurs even with minor triggers (extract 68).

A key aspect of the emotion dysregulation discourse, was that as a conceptualisation of what was occurring for clients, it could also provide clues as to what might be helpful to address the clients' difficulties. The discourse functioned to construct BPD as a solvable problem – a malfunction in the emotion regulation system, and provides a theoretical framework for therapy. This relates to the 'DBT as based on theory' discourse identified in Study One (Chapter Six). This aspect of the emotion dysregulation discourse will be discussed next.

Emotion dysregulation concept provides suggestions for therapeutic response

The construction of difficulties as emotion dysregulation was used by clinicians to explain to clients why DBT might be useful for them. This had the effect of presenting DBT as appropriate because of a strong theoretical base, which could explain the client's experience, and suggest an appropriate therapeutic response. The following extracts provide suggestions for therapeutic response (here DBT skills).

69. Anne:... if you have this emotional dysregulation problem then often you tend to have (1) um (.) problems in relationships because of your what do you do in relationships what happens with your moods how do they affect people around you do you think you know that sort of thing you get them to see (.) and then that way they get to see that oh yes I do have chaotic relationships um or where you can say what about emotion regulation this is where I think the skills would be useful for you do you think they would be? Do you have problems terminating painful mood states or sitting with them or changing their mood once it is there things like that

In extract 69, Anne explains how she would talk with clients about their difficulties, using the idea of emotion dysregulation to create a shared understanding of what has been happening for the client, and to promote the value for the client of participating in DBT, and in particular the usefulness of DBT skills for the client's situation. She uses the first person to convey the client as understanding experience according to this

conceptualisation. In doing so she uses more lay language of 'painful mood states' rather than the clinical term of emotion 'dysregulation' (in describing herself talking to clients). In utilising the term 'emotion dysregulation' rather than 'BPD' in talking to me (the interviewer) the stigma discourse is avoided. The existence of 'emotion dysregulation' was presented by all the clinicians as the criteria for admission to the programme, rather than a diagnosis of BPD or a history of suicidal or self harming behaviours.

70. Tony: yeah um (.) the criteria is like people with the emotional dysregulation bit (.) um how do we decide it once we've received the referral is it's discussed in the consult group (.) then (.) they get assessed and that's by a psychologist (.) and they have various assessment tools

In extract 70 Tony identifies emotion dysregulation as the target of the DBT programme, and the criteria used to assess eligibility for the programme. Tony constructs this assessment as accurate by identifying that it is more than one clinician making the assessment, that the assessment is made by a psychologist (who has presumably been trained in such assessments), and that assessment tools are used rather than relying on individual clinicians' judgements.

The emotion dysregulation discourse functioned to provide a formulation of the clients' difficulties (the making sense aspect of the BPD diagnosis) without including stigmatising meanings associated with BPD. In providing an explanation for behaviours, it also functioned to promote DBT as logically the best treatment for the clients.

Summary

This chapter has examined constructions of BPD in clinicians' interviews. The BPD diagnosis was constructed in a variety of ways. Clinicians indicated that the diagnosis could be useful if used appropriately, but this also carried negative connotations, linked to a 'stigma' discourse. These negative aspects of the diagnosis were described as being used by other clinicians or by themselves prior to learning about DBT. Several clinicians constructed the diagnosis as a complex combination of useful and potentially damaging. The way they discussed their thoughts about the diagnosis involved

presentation of both good and bad aspects of it. By doing so they mirrored a process of dialectical thought, or finding the synthesis between two opposing viewpoints.

Positive aspects of the diagnosis included the ability to summarise a set of client difficulties under one label, which could guide treatment. This was associated with a 'making sense' discourse. The 'making sense' discourse also carried the potential negative consequence of suppression of alternative explanations for client experience. This was described as reducing the client's ability to access inner resources because of a perception that help must come from treatment of 'illness' by others.

The mental health service (prior to DBT) was constructed as creating greater pathology in clients seeking help. This was described as resulting from reinforcement of a sickness role, giving labels which carried connotations of disorder. Society in general was also discussed as influential in the presentation and maintenance of disorder.

All five clinicians utilised a discourse of the clients' difficulties as resulting from 'emotion regulation problems'. This term was preferred over 'BPD', and represents an attempt to retain positive elements of 'sense making' while avoiding the 'stigma' discourse. The 'emotion regulation system' was constructed as a mechanistic entity underlying experiencing of emotion. Clients' difficulties were presented as an inability to control a swing of emotions, resulting in extreme fear of emotion. It was described as occurring as a result of biological vulnerability and environmental factors including exposure to mental health services. This conceptualisation promoted DBT as the theoretically appropriate response for clients' difficulties.

The next chapter will examine clinician constructions of DBT and their experiences working with DBT.

Chapter 8: Study Two part two: Clinicians' talk about DBT

This chapter focuses on discourses of DBT present in clinician interviews. As will become clear in the following examples, the division between constructions of BPD and DBT reflected in the separation of this study into two separate chapters is somewhat artificial, and it is not possible to discuss DBT without also constructing versions of the difficulties it is designed to treat. Thus the following section could equally have been presented as constructions of BPD.

DBT was presented as providing a set of skills which would enable clients to manage difficulties in their lives – providing hope for improvement. The provision of skills was constructed as external to the self, allowing clients to more easily accept them. DBT skills were described as useful for everyone, including those without a diagnosis of BPD, and the clinicians themselves. Mindfulness was presented as underlying all the other skills and as fundamental to DBT. Finally, the provision of skills was constructed as enabling clients to take responsibility for their behaviour. DBT was constructed as an integrated whole, bringing many different elements together to form a coherent therapy. There was also a discourse of professional security – noting that participating in DBT enabled clinicians to maintain confidence in their own practice with clients. This first section will discuss a discourse of DBT as providing skills.

DBT as providing skills

A key discourse in the clinicians' talk was that DBT provides a set of skills which can be learned. This reflects a corresponding construction that the clients' difficulties are related to a skills deficit (leading to emotion dysregulation). Describing particular behaviours in terms of learnable skills works to de-pathologise clients, as their difficulty is now not one of disease, disorder or personal deficit, but rather one of a skills deficit, which is external to the self. Although difficulties may be present, clients can develop the ability to manage them. Key features of this discourse were the hope that DBT skills could overcome existing deficits, that clients could accept the skills without a need to challenge their underlying personality or sense of self, and that clients were responsible for using the skills provided.

DBT skills provide hope

The construction of DBT as providing skills functioned to present DBT as able to provide something useful, which would be beneficial to clients (compared to previous treatments which had not done so). This allowed for hope for improvement for clients. The following extract illustrates the construction of hope through use of the skills discourse.

71. Tony: *and she's saying it's the skills ((laughter)) it's the skills she's learning and like wow that's so cool to do yeah actually do something offer something that*
- Mel: *yeah*
- Tony: *seems to work*

In extract 71, improvement is being reported by the client, which increases the perception that meaningful improvement can occur (unlike previous experiences with the mental health system). This sense of surprise at improvement is also apparent in Tony's words "wow that's so cool to actually do something that works", implying that alternative options, or options Tony has tried before, would not result in such improvement.

The use of the word "offer" in the above extract constructs the skills as available for use by clients to manage their difficulties, rather than something expected by or imposed on clients. This places responsibility for accepting (or refusing) the skills onto the client, and Tony constructs himself as a resource for the client rather than responsible for treatment success or failure. This 'availability' of skills enabled the construction of disorder as external from the client, because clients can choose to learn skills and are not necessarily disordered at a deeper level. The next section discusses this.

DBT skills allows for externalisation of 'disorder'

The construction of DBT as providing skills, which can be accepted or rejected by the client, also impacted on the dynamic between client and therapist – and was presented as increasing the acceptability of the therapy for clients. The following extracts illustrate this.

72. Rachel: but because in DBT the skills seem to be (.) in some ways kind of external (.) and they're not a dynamic between you and the client (.) they're mmm seem to be more able to kind of receive them [and]

Mel: [yep]

Rachel: experiment with them and practise them (.) yeah

Mel: that makes sense

Rachel: does that make sense (.) [yeah]

Mel: [yeah] it's like they're there and available to be used by everybody including the therapist the client

Rachel: yeah

Mel: other people

Rachel: yeah and they don't take need to take it personally as an attack against them that they have this deficit with this kind of thing

Mel: mm

Rachel: um they're just seen globally as something that they (.) need to be able to kind of upskill in

The construction of client difficulty as skills deficit functioned to remove the locus of 'disorder' from the clients' sense of self. The externalising of the problem created within this discourse is constructed as important for allowing clients to work on their difficulties and be receptive to trying out new ways of behaving and thinking (extract 72). The use of the word 'more' in the first sentence implies that clients have been unable to accept therapeutic intervention in the past, compared to this skills-based approach, and have shown resistance to therapy.

The idea of resistance suggests a power dynamic between therapist and client which is constructed as usually inherent in the therapy relationship, and hints at client recognition of and resistance to this. This resistance is described here as 'taking it personally' as an 'attack' and although no specific behaviours are mentioned it seems likely that the client did not respond as the therapist intended. Although not mentioned here, the discourse of the difficult client present in Study One comes to mind as Rachel comments on the 'dynamic' between client and therapist.

In addition to the reference to power dynamics, a sense of 'self' is constructed in this example. Skills are understood as separate from the self, which is the real essence of the person. The need for resistance is removed by this construction, because the therapy does not aim to change the client's 'self', and therefore does not represent an 'attack'. Using the word "experiment" presents the idea that clients can try out the skills (while not changing any fundamental aspect of the self) before deciding whether or not to adopt these new behaviours, and positions the client as in charge of this process. The next extract illustrates this separation between skills, and the self.

73. Rachel: *...because (.) in some ways the skills are kind of externalising the*
Mel: *yep*
Rachel: *the kind of named it named as things that (.) everyone (.) needs to*
practise so they're not (.) kind of directed (3) at the person at a time when
they're kind of so emotionally dysregulated they can't actually hear

In extract 73 Rachel again talks about the externalisation of the skills as enabling the client to be receptive to hearing about them. The reference to the client's 'emotional dysregulation' implies that in this state clients would be unable to respond to any feedback that could be perceived of as an attack (on the self). Using the word "everyone" positions the client on the same level as others, who also need to practise skills, countering the power imbalance created by the client assuming an illness role.

The function of the externalisation of skills provided by this discourse was not limited to client acceptance of skills. The clinicians also spoke of utilising DBT skills in their own lives and with other people, and the use of this discourse appeared to enable them to do so.

DBT as useful for everyone

The next section discusses how use of the DBT providing skills discourse functioned to increase acceptability and usefulness of DBT for all people, including clinicians.

74. Mike: *if that makes sense (.) and you know (.) sometimes I might you*
know (.) offer them to people in my own life who ((laughter)) are perfectly well
but upset you know because they're kind of things that that you can kind of

get a lot out of and I like I mean I've practised all the skills in the DBT manual and it's they it's made quite a difference to my (1) um just the way I think about coping with different things I [guess]

Mel: [mmm]

Mike: just as a person

In extract 74 DBT skills are presented as applicable to all people, regardless of whether or not they have BPD. Mike distinguishes these people from his clients using the phrase “who are perfectly well but upset”. In doing so there is still reference to an illness discourse inherent in this statement, because he has needed to refute the possible interpretation of ‘upset’ as illness. His statement constructs other people benefitting from DBT as both different from, and the same as his clients. In the final phrase “just as a person” the key criteria for benefiting from DBT skills is described as just to be human. This idea was also noted in the ‘emotion dysregulation’ discourse in which clinicians described emotionality as an aspect of being ‘human’ (see Chapter Seven, extract 65).

The idea that DBT was useful for the therapists as well as clients came through strongly in the clinician interviews. This included the use of DBT skills to manage their own lives, responses to clients, and interactions with other clinicians. This construction effectively reduced the perception of difference between client and clinician. The next extracts provide examples of this.

75. Mike: part of it was you know just (.) getting back to basics with behavioural stuff and um testing it out on ourselves and kind of (1) ooh what other kind of things noticing you know counting judgements and monitoring judgements and that kind of thing yeah which I have actually found really helpful and (.) um (.) in general like I actually view myself as a more settled person than I used to probably because of that yeah (.) and I also I've got a much better ability to focus too just through doing the mindfulness practice (.) mm which is always useful if you're um under stress 'cause you just focus on what you've gotta do now ((laughter)) yeah

In extract 75 Mike's description of performing behavioural analyses on his own responses in life constructs him as following the same behavioural principles as clients.

He describes mindfulness as useful in times of stress, linking this to the here and now focus of mindfulness. Again Mike's descriptions of how DBT has helped him mirror the process hopefully undergone by his clients. This constructs him as similar to his clients in experiencing stress, and needing to manage this. In the following extract, Anne describes her own reaction to her client presenting in crisis.

76. Anne: *and and I just made myself stay in the moment when I saw the message I thought (.) I'm not going to just panic and assume that she's going to go back to square one or she wants me to do blah blah and she didn't she was acting really skilfully and that was just (.) she just wanted a bit of sort of reassurance or validation (.) did this sound alright is this the right course which and I think well that's (.) anybody goes through something traumatic that makes their emotions very high we often want reassurance*

The DBT skills were not only used for clients in a crisis situation, but also to assist the therapist to manage such situations in their work with clients, and not respond in an emotional manner. In extract 76 Anne describes herself as actively using DBT language and skills ("I just made myself stay in the moment") in order not to over-react to her client's distress. It is Anne's own distress rather than that of her client which is reduced through her use of DBT skills. The description of the client's thoughts and presentation of the client's behaviour as normal validates Anne's response, of providing reassurance but not intervening in a more directive manner.

77. Anne: *...the most difficult part is going to be for the therapist with her in the acceptance in that you actually need to sit and bear pain skilfully*

Mel: *mm*

Anne: *and (.) and having contingencies around (.) not ringing up or being skilful in phone calls sort of thing (.) but one of the difficult things that (1) I didn't (.) I didn't do and I struggle with a bit um (.) when I started off individual therapy is (.) Marsha Linehan says clearly and it's in the book um (1) you need to make me want to do therapy with you*

In extract 77 Anne constructs clinicians as experiencing distress when they can't (or decide not to) respond to client "pain". This relates back to the construction that DBT

provides skills which enable clients to take responsibility for behaviours, and therefore should use those skills rather than rely on the therapist – requiring the therapist not to assist the client despite their difficulty. This is described as difficult for both clients (see extract 82) and clinicians. Transferring some responsibility for therapy to the client means that the clinician is no longer in a position to intervene and somehow take away pain. Anne highlights client responsibility beyond the need to use skills and includes responsibility for therapy process with the statement that clients need to “make me want to do therapy with you”. This construction of client responsibility being difficult for clinicians works to portray clinicians as caring, and not wishing their clients to experience pain. In the next extract, Anne describes using DBT skills in her interactions with other clinicians.

78. Anne: *and and sometimes and I've and I've learned to become (.) I'm still quite judgemental but I I probably notice it more (1) I've learned to become less judgemental and I and to notice how I react when (.) certain people say things that (1) trying to really understand where that clinician comes from*

Mel: *aha*

Anne: *and trying to remember some of the experience and incidents I know of that they've had with these clients (.) um*

Mel: *[yeah]*

Anne: *[that] have shaped them*

Mel: *yep*

Anne: *rather than just oh they're just you know (1) don't know what they're doing or they're just unkind or they're toxic it's really easy to deliver judgemental labels like that*

The clinicians talked about actively using DBT skills and “dialectical thinking” to manage their interactions with others as well as with their clients, in particular with other clinicians they work with and may come in conflict with. This extended beyond the idea of managing emotion to include a greater attempt on the part of the clinicians to understand the perspective of the other person. This was described as using dialectical thought, recognising the element of truth in several different perspectives. In extract 78 Anne describes herself as “judgemental” however then immediately refutes this, giving examples of how she has taken care not to judge people unreasonably. This is

described as occurring because she has “noticed” her judging, and is able to reflect on other possible meanings for behaviour.

Clinicians constructed DBT skills as assisting them in their lives, both privately and professionally as can be seen in the above examples. This functioned to construct clinicians and clients as fundamentally similar to one another, because clinicians also experienced distress and could benefit from DBT skills.

Although all DBT skills were constructed as useful, mindfulness was described as underlying the use of all skills. This next section looks at the construction of mindfulness in clinicians’ talk.

Mindfulness skills provide base

Clinicians constructed DBT skills in general as useful, however also promoted mindfulness in particular as fundamental. The next set of extracts illustrates constructions of ‘mindfulness’ and its place in the wider DBT context.

79. Anne: (2) *I suppose that the thing that I think is the basis of the whole programme (1) which I find find from my clinical experience and I think it’s coming out in the research is the mindfulness component*

Mel: *yeah*

Anne: *that’s the thing that it is really hard to teach them really hard for them to get but they end up (.) really getting it and understanding (.) you know (.) not necessarily in a verbal can talk about it (.) although they can talk about it but in a really sort of like a procedural memory kind of way where it is just part of what they [do]*

Mel: *[mm]*

Anne: *and they understand it and find it really useful*

Mindfulness was presented as the core skill that clients needed to learn. Anne’s description of mindfulness as “the basis of the whole programme” presents it as important for every aspect of DBT. It was described as initially difficult, but that eventually it became part of clients’ being, to the extent that it was no longer recognised

as an external skill. Anne constructs this description of mindfulness as valid, noting that it fits with both her clinical experience, and research.

Extract 79 also alludes to understandings of how learning takes place, and categories of learning. Verbal and conscious learning is separated from 'procedural' memory, which does not have to be recognised at a conscious level, and occurs at a more fundamental level. In making this distinction, understandings about levels of consciousness are alluded to, that there is a surface cognitive level, and a deeper behavioural level. DBT is constructed as teaching mindfulness at this deep level.

80. Alan: mindfulness (.) kind of embeds itself later on but not in and of itself

Mel: right

Alan: so clients might say things like (1) unrelated to mindfulness specifically they might say things like "the other night (1) when I was going to break something and scream at my partner (3) I saw it coming"

Mel: yep (.) because I was being mindful?

Alan: "yeah I was aware (.) and I kind of sat with it (.) and I still did a lot of those things but I was different because now it was like I was looking at myself" and and I say "you're getting it you've got it (.) that's what it's about".

In extract 80 Alan also presents mindfulness as something that clients need, but are not necessarily aware of as a tangible "skill". This use of first person and active voicing to describe a typical client response works to increase the immediacy and emotional impact of the client in this situation. The portrayal of improvement occurring without the client recognising it reflects an understanding of the clinician as knowledgeable compared to the client.

An important function of the discourse of DBT providing skills was that clients could be expected to take responsibility for using skills in their lives, once they have learned the skills. The next section will discuss this idea.

Providing skills leads to client responsibility

Regarding the clients' difficulties as a skills deficit leads to an expectation that skills can be developed which the client then has a responsibility to utilise. This expectation

comes about because the illness discourse associated with diagnosis is to a large extent removed. In the following extract, Mike identifies this sense of client responsibility.

81. Mike: *yeah (2) yeah (2) but I think that that's a really difficult idea for clients because (.) we you know when a clinician expresses to them something along those lines that they have everything that they need (.) um and that they they already have all the skills (1) and the capacity there's kind of like if someone believes in you like that it means that you actually have to do something*

Mel: *mm*

Mike: *and that's very scary like they can get quite stuck on wanting to prove that they actually haven't*

The most notable effect of the comments in extract 81 is to highlight the power of language to encourage change, and to resist dominant discourses, such as the illness discourse. Mike talks about the impact of clinicians expecting clients to take responsibility and introduces the idea that this is potentially scary for clients, who are then expected to behave in different ways to previously. The construction of the client as someone who has skills already removes the possibility for the client to assume a passive sick role, or utilise an “illness” discourse, and forces the client to take responsibility for actions. There is some resistance to this new conceptualisation evident in clients wanting to avoid the risk of new responsibility by presenting themselves as unable to use skills. In the next extract, Anne notes this client discomfort.

82. Anne: *it's hard to (.) it's hard to convey how incredibly scary it is for these clients when they might have had these behaviours which to them (.) might be uncomfortable but they're also comfortable because they are familiar*

Mel: *yes*

Anne: *and to be faced with a whole new way of life and way of doing things and other people with different expectations of it and their own expectations of themselves (.) and knowing that they can't just do their old [comfortable]*

Mel: *[yeah]*

Anne: *stuff in the group because it doesn't feel comfortable any more*

Mel: mm

Anne: and we take the comfort away

The construction of clients' experience of discomfort in losing old behaviours is elaborated on in extract 82, as Anne explains that acquisition of skills carries expectations from other people and themselves. She describes a discomfort both in the new behaviours, and also in the old behaviours which used to provide comfort. Her statement "we take the comfort away" works to intensify the paradoxical nature of this process. Therapists, whose role is normally presented as giving comfort, are here presented as removing it (in pursuit of client responsibility for behaviour and ultimately improvements in clients' lives). The illness discourse is no longer available for the clients, and yet at the same time the level of discomfort is recognised in a compassionate way, which contrasts with the earlier alternative of the 'difficult' client choosing to disrupt treatment.

83. Anne: one of my clients has um (.) she says it with some satisfaction now but she has said it with um with a vein of irritability in the past saying Anne you can't unlearn these skills

In extract 83 Anne notes her client's awareness of this new responsibility, and the impossibility of returning to old ways of behaving in response to stressors. She notes also a reduction in discomfort as the client becomes more used to using the skills, which works to validate the role of the therapist and affirm that the therapy does work to improve the client's situation, despite discomfort with new responsibility.

The previous extracts have presented clinicians' talk about DBT skills and the impact on clients' lives, and clinicians' lives. The most important aspects of this discourse were the suggestion of a skills-based pathway to improvement, as skills could be effectively learned by anyone – which worked to increase hope; an externalisation of the clients' difficulties in such a way that therapy did not present an attack on the self; acceptability and usefulness of DBT skills in clinicians' own lives; construction of mindfulness as a key skill underpinning DBT; and the function of the discourse to place responsibility for improvement onto clients. DBT skills were often the focus of discussion however DBT

was also presented as a coherent and integrated whole. The next section will discuss this.

DBT as integrated whole

This discourse constructed DBT as both compartmentalised, yet integrated at the same time. The clinicians described the multiple components of DBT as having a different yet integrated purpose. The separation of group and individual therapy in particular was described as positively impacting on the therapy process for the client. The following extracts illustrate this.

84. Mike: people struggling with that (.) which is good (1) um (1) just from my own experience like thinking on one client who's in the group um (1) who was already in individual therapy and who I was (.) trying to work with in a DBT way but was really struggling because (1) I (.) the amount of skills based stuff that I needed to do (2) consumed almost all the time that I had with this person

Mel: mm

Mike: who (.) therefore felt quite um (2) I'm not sure if deprived is the right word (1) it was kind of like I was always doing skill based and almost fire fighting stuff and it was hard to get on track (.) with individual stuff

In extract 84 therapy sessions prior to DBT were described as “fire fighting” implying that they were not effective in solving difficulties before they reached crisis point, and skills which could have helped the client avoid the crisis were not being taught because of this. The therapy was therefore ineffective in helping the client. This presents a need for all components of DBT to be present in order for progress to be made. This extract also constructs therapy as needing both a skills-based and an ‘individual’ component, and defines the roles of each component – skills group, and individual therapist. In the next extract Mike discusses his integration of skills (learned in the group) into individual therapy.

85. Mike: mm (.) and it's the individual therapist that's a real strong role of theirs is to you know what's going on in your life hmm I wonder what skill might be helpful there or

Mel: mm

Mike: yeah

Mel: so she's found that useful

Mike: yes yeah and it's kind of kept us on track with treatment really like it's (.) making us more (.) efficient

In extract 85 Mike talks of the individual therapy being the time to talk about the client's life. Skills taught in the group are utilised and applied to specific situations in individual therapy. In this way the DBT package of individual and group therapy is constructed as improving the efficiency of therapy.

The function of this discourse was to promote the need for all aspects of DBT to be present. This validates the need for group and individual therapy, and promotes the idea that the use of resources required for both group and individual therapy (greater than for most therapies) is necessary and efficient. This is important in context of a mental health system subject to financial constraints. The expert role of clinicians and importance of clinical knowledge and research is promoted by the use of this discourse. It constructs DBT as complex and requiring expert integration of parts.

In addition providing skills to manage distress in clients' and their own lives, clinicians also spoke of the wider framework of DBT was described as offering a secure base to their work. This sense of professional security is outlined in the following section.

DBT as professional security

An important discourse connected with DBT was related to professional security, rather than client experience or outcome. Here DBT is constructed as offering a support system which ensures safe practice, even though clients may still harm themselves despite treatment. The clinicians constructed themselves as feeling safe and secure in their practice with clients using the DBT framework. This was in contrast to feelings of uncertainty prior to having this framework. Although this sense of safety was related to the perception that what they offered could be useful for clients, it was related to a construction of the clinician providing good, and defensible practice, rather than necessarily positive outcome for clients. The next extracts utilise this discourse.

86. Tony: *I honestly ((laughter)) yeah and and (.) um and I guess what's changed is that (1) I just feel safer working with them (.) I've got I guess more to offer*

Mel: *mm*

Tony: *and I've got more of a structure sh should it happen and you know it can't always be prevented it can (.) I've got a good evidence base as to (.) why I've done what I've done*

In extract 86 Tony refers to the possibility of having a client suicide, and he links his feeling of increased safety to the structure he now feels he has. The feeling of safety is not the same as feeling safe that the client will not suicide – he makes this overt in his statement “you know it can’t always be prevented”, but is linked to the idea that practice has an “evidence base”. So Tony constructs safe practice as a way of working which has a good research background, meaning his practice could be defended should the client suicide. Tony’s sense of safety is also linked to his perception that he now has something to offer clients. This means he is able to fulfil his clinician role and provide the best care possible.

87. Tony: *um (1) when I'm talking with a client and like when I met her on the ward after the attempt (1) I had a framework I knew (.) where to go I didn't have to sit there feeling lost oh God now what do I do*

Mel: *mm*

Tony: *she's still really suicidal it hasn't worked ((laughter)) get that*

Mel: *so you feel less useless*

Tony: *yeah exactly yeah less useless and (.) I suppose a bit more in control*

This theme of feeling safer in his practice despite possible suicide of clients is continued in extract 87. Tony describes an example of his client actually attempting suicide and being admitted to hospital, and presents himself as feeling secure in what he needed to do – and secure in the knowledge that the best care was offered - despite the severity of the client’s behaviour. This contrasts with his pre-DBT sense of feeling “useless”. In the next extract, Tony describes an increased acceptance of his own practice since DBT training.

88. Tony: *and when you show (.) validation or empathy with clients that's not encouraged*

Mel: *so when you before you did this training you felt like when you did that that you were doing something wrong*

Tony: *I was being soft and I had to keep it under wraps (.) and I wouldn't say that you know I wouldn't advertise that I was*

Mel: *no*

Tony: *working in that way with the team*

Mel: *no*

Tony: *no way*

Mel: *but now are you able to recognise it as a valid skill?*

Tony: *yeah I can actually just yeah reel off whatever literature and (.) go with this is the strategy that I'm using ((laughter)) thank you yeah which is genuine but yeah the biggest change is validating the valid*

Tony continues the construction of feeling safe in his practice as he presents the DBT training as now giving him backing to what he actually always thought was good practice, but had felt criticised by others. DBT provides a set of socially accepted ways of being as a therapist. His reference to literature works to construct DBT therapist strategies as based on research and theory, which reflects the presentation of DBT as empirically sound. The security offered by DBT allows him to challenge workplace beliefs, such as not being 'soft' when working with clients with BPD

The consult group as providing professional security

The next set of extracts refers to the 'consult group' of therapists who meet weekly to discuss their work with DBT. This consult group was constructed as an important aspect of DBT providing professional security for the clinicians.

89. Mel: *tell me about the consult group because um (.) that's quite a unique thing about DBT isn't it?*

Mike: *yeah (.) yeah that's (.) the point of that is to kind of (.) be able to create a community of therapists (1) who are all treating the client so it's not*

just my client I take (.) you know if I go along and review a client that I'm working with it's like the team is there to treat the [client]

The support provided by DBT included candid feedback, which was not always easy for clinicians, but was described by all the clinicians as beneficial for their work with clients and their development as clinicians. Participation in the consult group was seen as central to successful functioning of the DBT team, and was described as “treating the clinicians”, which is congruent with ideas in the DBT model itself.

In extract 89 Mike explicitly describes the consult group as a “community” of therapists, all treating the client together. The word “community” works to create the idea of a cohesive group of people, who share a common bond. It creates the idea of belonging, which is in contrast to the isolation and lack of safety conducting therapy without this support. This sense of community means that Mike portrays himself as not the only person responsible for treating the clients he works with. In the next extract, Alan expands on this – presenting the DBT consult group as allowing him to accept feedback from others because of their common understanding.

90. Alan: *but in the DBT consult there's kind of like a holding (.) that says it's ok for us not to treat each other as fragile (1) so I'm I'm (1) better able (.) to (.) listen to what's being said back to me (1) and some of it's um (.) quite central to how I see myself as a therapist*

Mel: *yeah*

Alan: *um I've had feedback that I've been too protective of clients (1) um and in the past I would have said I'm not (.) you know without even listening*

Mel: *yeah*

Alan: *um other times um feedback I've got is (.) um maybe I'm too directive with clients (.) and again I think I'm not (.) you know I'm not too directive but then I appreciate where they're coming from so I make the DBT consult is really good because we're able to (.) um take a dialectical position on things so we don't sort of say well this is the one way it is*

Mel: *mm*

Alan: *so I'm much more open to feedback*

Mel: right

Alan: because I also know they're coming from (.) a common understanding on what therapy's about in DBT

The consult group was constructed as working well because it enabled the clinicians to be open to feedback and criticism that they perhaps otherwise would not have properly heard or accepted. They spoke of the group creating a safe space or arena, where the expectation of looking for difficulties in their own behaviour was created. This safe place is constructed as occurring because of the group understanding or rule “not to treat each other as fragile”. In extract 90 Alan creates this idea using the word “holding” to convey the sense that negative emotions or defensiveness that might otherwise interfere with feedback can be put to one side in this consult group situation. He does this by first describing how he is now able to receive important feedback. The importance is stressed by the words “central to how I see myself as a therapist”. He then contrasts his current ability to hear feedback in the consult group with earlier experiences when he says he did not listen and became defensive when given feedback about his practice that he did not agree with. Finally he constructs this ability to receive feedback non-defensively as specific to the DBT consult group because of the shared understanding they have about what therapy means. He uses DBT language to describe the working of the group in that “we are able to take a dialectical position on things” and links this process to his willingness to consider alternative viewpoints.

This ability to hear and integrate feedback can be compared to the presentation of skills as external to the self, which was constructed as allowing clients to take in new information without feeling threatened (see examples 72 and 73). The sense of the ‘self as therapist’ being threatened by negative feedback is ameliorated by the shared understanding that respects different viewpoints and responses.

This discourse functioned to construct clinicians as following ‘best practice’, in line with research and current recommendations. The construction of the DBT ‘therapist group’ acting as a unit to treat clients diffused potential responsibility which might otherwise have been assigned to an individual clinician. It also functioned to construct alternative ways of working as potentially less safe professionally.

Summary

This chapter has examined clinicians' constructions relating to DBT and their experiences working with DBT. DBT was presented as providing the clients new skills which they could apply in life. Constructing the clients' difficulties as a skills deficit was seen as enabling clients to perceive the problem as external to themselves, which then allowed them to accept the need to work on developing skills. The framing of difficulties as skill deficit meant that clients were presented as largely intact, rather than experiencing illness or pathology. The ability of DBT to provide a framework for therapy, which was acceptable to both client and clinician, worked to lessen the sense of difficulty for clinicians working with this client group. This is important because of the inherent sense of difficulty associated with the BPD diagnosis by the difficult client discourse identified in the articles study, and the stigma discourse in the clinicians' study.

Clinicians all discussed the use of DBT in their own lives. They described utilising DBT skills to manage their own distress as well as to modify behaviour of others in their lives, including other clinicians. An important aspect of this was the clinician's ability to tolerate clients' distress in a non-reactive yet empathic manner. Use of the DBT as providing skills discourse meant that responsibility for behaviour became that of the clients, once skills had been learned. Recognition of this was described as important, in order for clinicians to respond appropriately to client distress – without assuming responsibility.

Although all the skills were regarded as useful, mindfulness in particular was presented as central to client progress, and was described as becoming an unconscious part of clients' responses to situations, once the skills had been thoroughly learned.

The components of DBT were presented as complementing each other, to provide a coherent whole, which could not be provided without all of the component parts. This was presented as an efficient use of resources and clinician time, benefitting both client and clinician. The construction of efficiency is also an important consideration, when the context of the wider mental health service is considered, with the need to justify use of limited resources.

Clinicians constructed DBT as providing a level of security to their practice when working with suicidal clients and talked of the treatment being delivered by the DBT team rather

than working as an individual clinician. This sense of security was an important aspect of DBT for clinicians, again because of the difficulty associated with working with people with BPD. Client, clinician and the wider DBT team were constructed as a system working together. In this way clinicians experienced the same processes as their clients did. This construction worked to validate the needs of clinicians, and ensure that clinicians' experiences could be presented as important outcomes for DBT, in addition to the experiences of the clients.

The next chapter will discuss clients' talk about their diagnosis of BPD and their own behaviours and contact with mental health services.

Chapter 9: Study Three part one: Clients talk about BPD

This and the following chapter will present discourses of BPD and DBT in client interviews. The five client participants were drawn from the DBT groups run at a New Zealand DHB. The clients were interviewed at different stages of their involvement with the DBT programme, because some did not respond to an initial approach, however agreed to participate at a later date. Kate was interviewed after having completed the programme. Jane was interviewed after completing the first module of the programme. Angela, Lisa and Sasha were interviewed twice each, once soon after they started the programme, and again after they completed it. The process for conducting interviews, transcription and analysis was the same as that followed for clinician participants, and is described in Chapter Seven.

Clients constructed themselves as having been 'a hopeless case' prior to DBT, with complex lives, lack of access to help, and confronted with negative staff attitudes towards them. They talked of receiving the BPD diagnosis and the paradox of positives and negatives of this experience – utilising discourses of illness and stigma, as well as a choice. Their talk contained references to difficult and at times contradictory relationships with mental health services prior to DBT. The construction of difficulties as a skills deficit was also utilised by clients, in a similar manner to clinicians. The next section will outline an illness discourse, which was utilised by clients.

The Illness discourse

This discourse corresponded to the illness discourse identified in the journal data and recognised in clinician interviews, however in the case of the clients the construction was of a severe disorder associated with lack of hope, rather than difficult behaviours or clinician experience of difficulty. The clients described themselves as having had no hope for the future before DBT. They described complex and longstanding difficulties, which did not respond to multiple attempts at treatment. They talked about the clinicians who worked with them as not believing they could improve, and gradually giving up on attempts to help meaningfully. The illness discourse functioned to present clients as helpless, and the responsibility for improvement on the shoulders of clinicians as the following extract illustrates.

91. *Lisa: and I was really pissed off when I found out that it was in my hospital notes in 2004 (2) that I was possibly borderline personality disorder (.) why was that not followed up*

Mel: mm

Lisa: why wasn't some (.) something done back then (3)

In extract 91 Lisa uses the illness discourse – that receiving the diagnosis meant that she did in fact have something wrong with her – to validate her demand to receive appropriate treatment. In utilising the illness discourse, Lisa places the responsibility for treatment with mental health services rather than herself. She expresses anger that her ‘illness’ was not treated. Her anger is constructed as a natural response to receiving inadequate treatment for her illness. Clinicians are portrayed as having not fulfilled their role as treatment providers. The removal of responsibility from the client – in context of repeated contacts with mental health services without improvement – constructed the clients in a position of hopelessness. This will be outlined next.

Hopelessness

The next two extracts construct a general perception of hopelessness, which was described by clients as present in their own thinking and in that of others. These extracts contain less blame than the previous extract however the construction of ineffective treatment was also present in these examples.

92. *Kate: umm (.) I had tried so many times (.) to make my life better and it never worked*

Mel: aha

Kate: nothing would ever help me (.) and I'd come to a point where I'd lost hope and I didn't believe that it could help me (.) anymore (1) mm

In extract 92 Kate describes how she had come to a point where she had lost hope. Even when thinking about beginning DBT she did not think it could be useful for her because other treatments had not worked. This lack of hope is evident in Kate's talk and there is a perception of going through the motions of the client role and accessing services without expectation of improvement.

93. *Kate: the psychologist at the hospital I saw a psychologist and she just saw from my records that I had numerous suicide attempts (.) and had been in the mental health system for 20 years*

In extract 93 this presentation of hopelessness is reinforced, with reference to the length of time Kate has been engaged with the mental health system, and that she has made several suicide attempts. This paints a picture of a lifetime of severe difficulties. The reference to length of time in the mental health system rather than length of time experiencing dysfunction (of whatever kind) works to link those two meanings – engagement with the service indicates disorder. Despite lack of progress, Kate has remained a client of the service for 20 years, suggesting complete ineffectiveness in ‘treatment’ provided for her ‘disorder’. Again, Kate is trapped ‘going through the motions’ despite lacking any evidence of improvement. Her situation is one of a person trapped with a severe and complex disorder, continuously seeking help. This construction of severity of disorder is discussed in the next section.

Severe and complex disorder

The clients constructed themselves as having significant disorder, which was complicated by multiple diagnoses and lack of understanding of what might actually be wrong. The following extracts illustrate this.

94. *Mel: ok (.) did you feel like did you get a diagnosis?*

Kate: I've had four (1) or five

Mel: what ones

Kate: bipolar (1) ADHD (2) ah post traumatic stress disorder (1) and I think personality (1) something personality disorder

The complexity and difficulty of the clients’ lives was reflected in their descriptions of being given multiple diagnoses. All of the clients had received a range of diagnoses over time. Kate, in extract 94 talks of receiving so many diagnoses that she can’t remember exactly how many. This attaches multiple diagnoses to the meaning of BPD. Kate’s listing of diagnoses works to present her as significantly disordered, and the history of changing diagnoses suggests she experiences difficulties which could be

linked to each of these disorders. This can be compared to the alternative construction which was evident in clinician interviews – and presented the act of diagnosing (and utilising the illness discourse) as maintaining and increasing client distress over time.

95. Sasha: to know that I'm coming back to normal (1) 'cause it's really hard (.) if you don't have a depressive disorder people don't understand it

In extract 95 Sasha's comments of coming back to 'normal' imply that her experience has been beyond the range of normality. By doing so she constructs herself as having been 'abnormal' and disordered. She separates disordered people from others, by reporting a lack of ability for those who have not experienced it to understand.

Despite the inability of mental health services to treat BPD, clients presented themselves as needing treatment, and this need being recognised by services. This was apparent in the length of time clients remained engaged with services (extract 93) and the continued effort to label the clients' difficulties as disorder

The next section will outline a second discourse evident in clients' talk about BPD – that of the stigma attached to the diagnosis. Clients were well aware of potential negativity associated with the diagnosis.

Stigma

The stigma discourse, which was apparent in clinician interviews, was also utilised by clients. It was associated with pejorative behaviours directed towards clients by staff in mental health services. The clients constructed the BPD label, and associated hopelessness as reflected in stigmatising behaviour or mental health staff (in their pre-DBT experience). This is congruent with clinicians' constructions of their own prior experiences (for example extract 48). The following extracts illustrate this.

96. Kate: not good (.) no not good (.) not good at all they just thought they actually the nurses (.) not all of them some of them were really great but um will just ignore you

Mel: mm

*Kate: they will ignore you you say excuse me please excuse me please
(.) and they sort of think well you're drugged out you're mental well that's
what we thought we felt*

In extract 96 a power differential between clients and clinicians is highlighted. Kate uses repetition to emphasise how badly she was treated on an inpatient psychiatric ward: “not good,” “no not good,” “not good at all”. In the role of inpatient client she has no power at all. The description of the nurses as ‘ignoring’ clients implies that nurses did not consider Kate’s behaviour warranted a response of any kind, let alone a caring response. This does not fit the image of caring health professional, with client focussed treatment.

Kate’s construction of herself as a reasonable historian with an accurate description of the lack of care is enhanced by her stated recognition that some of the nurses were “really great”. By doing this she positions herself as reflective and able to recognise differences between people and is not including all nurses in her negative evaluation. This construction is enhanced by her reporting of events as ‘what we thought we felt’ rather than as fact. In the next extract, Jane describes her experiences of mental health services prior to DBT.

*97. Mel: what were your experiences of mental health services like before
DBT?*

*Jane: (6) In my no I don't think um (.) I think it was my thoughts um (.) I
thought they were cold and (1) they (.) were very criticising*

Mel: yeah

*Jane: um (1) with me they focussed on drinking rather than actually (4)
real um (.) working on anything else*

In extract 97 Jane describes a similar experience to Kate with mental health professionals and describes them as focussing on only one aspect of her difficulties (alcohol abuse) which from Jane’s point of view meant they were not recognising the true nature of her problems – although it is unclear what these are. Her drinking is presented as almost a distraction from this core difficulty. Again the inclusion of the

statement 'I think it was my thoughts' works to include the possibility of alternative explanations.

Clients did not only construct others as behaving in a stigmatising manner towards them, but also utilised the stigma discourse themselves, constructing themselves as accepting the negative meanings associated with the BPD diagnosis. The following extracts illustrate this.

98. Mel: *what is that what did that diagnosis mean to you?*
Kate: *that meant that I was um (1) probably not a nice person*
Mel: *yeah?*
Kate: *yep*
Mel: *is that how you felt with that [diagnosis?]*
Kate: *[because] dia that 'cause when I looked it up and read all about it which I do um I see that borderline personality person as being quite manipulative and controlling um selfish um horrible basically horrible yeah*

In extract 98 Kate's comments present a process of self construction, and link to a 'difficult client' discourse, which she identifies with. The information she has obtained reflects the stigma discourse rather than the illness discourse, as it includes judgements rather than symptoms. This adds credibility to the idea that the diagnosis comes loaded with additional negative judgements.

Kate's assertion that she has obtained a correct meaning for the diagnosis, because she has "looked it up and read all about it", serves to privilege academic knowledge. Her description of basing her self-appraisal on reading material to come to such a negative conclusion illustrates the power that language and dominant discourses can exert. Other versions of knowledge, for example her former interpretations of experiences, are subjugated by the pathology discourse contained in the literature she has read. In this example there is little evidence of resistance to the dominant knowledge. In the next extract she constructs herself as more ambivalent about the diagnosis.

99. *Kate: the good things was that there was other people in there that were similar to me (1) the bad thing was yeah that that negative borderline personality disorder type thing where you're around people that are like you and you can see it really*

The clients had mixed reactions to being given a diagnosis of BPD. The existence of two discourses in opposition with one another is evident in extract 99, as Kate describes the experience of recognising people like herself as good and bad. Recognition of sameness in others was described in positive terms, reducing isolation, and here the recognition is a good thing. In opposition to this, reference to a stigma discourse is also made here, with the statement 'that negative borderline personality disorder type thing'. Although this recognition is described as a bad thing, her statement 'you can see it really' presents her as now better able to identify what aspects of others' - and therefore her own - experience are causing difficulty, and hints at the possibility for change. This constructs the experience of being in the group as encouraging self reflection. In this way Kate is also presented as reflective, and examining her experience for possible meanings.

A process of identifying the self as pathological or disordered is also evident in the above example. Linking the good feeling associated in being in a group of people like herself, and the difficulty in also recognising pathology in those same people – works to construct this process as occurring in moments of recognition, leading up to a change in how the self is viewed.

Clients clearly utilised both the illness and stigma discourses. In addition to this they also used a 'skills deficit' discourse to construct their difficulties. This will be discussed in the next section.

Skills deficit

A discourse of BPD as a skills deficit was also prominent in clients' talk. This was constructed as derived from their engagement with DBT. It contained the skills deficit element of the 'emotion dysregulation' discourse identified in chapters five (journal articles study) and seven (clinicians' study), however did not include the more theoretical explanation of the 'emotion regulation system' present in those studies. The skills deficit

discourse of BPD evident in client interviews constructed client difficulties as related to skills deficits, based on dysfunctional learning when they were younger. The following extract sums up this point.

100. *Sasha: well like I said to my therapist um (.) with the DBT therapy I'm learning now what I should have been taught as a child (.) and it's and I look back at it because I am a mother (1) I have taught my kids what they need to know to survive (2) but I never taught myself*

Mel: yeah

Sasha: so and my parents didn't teach me so (.) yeah yeah you learn that you can be in control of your relations and sort of feel (.) normal

Mel: so (.) do you believe that some of the problems that you've had (.) stemmed from childhood?

Sasha: oh absolutely (.) I had totally dysfunctional family

In extract 100 Sasha's description of learning skills now and ensuring that her children also do so constructs her difficulties as skills deficits, related to impaired learning as a child. Difficulties are no longer a result of illness, or a deliberate choice, but a result of environment and learning. This removes the difficult power dynamics between client and clinician created by the tension between illness and responsibility (also see Chapter Eight, extracts 72 and 73 for the same idea in clinician interviews). There is a sense of optimism inherent in this construction, because skills can be learned. In particular this extract suggests breaking of a generational cycle, as Sasha ensures her children learn skills for the future.

Clients constructed the difficulties in their lives as related to skill deficit. In particular, clients focussed on self harming behaviour as something they wished to change through acquisition of skills.

Self harm performs a function, in absence of more adaptive skills.

Clients constructed the self harming as performing a function in some way, and themselves as having no alternative skills to complete these functions. The following extracts illustrate the meanings associated with self harm which were evident in their talk.

101. *Mel: so what did the self harming do for you?*

Angela: (.) um (.) it just sort of took me away it just like it just took me away from how I was feeling (.) like um I had (.) like ever since I can remember I had really negative thoughts about myself like everything you know I was stupid

Mel: mmm

Angela: not clever and that sort of just stopped it and

Mel: just so it worked to just stop those

Angela: yeah it validated everything I felt yeah

Mel: so it was (.) by validating what do you mean?

Angela: (2) well it just made me feel like (1) like it was ok (.) like it that I could control (.) the pain I guess like

Mel: ok

Angela: it sort of felt like by doing it (.) it was allowing only me to hurt myself rather than other people hurt me

In extract 101 Angela's description constructs the self harm as purposeful, in order to bring about personal relief. Negative thoughts and feelings were associated with loss of control, particularly over the ability to protect herself from other people inflicting pain, and self harm worked to ameliorate these unwanted thoughts and feelings. Understanding self harm in this way works to validate the client's experience, and removes association with the discourse of 'difficult client', with associated deliberate client behaviour and negative staff attitudes. Although the self harm is deliberate, the aim is not to be malicious or difficult, and is not aimed at causing distress to others.

102. *Lisa: and (.) that was just (2) the high needs was (2) oh (2) mind numbing (2) like the drugs they gave you you just couldn't (1) think or feel*

Mel: mm

Lisa: and that's when I started putting cigarette butts out on my arms

Mel: mm

Lisa: just so I could feel something

Lisa describes using self harm in order to be able to feel something, rather than to stop the experience of negative emotion. In extract 102 she presents an opposite effect of self harm compared to Angela's description above. Instead of feeling too much, medication has reduced Lisa's ability to experience emotion altogether. Again self harm is presented as a tool which enables her to experience her emotions, and is not aimed at causing distress to others.

103. Lisa: and I that night (.) in high needs I um (.) managed to get hold of a razorblade and cut my wrists and (1)

Mel: so

Lisa: cut my veins up here

Mel: so when you were doing that that self harm that time was it an attempt to get help or an attempt to kill yourself or an attempt to feel something?

Lisa: an attempt to die

In extract 103 Lisa describes a particular self harming incident, when the goal was a suicide attempt rather than an attempt to get help, or to regulate emotions. She is clear in making her distinctions between reasons for self harming. This incident is described as qualitatively different to her previously described example (extract 102). She presents herself as having reached a stage of desperation, so that the only end to the situation was to commit suicide. Although a suicide attempt can not really be regarded as 'skilful', it was a goal directed and deliberate act.

The skills deficit discourse functioned to explain clients' behaviour, without use of illness or stigma discourses. It provided hope for improvement because skills could be learned and passed on to the next generation (see extract 100). This suggests hope extends to generations to come. The skills deficit discourse provided a non-illness explanation for clients' difficulties. There was also some evidence of a discourse based on this non-illness meaning. This will be discussed next.

BPD as absence of disorder

A final discourse associated with the BPD diagnosis in clients' talk was that of being 'not crazy'. In this discourse the BPD diagnosis provided reassurance that they were not mentally unwell, and despite their difficulties could think of themselves as sane. This

discourse differs from the others in that it is defined by what it is not. The following extracts provide examples of this.

104. *Mel: ((laughter)) what what um what did you feel like when you were given those diagnoses?*

Jane: um relieved (.) actually

Mel: can you explain that?

Jane: um because I thought (.) I know it sounds stupid I thought I was mental (.) like mental mental

A BPD diagnosis could also be described as indicating absence of mental illness. In extract 104 Jane's description of relief presents mental illness as a serious disorder and something to be feared. By accepting the BPD diagnosis, she is defined more by what the diagnosis does not mean (mentally unwell) than something she is. BPD provides an alternative explanation for her experience, although it is unclear what this explanation is.

105. *Mel: did you know what it was?*

Angela: yeah I knew what it (.) I'd sort of thought well maybe I did have (.) like cause I'm interested in psychology just

Mel: mm

Angela: generally you know um and I sort of thought like some of the things sounded like

Mel: aha

Angela: how I felt (1) um and for me I found it quite validating

Mel: ok yeah

Angela: like it meant that I wasn't crazy

Angela's description in extract 105 also understands the diagnosis as representing something other than illness, or 'craziness'. Again professional knowledge is privileged, as Angela links her interest in psychology to her acceptance of the diagnosis as fitting her experience. It seems the information Angela has obtained through her interest in psychology avoids the stigma contained in Kate's reading material (see extract 98). Here the diagnosis provides a framework for Angela to conceptualise her experience, and importantly, the framework does not include mental illness (or at least not "craziness"),

although the conceptualisation does provide evidence that her experience can be labelled, and is recognised within psychology. This utilises the ‘making sense’ discourse identified in clinicians’ talk (see Chapter Seven), because it provides an explanation for some of Angela’s experiences.

The next section examines the clients’ use of the illness, stigma, skills deficit, and absence of disorder discourses to negotiate agency and responsibility for their behaviour. Like clinicians the clients reported contradictory meanings attached to the diagnosis. In utilising these discourses, and at times switching between them, clients negotiated subject positions within the interactions described. The construction of responsibility for behaviour was central and will be discussed in the next section.

Responsibility and agency

The construction of what it means to be diagnosed with BPD - and the attached ideas of responsibility for behaviour and agency or ability to control behaviour - fundamentally influence the interactions between clients and other people in their lives, particularly the clinicians involved in their care. The following extracts illustrate the function of discourses in allocating or accepting responsibility.

106. Kate: they just used to chuck me out to do it again (.) I used to sit there have a time period of waiting go back out

Mel: yeah

Kate: wait for myself to get in trouble again (1) just think of you know um I'd end up back in hospital anyway

In extract 106 clinicians are portrayed as not fulfilling their healing role. The description “chucked out” implies an attitude of frustration and callousness exhibited by clinicians. In referencing her comment to an unknown “they”, Kate generalises to include all mental health clinicians. The comments “I used to sit there” waiting for the cycle to repeat describes a cycle of recurring events, with no apparent way out. Kate, in the above example, has no power to change her behaviour, and it seems that clinicians are also powerless to make a difference, although the construction of responsibility remains with the clinicians. There is an element of depressing predictability in the above example, and expectation that no improvement would be made. She draws on the illness

discourse to validate her right to receive treatment –and to place the responsibility for this onto clinicians, and the stigma discourse in describing the response of clinicians.

107. Kate: yeah after all of that yeah something had to be done they were trying to help me

In extract 107 this presentation of powerlessness is continued. The sentence ‘something had to be done’ contains an unspoken “about me/to change me” and removes any agency that Kate might be expected to have in dealing with her situation. It constructs her life as a problem that other people needed to do something about – hence the referral for the DBT programme as a kind of last resort. In this extract she presents the people who worked with her as wanting to help her (although any attempt to help was likely to fail) which is in contrast to Lisa’s angry response to lack of help (extract 91). In the next extract, Angela speaks of a specific encounter with the mental health emergency team.

108. Angela: um (.) oh yeah I had talked to the crisis team and a couple of times I like I went to A and E and had talked to them yeah (2) um I probably shouldn't tell you this but I found them quite easy to manipulate (1) like um

Mel: can you just explain that a bit more?

Angela: well I mean I wasn't trying to kill myself like

Mel: yeah

Angela: when I was trying to self harm I generally wasn't trying to kill myself but (.) like (.) you know they asked me questions like are you trying to kill yourself and I mean I know that if I (.) had (.) then I know I wouldn't admit it and like they asked me if I would do it again and I knew I was going to and I just said no

In extract 108 Angela’s story also constructs the service as being ineffective in helping her, and places the responsibility to make the right decision (despite her providing incorrect information) on the crisis team clinicians. Presumably a more effective crisis team would be less easy to ‘manipulate’.

Angela is positioned as in opposition to the mental health service in this example. Her description of her behaviour towards the crisis team represents a move to resist the power differential between herself and the mental health service. This demonstration of resistance is enhanced by her comment “I probably shouldn’t tell you this”, implying that she is aware her behaviour is outside what is expected for the client role. This is congruent with the difficult client discourse described in Study One. In the following extract, Lisa talks of her interactions with mental health services, utilising both illness and skills deficit discourses.

109. Lisa: and um (3) yeah and hence I had to go to extreme measures (2) to (.) get the help that I needed to get (.) and (.) um (.) in doing that a lot of the time I I was completely out of control

The idea of deliberate choice was not a simple one. In extract 109, self harm is presented as a deliberate method of communication with mental health services – and utilises the skills deficit discourse. Lisa states this is necessary behaviour, because she was not listened to unless her behaviour reached extremes. Self harm is an attempt to obtain a reaction from a much more powerful force than herself. In this way self harm can be viewed as a strategy (albeit a problematic one) which obtains results. Lisa’s statement that she was ‘completely out of control’ seems to contradict this sense of purpose (and control) in her self harming. It links to the illness discourse, and validates her need for help. This is an example of contradictory ideas being held in the same small section of talk – her behaviour is both deliberate and out of control.

Lisa’s use of contradictory discourses works to justify both her behaviour and demand for care as appropriate. In doing so she creates a dialectic argument of control and lack of control to justify both the need for her actions, and the reality of her distress. She draws on two available discourses – a ‘absence of disorder’ discourse of responsibility and deliberate choice; and an illness discourse (with an associated understanding of lack of control). This was similar to Malson, Finn, Treasure, Clark and Anderson’s (2004) study of clients with anorexia, which identified that clients constructed themselves as simultaneously healthy and disordered.

110. *Lisa: yeah (.) so back in high needs again (2) and um (3) yeah it was just a (.) a vicious cycle from then from (.) being discharged to going back in (.) um (.) to running away*

The complex relationship between clients and mental health services reflected difficulty in finding synthesis between the illness and absence of disorder discourses, with associated differing expectations for behaviour. In extract 110 Lisa describes a “vicious cycle” where she was locked in a fight with mental health services, and not able to break out of this pattern of behaviour. Paradoxically she fights to achieve an admission to the ward, and then runs away, continuously in opposition to the mental health service she is trying to access.

As described above, the BPD diagnosis seemed to carry a meaning of both illness and non-illness, resulting in a complex relationship between client and mental health services. The stigma discourse was utilised in constructing past clinician responses as unreasonable, and at times to construct themselves in a similar manner. The clients also utilised the idea of skills deficit inherent in the DBT formulation of their difficulties.

Summary

This chapter has examined client constructions of their own behaviour and diagnosis of BPD. Clients described themselves as having experienced severe difficulties, and having believed they were “hopeless” cases prior to DBT. The sense of hopelessness included both their own and mental health services’ attitudes. Some of the clients reported that negative staff attitudes had increased their distress and sense that no help was available to them. In constructing themselves in this way, clients were in agreement with clinicians’ discussions of their pre-DBT attitudes towards clients with BPD, as being difficult to work with, and unlikely to make progress in therapy. Taking this position made it difficult for clients to believe that they could improve their lives.

All of the clients had received a diagnosis of BPD, among other diagnoses. Their responses to this were varied, with most regarding it as at least partially positive. This was because the diagnosis provided a sense that their difficulties were validated and that they were not “crazy”. For others it provided evidence that they were mentally unwell and required treatment. The subject positions offered by the available discourses

resulted in responsibility for behaviours being placed on either clients, clinicians, or the wider environment. Clients worked to produce acceptable narratives of their behaviour in such a way that they could both take control and move forward with their lives, while maintaining their claim and need for mental health service assistance. Clients utilised both non-illness and illness discourses, and positions of being in and out of control.

Clients utilised a 'skills deficit' discourse in a similar way to clinicians, which worked to externalise their difficulties. Although they did not describe maladaptive behaviours as skilful, clients identified that these behaviours had effectively served a purpose. Self harming was described by clients as performing a variety of functions, including help seeking, reducing overwhelming emotions, attempting to feel something other than numbness, and suicide. The clients constructed self harm as a complex response, and one that was not always experienced as negative.

The diagnosis, despite the difficulties associated with it, led to the clients' involvement with DBT. This was presented by clients as an advantage of having received the diagnosis. Discourses of DBT in client interviews will be presented in the next chapter.

Chapter 10: Study Three part two: Clients talk about DBT

This chapter presents constructions of DBT present in client interviews. There was a sense of eagerness to try this therapy which offered a way out of a desperate situation. The clients utilised the conceptualisation of their difficulties as a skills deficit offered by DBT, and presented themselves as applying new skills successfully in life. They also talked of a sense of self, and spoke of fundamental change occurring in their self-perception. This was a frightening process for some clients. In addition to the provision of skills, clients identified participating in the DBT group and the relationship with their individual therapist as fundamental to their progress. The next section outlines the construction of DBT as providing hope.

DBT as best hope for improvement

This discourse presented DBT as the best way out of the clients' difficulties, in an uncritical manner. DBT was constructed as 'the' answer to problems, and the best and possibly only way to improve their lives. Clients in this study presented DBT in an overwhelmingly positive light, and all five said that they would recommend it for other people experiencing similar difficulties to themselves. The next extracts illustrate this.

111. *Sasha: ... I just thought (.) I want to do something and I'd waited over a year to do it (.) so by the time I got into it I was just itching to go (.) so I yeah (.) 'cause I missed out on the last group (1) and then it kept getting put back and back and back and it was like when am I going to start this*

In extract 111 Sasha's description of waiting over a year indicates that nothing else could have taken the place of DBT – it is "the" treatment. This construction of DBT as the 'cure' for BPD, which is able to be withheld by mental health services reflects a power differential between client and mental health service. In this example, Sasha has no power to influence the length of time before she can receive DBT, while mental health services are able to change the start dates as they wish. In the next extract, Sasha continues her positive appraisal of DBT.

112. *Mel: what are you hoping to learn from the next module?*

Sasha: (2) well because I'm not sure what it is (.) I'm just (.) I'm just really keen (laughter) I know that sounds weird but I'm just really excited to get to another bit (1) and then I'm hoping by all the modules everything will gel out (.) nicely and I can (2) make future plans like at the moment I'm not making future plans 'cause I just want to (2) get through this and see where I am (2) but lots of people have said that I'm a lot more positive

In extract 112, the fact that Sasha has no real idea what the modules of the DBT programme will consist of seems irrelevant, as she expects DBT to work well to give her a positive future. She bases this prediction on her initial experience with DBT and related improvements. She presents herself as an accurate historian, as improvement has also been noted by others. Her lack of knowledge about what she will do in DBT or where it will take her seems inconsistent with her expectation of improvement. There is no sense of agency attributed to Sasha herself in this example - instead improvement is due to DBT. In the next extract, Sasha provides a comparison with another therapy she has tried in the past.

113. Sasha: and it just it just clicked (.) straight away whereas cognitive (.) you have those core beliefs (.) and ok yeah I did have a core belief (.) but I didn't get to (3) I didn't really know how to rectify it (.) it was more (.) clinical (.) whereas the DBT's more therapeutic you can find ways of doing it

The presentation of DBT as the ideal treatment is apparent in Sasha's comparison with cognitive therapy. In particular she makes a distinction between 'clinical' cognitive therapy, and 'therapeutic' DBT. This works to create a separation between a 'clinical' understanding – which is inaccessible to ordinary people, and the understanding she (and other clients) have. DBT is presented as able to bridge this gap. In contrast to the suggestion of lack of agency in extract 112, Sasha describes herself as able to utilise DBT in life, and links this ability to the effectiveness of DBT. DBT is described as practical rather than inaccessibly theoretical. In the next extract, Kate utilises this discourse as she lists a series of positive changes she has made.

114. *Kate: ok I've learnt that promiscuous behaviour has consequences (.) and (.) I've learnt how to prevent that (.) I've learnt violent relationships (1) are (.) not acceptable (.) and I've learnt the ways to keep me safe from violent relationships um (.) I've learnt about self harm (.) and the consequences of that (.) which I never thought of the consequences*

Kate provides a summary of what she has learned in DBT (extract 114). Her summary includes multiple areas in her life including relationships and self harm, in which she has experienced severe difficulties in the past. It provides a ringing endorsement for the success of DBT in changing her life for the better.

The function of this discourse was to promote DBT and to validate the choices made in undergoing therapy. Using this discourse validated both the clients' previous negative experiences of interaction with the mental health system, and also the construction of hope despite the clients' lengthy histories with mental health services. Using this discourse also worked to validate clients' use of the illness discourse and lack of responsibility for past behaviour (as their 'illness' was not treated appropriately) and to construct past therapeutic failure as unavoidable. Use of this discourse functioned to provide hope for the future and also allowed for use of the skills deficit discourse, and new ability to change (due to DBT being the 'right' treatment). In talking about a new ability to make changes, clients utilised the same DBT as providing skills discourse that was evident in clinicians' talk (see Chapter Eight). This will be discussed next.

DBT as providing skills

DBT was constructed as providing a set of skills which can be learned. Clients utilised this discourse to describe their situation and the way forward. The following extracts illustrate this.

115. *Sasha: the thing I find (.) the irony of it all I think is (.) if I'd just been taught these little simple coping things*

Mel: mm

Sasha: I don't think life would have been so hard

In extract 115 Sasha's difficulties are presented entirely as skills deficit. These are presented as likely to be easy to learn, as they are "little" and "simple". In this extract the illness and stigma discourses are dismissed. The word "irony" alerts the listener to the incongruity between the severe difficulties experienced in Sasha's life, and her current description of her difficulties – as needing to learn simple skills. In this way both the extent of her struggle, and the construction of difficulty as skills deficit are validated. In the following extract, Lisa describes how she may utilise skills in the future.

116. Mel: so how would (.) what would you describe your experience as?

Lisa: well (.) I would say I had a total (.) mental meltdown

Mel: right

Lisa: and um (3) looking back (1) and with the skills that (.) that I've got now (3) hope I (.) I would hope that I wouldn't react in that same way

Using a skills deficit discourse allowed clients to take responsibility for behaviour in such a way that they could avoid shame associated with previous behaviours. In extract 116 Lisa validates her position as having been unwell, out of control, and not responsible for behaviour ("I had a total meltdown"). At the same time she utilises the illness discourse, she also validates the skills deficit discourse, which paradoxically presents her as now able to choose how she will react to stressors in the future. For Lisa, who described such a conflictual relationship with mental health services (see Chapter Nine extracts 109 and 110), this ability to take responsibility and maintain face is very important.

While generally referring to "skills" as a generic concept, clients presented mindfulness as the core skill, underlying the others. This was congruent with clinicians' talk. The construction of mindfulness is discussed next.

Mindfulness

Similarly to clinicians, clients constructed DBT skills as generally important, and mindfulness skills as fundamental. This is apparent in the next two extracts.

117. Mel: um (1) how have you found that?

Jane: um (1) pretty good um but you you really got to try and concentrate to stay in (.) your one minded mind (.) um (.) 'cause there's like the emotional one (1)

Mel: are you talking about those three circles?

Jane: the three circles yeah the wise mind and the other one

Mel: rational mind

Jane: yeah and I like I used to spend a lot of time in the emotional mind (.) and now I can (1) go between and actually think (.) and as long as I write it down on paper (.) so I can see it in front of me (.) to go into a mind I can work something a lot easier

In extract 117 Jane indicates that she is still finding the use of mindfulness difficult and something she must actively work through each time. In this extract the process of learning a 'skill' is outlined, as Jane describes utilising learning tools (pen and paper) to assist her. She presents herself as a good student, working through the steps of the process. The conceptualisation of mind-states (as presented in DBT) is accepted as reality, as she works towards being able to use "one minded mind". The construction of self as a stable being also occurs here, as she can choose to "go into" a mind or not. This is an example of how the skills deficit discourse allows preservation of the sense of self, or continuity, in a person who experiences extreme fluctuation in emotions. Or – in Jane's words – 'mind' states. In the next extract, Lisa describes a description of herself using mindfulness.

118. Lisa: yeah (.) yeah like after this (.) I'm going to go home and feed the cows

Mel: yeah

Lisa: because I love just standing there (.) and (.) observing them

Mel: mm

Lisa: doing my proper skills and observing them and describing them (.) and when you're doing the two of those you actually do end up participating and it's just nice just to stand there (.) and watch them eat

Mindfulness was presented as an awareness of sights, sounds and sensations. The skills were constructed as useful, and used in a deliberate and targeted manner – here

Lisa intends to resolve any tension which may occur as a result of her interview by feeding and observing cows, and utilising 'mindfulness' skills.

Lisa's description of doing "proper" skills and utilising words from the DBT manual ("observe", "describe" and "participate") constructs her as being a diligent student. Although there is no mention of clinicians in this example, there is a sense that Lisa is seeking approval for her correct use of skills, either from myself (the interviewer) or from absent clinicians. This is in contrast to the antagonistic relationship presented in her descriptions of pre-DBT relationships with mental health services.

In addition to mindfulness skills, clients also constructed other DBT skills as useful. Some of these are illustrated in the following extracts.

Other DBT skills

DBT skills were constructed as helpful for clients in managing different situations, and in providing alternative responses to self harm, which had been a prior strategy in managing difficult situations. Two of the skills mentioned were 'pros and cons', and 'distract', as can be seen in the next extracts.

119. Angela: mmm I (.) I (.) one of the first things I did when I started therapy was the pros and cons of self harming

Mel: mm

Angela: and it was actually really good like (1) because I at that point I thought self harming was good like it was help helping me

In extract 119 the use of a specific 'skill' (pros and cons) is described as having changed Angela's evaluation of behaviour – changing the meaning of the behaviour for her. Angela's new evaluation of self harming as unhelpful, compares to her earlier construction of self harm as fulfilling a positive function (see Chapter Nine, extract 101).

120. Kate: I had to tear myself away from harming myself to do it but in my brain (.) that distract skill came up when I heard the knock I thought I'm not answering that (.) and then I remembered the distract skill and I thought ok I'm started I can't go back now

Mel: mm

Kate: but (1) we'd been put so much I did stop (.) and I didn't need to go back and finish the job

In extract 120 Kate describes a scenario when she was beginning to self harm, and was interrupted by someone knocking on her door. She is presented as the agent of change in this situation, actively using her new skill ('distract') to change her own behaviour. This is in direct contrast to alternative discourses that could have been utilised to describe this exact situation – for example she could have utilised the illness discourse and portrayed herself as a victim of mental illness, being rescued by the unanticipated arrival of her visitor. Her use of the DBT as providing skills discourse (and implicitly her construction of her own difficulties as skills deficit) allows for the possibility of learning more functional replacement skills. In the following extract, Kate describes her experience of providing her telephone number for other DBT group members.

121. Kate: mm (.) see it took me three weeks to take the phone number in (.) my phone number in on a piece of paper to give people (.) I'd actually meant to do it a bit earlier so I could say (.) reinforce

Mel: mm

Kate: reinforce that I did actually want to hear from them and (.) it would be good um (.) but I was unable to do that it was it took all of my skills up just to do it the last time and then (.) to actually hand them over you know it was very [it's]

Mel: [mm]

Kate: it's yeah it's good exercise (.) 'cause it's something I would never have done

In addition to managing stressful situations, clients also constructed skills to enabling them to do new things that had previously been too difficult. In extract 121 Kate's description of using skills to approach a difficult task promotes the usefulness of skills in everyday life. She positions herself as a good student – approaching her fears and treating it as an 'exercise' (compare Lisa's description of 'doing proper skills' in extract 118). Her comparison to pre-DBT behaviour ("something I would never have done")

presents her as having made progress despite the difficulty involved in the task described.

Using the DBT as providing skills discourse functioned to construct clients as gradually assuming responsibility for behaviours, as new and effective skills are developed. It functioned to negate the illness discourse, because the difficulty was located in a lack of learning rather than a disorder. It also functioned to discount the stigma and difficult client discourses because clients were constructed as doing their best, even prior to DBT with the few skills they had.

The process of change was described as occurring on a skills level, where clients are learning and practising new skills to manage individual situations, and also on a personal identity level, where they are gradually working on improving quality of life and creating new identities as people who can have some hope for the future. This process of DBT changing identity was prominent in client interviews. The next section will discuss this discourse.

DBT as changing identity

DBT was constructed as a life changing experience, which involved changing the person in a fundamental way. It was presented as not simply a set of skills to be learned, but a process of finding the self and creating a new identity. This change could be a scary process for clients even though it was positive. The next set of extracts illustrates this changing identity.

122. Sasha: (3) I think I'm starting to believe in myself (1) like my self esteem's (1) getting there (2) wouldn't say about the confidence but I'd definitely say I'm starting to like myself (2) I don't see myself as a bad person or a (.) or a worthless person any more

In extract 122 it is clear that learning new skills to remedy a skills deficit was not the only discourse associated with DBT utilised by clients to talk about their progress. Sasha reports that the way she sees herself has changed. Her descriptors of 'worthless' and 'bad' are utilised to describe her perception of a stable self, rather than specific examples of behaviour or thinking.

This example is complex in the manner in which it constructs a 'self' as both stable and changing. Sasha reports on her perception of underlying self, as observed by a stable "I". The "I" position from which the observation is made stands back in order to make judgements. The phrase "I see myself" is common in English, and works to construct the observing self ("I") and observed self ("myself") as separate from one another. Sasha notes that her concept of herself is shifting, but it is important to note that she has not become a different person. This separation into observing and observed self are also described as "self as context" (observing self) and "conceptualised self" (verbal descriptions and evaluations) in Acceptance and Commitment Therapy (ACT) (Bach, Moran, & Hayes, 2008) which works to construct a place of stability from which observations can be made without 'fusing' with the language. This need to separate oneself from language (here Sasha describes herself as now able to observe her previous identification with the word 'worthless') was also described in the clinician study (see Chapter Six, extract 55). In the next extract, Angela provides a description of a process of identity change.

123. *Angela: um (.) it was scary in that the (.) I had (.) I felt like I had what little I knew about myself was (.) going*
Mel: ok (.) so that identity
Angela: yeah
Mel: who am I? kind of question
Angela: yeah (2) and same with the self harm like (.) the harm (.) like for years I thought of myself as a self harmer and like now it's gone it's (1)
Mel: mm
Angela: getting used to it but at the start it was really scary

The construction of DBT as changing identity and self-definition is apparent in extract 123. A sense of 'self' which is deeper than behaviours or emotions is constructed, and clients were becoming aware that their understanding of this was changing. Not being able to recognise one's 'self' was a disturbing experience. This is congruent with clinicians' talk about their client's fear at having to use new behaviours and take responsibility for actions, because of the new expectations this would entail.

The ability of language and words to create identities is apparent in extract 123, as Angela articulates her discomfort at losing the label 'self harmer' without knowing what to replace it with, leaving her with a sense of lack of self knowledge or identity. There is no indication of this change being imposed on the client by mental health services, and no resistance on the part of the client to imposed change (or perceived attack), despite the discomfort experienced.

The process of change, out of a traumatic past, was presented as occurring gradually over time, and only recognisable from the current point in time when some changes have already been made. In the following extract Kate talks about her recognition of change in her identity.

124. *Kate: which is why I started it (.) because I could never keep going with the writing diary so (.) I started that and then um (.) then a year later I'm able to look back at myself (.) in those states and see (.) yeah you can actually tell when I'm on drugs*

Mel: mm

Kate: when I didn't think you could

Mel: mm

Kate: tell and I can see that I can see I'm suffering a whole lot and I'm talking about (.) all of this stuff that wasn't even the issue (.) I couldn't see that at the time (1) and it's really helpful for me to be able to (.) see how I was then (.) and how I was now

Mel: mm

Kate: how I am now

In extract 124 the process of changing identity is presented as valid, because Kate is able to report on diary entries, and note changes in her own thinking and understandings that have occurred over time. In talking about this she frequently changes from the present to past tense and back again. This tense switching links her past and present in a way that emphasises the degree of change she has experienced. A separation of observing and observed self is especially apparent in this example (see also extracts 122 and 123), because this separation includes distance in time. There is a suggestion of ongoing change into the future, as she initially describes her current state in the past

tense, placing herself as future observer. Her final comment however, moves her back into the present, with emphasis placed on the present tense “how I am now” and positions her as now able to accurately observe her current state.

Some of the clients spoke specifically of abandoning old constructions of the self as a victim of trauma and abuse. This includes a movement away from an illness discourse, and towards one of absence of disorder. The next section illustrates this.

Moving on from past trauma

Several of the clients reported past trauma and abuse, which had shaped their lives prior to DBT. For some clients, the process of creating new identity roles included an ability to feel able to move on from their traumatic past.

125. Sasha: and I think I've got to the point where I don't want (.) to be a victim for a better word (.) I don't want to be a statistic (2) I want to be a normal human being that can function in life

In extract 125 Sasha's rejection of 'victim' status recognises the power of that label to create an identity, along with associated beliefs and behaviours. She wishes to lose that "victim" identity. Her expressed wish to be "normal" implies that being a victim is incompatible with normality. There is an implication that her former acceptance of the victim label may have perpetuated some of her difficulties and she now presents as challenging the permanency of that identity, opening up the possibility of change. This disengaging from the 'victim' label is the same as the ACT process of de-literalisation described in the clinician study (Chapter Seven, extract 55). In the next extract, Kate discusses her plans to lay charges against her historical abuser.

126. Kate: yeah (.) definitely it's made me realise that I will be able to cope if he doesn't get charged because (.) it's not so much about (.) him being punished because of the time lapse (.)

Mel: mm

Kate: it's been 20 years (.) um (.) it's about me being able to get closure and move on with my life

In extract 126, the move away from a 'victim' identity was associated with an almost symbolic gesture of defiance against her abuser – as Kate contemplates laying charges against her abuser. Her actions in laying charges are presented as a statement of her own recognition that what happened to her was wrong, and a symbol of her laying the blame for the abuse on the abuser, which she hopes will enable her to move on with her life. There is a high degree of optimism about the future, and life after trauma.

The construction of DBT as 'the' answer to clients' difficulties included descriptions of clients trusting to the process of change with positive expectations. This construction of DBT as a process is discussed in the next section. Here the change of identity is constructed as gradual, and ongoing, likely to continue into the future.

DBT as a process

The clients constructed DBT as a process or pathway, towards an improved life. This discourse presented DBT as likely to continue the process of change in the future, even after the completion of treatment. Even if clients have not yet reached a point where their difficulties are reduced, they expressed confidence that participating in DBT would lead them in the direction they wished to go. This section describes this.

127. Sasha: so I think (2) with everything that I've done through the mental health team (2) it's it's put me on a (.) a good path instead of a bad path

Mel: mm

Sasha: so yeah

Mel: and before that you felt like you were on a bad path

Sasha: oh (.) I was going down (.) I just yeah I didn't want to be here

In extract 127 Sasha uses a metaphor of a path to construct an image of her life direction being changed by her participation in DBT. The "good path" she is now on leads to a hopeful future, compared to the "bad path" which seems to lead to hopelessness and possibly suicide, as her statement "I didn't want to be here" seems to hint at. The image of a pathway suggests a change of life direction, more than simply a new skill learned or behaviour changed. It describes an ongoing process rather than an endpoint. In the next extract, Kate compares her current thinking, to earlier times.

128. *Kate: yeah (.) I mean I wasn't even thinking that about quality of life back then you know it didn't even occur to me to think of quality of life*

In extract 128 Kate emphasises the extent of the change by indicating that she is now able to examine areas of her life which had been completely inaccessible before. This creates a scenario of changing horizons, bringing new aspects of life into view as she progresses through DBT. This extract also hints at the degree of despair prior to DBT, when any kind of enjoyment of life had been beyond her, even beyond her imagination. It suggests even greater hope for her future. In the following extract, Angela describes her

129. *Angela: it's just a long process like*

Mel: mm

Angela: the stink thing is I think (.) you know in other places like in the media (.) they show antidepressants like as making you happy and yeah yeah and you know like it's sort of like when I first came (.) I saw my GP when I first started like (.) I expected everything to work the next day and feel great

Mel: right

Angela: like you know like five years from then I still don't feel great but I feel better (.) and you know that's ok

In extract 129 the media is constructed as having created an unrealistic expectation of the pathway through mental health services - utilising an illness discourse, and suggesting associated medical treatment without the need for hard work on the part of the client. Angela's description of this as "the stink thing" presents this as an unhelpful construction, which only worked to raise expectations and cause increased distress when expected improvement did not occur. This idea was also outlined in the clinicians' study where the idea of the mental health service as unwittingly increasing pathology was put forward (see Chapter Seven, extract 57). Angela's final comments present her as recognising and accepting the absence of a quick 'cure' and achieving contentment with the progress she has made. Again there is hope that improvement can continue into her future.

The discourse of DBT as changing identity functioned to construct clients as changing in a fundamental way, which contrasts to the more superficial construction of change provided by the DBT providing skills discourse. Clients utilised the changing identity discourse to emphasise the extent of change, and to construct themselves as beginning new (and more positive) lives. The use of both discourses enabled clients to construct themselves as both essentially the same as before – and with new skills which they could utilise in their lives, and at the same time changed in a fundamental way. The change of identity was constructed as irreversible and permanent. It involved abandoning familiar understandings and beginning to utilise others. A dialectical understanding of identity is apparent, in which both sameness and change can be embraced.

The above examples have illustrated clients' constructions of their changing self-perception across time. Their descriptions of DBT presented them as making progress in many facets of their lives. This included the application of skills described in the first section, and the deeper change in self-perception described above. A common construction was of a process of change, in a positive direction, with different components of DBT influencing change along the way. In this way the process of DBT was constructed as a pathway to a better future.

The process of DBT was constructed as a pathway however there were specific components of DBT which were constructed as important for clients. These will be discussed in the next section.

DBT as an integrated whole

In addition to the global process of DBT, clients also constructed DBT as a coherent whole, consisting of different parts, each of which fulfilled important roles. This discourse was also found in clinicians' talk (see Chapter Eight). In addition to the skills, the DBT group, the individual therapist, and the way these two aspects of DBT worked together were constructed as useful by clients. In the following extract, Sasha speaks of her first encounter with the DBT skills group.

130. *Sasha: the first time we ever went it was like and I'm thinking everybody else here is exactly like me and a couple of them went and it was like ah whew yeah (.) so that was good um*

The skills group was constructed as extremely important by the clients, for several reasons. An important factor was the clients' experience of being with people they could identify with as experiencing the same kind of difficulties as themselves. In extract 130 Sasha's sense of relief that others were "exactly like me" presents the group as comfortable and appropriate for her. The moment of entry into the group was constructed as pivotal for her, and she describes herself as experiencing a moment of recognition that this was the right group for her. In the following extract, Sasha describes how beginning the DBT skills group impacted on her weekly individual therapy sessions.

131. *Mel: so it sounds like that was (.) um in some ways (1) what you said before about every time you saw her you had to deal with the stuff that was on top*

Sasha: yeah and it got hard to actually deal with the DBT and now I find (1) um (3) oh the I think the first two times after DBT that we started (.) we actually had a hard time finding something to talk about

Mel: mm

Sasha: 'cause I didn't have all these yeah all these issues to deal with because DBT was actually helping me (.) to deal with them

In extract 131 Sasha presents DBT as a coherent whole, with interacting components. Here she utilises the 'DBT providing skills' discourse when using the word DBT – as she recalls previous therapy sessions which were spent dealing with difficulties in her life with no time available for learning skills, which ironically could have helped her manage those same difficulties. After two DBT skills-based group sessions, she no longer had the same urgency to talk about current difficulties with her therapist. The relationship with the therapist continued to be presented as fundamental however, as can be seen in the next extract.

132. *Sasha: he gave me a scenario that said if you're having a crisis go with it*

Mel: right

Sasha: and my immediate reaction was uh oh (.) warning light that's not good (1) and I said to him isn't that dangerous (2) and he goes I don't know (1) and he never gives you (2) the answer (.) so that used to frustrate me but now it's yeah he's making me stop and think

Mel: so what do you mean by dangerous? What were you thinking?

Sasha: well to me (.) if you're in a crisis and you go with it (.) well before DBT anyway (.) um (.) that could lead to dang- you know self harm or horrible negative thoughts and you just re-affirm all that bad stuff

Mel: so by going with it you mean allow it to happen

Sasha: yeah and and I did and (2) instead of it lasting a week it lasted two days or a day and a half and (1) it wasn't a big deal so (.) there is that

The clients constructed DBT as giving them the skills to try new things and new behaviours. The relationship with their individual therapist was presented as important for a sense of trust and security to enable them to try these new things. In extract 132, Sasha describes her therapist as pushing her, in a supportive manner, to extend herself and take risks. Her trust in his judgement allowed her to take the suggested risk. Her experience was a positive one, and she can now move to a set of expectations related to a 'crisis' that is less frightening or 'dangerous' than before. In saying this she is also presenting herself as open and willing to work hard in the service of change. The construction of the therapist providing security to try new things is also apparent in the following extract.

133. Mel: when did you first start thinking there might be a way out?

Sasha: (3) ooh that's a good question (4) actually I'd say when my therapist and I signed a DBT contract

Mel: so that contract signing was

Sasha: because she made a pledge to me that she would be there for me and I made a commitment to her

Mel: aha

Sasha: I think that was the turning point

The commitment of the therapist to the client was described as extremely important by some of the clients. In extract 133 Sasha presents the DBT contract as fundamental to her sense of security. Signing the contract represented an act of making a commitment, a gesture of moving forward, the symbolism of which is evident in her statement that it was “the turning point”. It can be compared to Kate’s symbolic gesture of laying charges against her abuser – rejecting the victim label and choosing a new direction.

The above elements of DBT were constructed as combining to form an integrated whole, with individual components which were important in themselves. This discourse functioned to construct DBT likely to be effective in addressing most if not all aspects of clients’ difficulties. It worked to promote DBT and at the same time to validate constructions of the clients’ difficulties as complex and requiring intervention at many points.

Summary

This chapter has examined client constructions of DBT, their experiences with DBT and how DBT has impacted on their lives. The clients were uniformly positive about DBT and would recommend it for other people who had the same experiences and difficulties. The discourse of DBT as the ‘best’ therapy was prominent in the client interviews. This was evident recommendations that others should try DBT.

DBT was constructed as providing useful skills able to be used in everyday life. The clients described a range of situations in which specific skills had been useful, and had been deliberately used. Mindfulness in particular was described as fundamentally important to their ability to use the other skills, and to apply them in life.

Clients described the process of change as a fundamental, life changing experience. This included a change of identity, which at times was described as a difficult process. Clients presented themselves as having to give up old behaviours, which had formerly provided them with a means of managing difficult experiences, for example self harming behaviours. In doing so they constructed themselves as able to reflect and notice positive change within themselves over time. A process of losing their former ‘victim’ identity, and gradually taking back control and responsibility in their lives was constructed in their talk.

The process of DBT itself was discussed in terms of the clients' experiences. All of the clients constructed DBT as a good fit for them, and as targeting the problems they had. The process was described as long and difficult, as well as rewarding. In particular the DBT group provided an opportunity for clients to interact with other people experiencing similar difficulties. This recognition of the same difficulties in other people was constructed as important for the process of recovery, and important for recognition and acceptance of their own difficulties.

The next chapter take a closer look at the experiences of three of the clients – Sasha, Angela and Lisa. These three clients were interviewed twice, and completed a set of psychometric measures. These will be presented as a set of case studies.

Chapter 11: Study four: Case studies

This chapter presents three case studies, based on interviews and self report measures completed by three of the clients – Sasha, Angela, and Lisa. This study attempts to combine the use of both empiricist and social constructionist understandings in order to identify potential alternative explanations for results. The study shares some of the same epistemological concerns that are present in a clinical setting, when a clinician is faced with the juxtaposition of utilising psychometric instruments, and interpreting these in context of the clinical interview.

From a social constructionist perspective, use of all individual assessment devices (such as psychometric measures) is questionable (Iverson, Gergen & Fairbanks, 2005). This is because assessment devices are designed to transform a changeable world into a fixed structure, which is created using the professional's way of understanding. The devices privilege certain constructions over others, and simplify the representation of these so that alternative constructions are suppressed. In addition to this, measures often contain a focus on 'problems', further prioritising illness or disorder discourses (Iverson et al, 2005).

It is useful to think about psychometrics through a social constructionist lens. In this way a self-report psychometric questionnaire can be viewed as a simplified example of language in action. It provides a selection of available resources or discourses (questions) from which the client makes a selection. In doing so she produces a construction of what is occurring for her, situated in context. Her construction is enabled by the availability of a selection of questions to describe her situation. It is also limited by those same questions, which may not contain items which exactly fit her situation. She may attempt to alter the questions or write on the test paper – but this will invalidate the construction, and will not be understood by others.

Iverson, Gergen and Fairbanks (2005) remind readers that from social constructionist viewpoint, empiricism can be understood as a construction of reality, which is no less valid than that provided by alternative understandings. They suggest that 'evaluative devices' could instead be named 'constructing devices' (p. 696) and advocate asking pragmatic questions, such as who benefits from assessment? who is silenced? And

which meanings are promoted or subdued? Iverson et al (2005) discuss these ideas in terms of social work assessment instruments, and they mirror the ideas of Fishman (1999) who advocates a pragmatic approach to clinical research, and defines truth as related to the usefulness of a particular outcome.

In accordance with social constructionist ideas, and also those of pragmatic psychology, it is important to recognise the political and cultural context of research and practice. 'Evidence based practice' is a political and cultural force in the current research and practice environment. It is a movement which began as 'evidence based practice' in the United Kingdom and 'empirically supported treatments' in the United States in the early 1990's. It contends that interventions in health, including psychotherapy services, should be based only in "scientifically valid empirical evidence" (Djulgovic, 2006). In New Zealand the evidence base practice movement is generally accepted as important in providing the best care for clients. This has led to the development of a series of clinical practice guidelines for various conditions that a clinician may encounter in practice (Didsbury, 2003). The existence of such guidelines reflects clinical and political understandings of what constitutes good research and clinical practice. From social constructionist and pragmatic perspectives these forces provide context for research and can not be ignored. For clinicians to ignore the importance given to outcome measurement, and empirical understandings of disorder is to ignore the context in which they work.

With this background in mind, this study acknowledges the role of the clinician working with a client, in context of mental health services and clinical psychology, both founded on empiricist understandings. The clinician must integrate knowledge available, which includes a majority of outcome research studies and clinical theories based on empiricist understandings, with the understandings constructed in the clinical interview, at that time and place, and with that person. In this study I hoped to bring different understandings of a common scenario – the administration of psychometric measures – to light.

In order to coherently discuss the empiricist aims of this study, and the choice of measures, it is necessary to assume an empiricist lens for a brief time, and assume

that there are underlying states (variables) which can be measured. This section should be read with this in mind.

The study was designed to look at outcomes of the DBT programme for two variables, constructed within DBT theory as important goals for therapy: the development of mindfulness skills, and changes in quality of life for participants. Mindfulness was chosen as a variable because mindfulness is at the heart of DBT theory and should (according to that theory) increase as the participants progress through the programme. Quality of life was chosen because of the stated goal of DBT being “a life worth living”. It was hypothesised that measures of both mindfulness and quality of life would increase between the beginning and end of the DBT programme.

Mindfulness skills are central to DBT and are the first skills taught (Linehan, 1993). They are versions of Eastern meditation skills (Zen), adapted so that they do not necessarily contain the spiritual element of Zen, and are acceptable to Western ways of thinking. Linehan describes three “what” skills – observing, describing and participating, and three “how” skills – taking a non-judgemental stance, focussing on one thing in the moment, and being effective. Mindfulness is conceptualised as the quality of awareness a person brings to activities. It is thought to decrease suffering, and increase positive qualities such as awareness, insight, wisdom, compassion, and equanimity. The skills have been incorporated into several Western psychotherapies as well as DBT (Baer, Smith & Allen, 2004). Mindfulness-based interventions have been reported to be effective in reducing symptoms for a wide range of disorders (Baer, Smith, Hopkins, Krietemeyer & Toney, 2006). In DBT, mindfulness is closely linked to dialectical theory, because a ‘mindful’ awareness is necessary to allow understanding of aspects of experience, and the interactions between those parts, in a non-judgmental manner (Robins, Schmidt, & Linehan, 2004).

The stated goal of DBT is “a life worth living” (Linehan, 1993). A focus on quality of life rather than symptom relief is appropriate for a therapy which teaches mindfulness and acceptance of unwanted experiences (which are likely to include ‘symptoms’). Current conceptualisations of health refer to well-being, rather than absence of disease (Gladis, Gosch, Dishuk, & Crits-Christoph, 1999). Quality of life includes physical, emotional, social, occupational and spiritual well-being (Michalak, Yatham, & Lam, 2005). The

relationship between quality of life and psychiatric disorders is difficult to measure, because of difficulties defining quality of life, and overlap in content between symptom and quality of life measures (Masthoff, Trompenaars, Van Heck, Hodiament, & De Vries, 2006). Despite these difficulties in measurement, quality of life is essentially the aim of DBT (once the initial goal of maintaining safety is accomplished) and as such is an important variable to consider.

It should be noted that although I have called these 'case studies', they are not case studies in the clinical sense in that I have not reported on the clients' specific difficulties, history and background, or their progress in terms of hospital admissions and treatment contacts. As a researcher I was not involved in the clinical aspect of their treatment, but in constructions of their experience. I have therefore not provided detailed information about each client.

Method

The study used a case study, local scientist design (Stricker, 1992; Sticker & Trierweiler, 1995) to record quantitative outcome data for each participant. The local scientist design is an empiricist design involving a detailed examination of the data to explain 'local' phenomena. A combination of qualitative and quantitative data provides information about the experience of the participants. In addition to this, the quantitative outcome data was interpreted from a discourse analysis perspective, and potential alternatives to the empiricist understandings are discussed.

Three clients participated in this study, and were each assessed twice, during the first module of DBT, in October 2008, and then at the end of the DBT programme, in June/July 2009. The measures were given at the same session as the interviews, on which Study Three (see Chapters Nine and Ten) was based. In combining measures and discourse analysis in this way I hoped to show that both empirical and social constructionist knowledge can provide useful information, and that in combining both, different viewpoints on DBT would be obtained.

Measures

The following measures were chosen because of their brevity, and ease of administration in the short time frame available. They were all self report measures, and each required less than ten minutes to complete.

Mindfulness

The concept of mindfulness in DBT refers to bringing attention to the present moment, in a non-judgemental way (Baer et al, 2006). It includes compassion for and acceptance of one's experience in the moment. The following measures were chosen with this understanding in mind.

The Kentucky Inventory of Mindfulness Skills (KIMS) (Baer et al, 2004) is a 39 item self report questionnaire designed to measure mindfulness, based on the DBT concept of mindfulness skills of observing, describing, acting with awareness, and accepting without judgement. Content validity evaluation by DBT experts in the initial evaluation studies produced high ratings of item clarity and representation of mindfulness skills. The scale has been shown to have high internal consistency and adequate to good test-retest reliability.

The Neff Self Compassion Scale (SCS) (Neff, 2003) is a 26 item self report questionnaire, designed to measure compassion towards the self in six domains: self kindness, self judgment, common humanity, isolation, mindfulness, and over-identification. It also contains a global self compassion scale based on combining scores from the six domains. Self compassion differs from self esteem in that it is non-evaluative, and therefore fits with the non-judgmental aspect of mindfulness. It has been shown to have test retest reliability of 0.93 over a three week interval, and to have good internal consistency, and displays both convergent and discriminant validity.

Quality of life

The concept of quality of life is less clearly defined, and less obviously located within a theory, than the concept of mindfulness. The World Health Organisation (WHO) defines health in terms of well-being and not has the absence of disease (Gladis et al, 1999). Despite this, many studies have utilised measures of psychological symptoms in studies of quality of life, and these are often features of quality of life measures. Gladis et al

(1999) state that quality of life is best defined as an 'emergent variable', and suggest researchers write of 'indicators' of quality of life rather than quality of life per se. The following measures include one measure designed specifically to measure quality of life, and three brief measures of psychopathology, commonly used in clinical practice.

WHOQOL-BREF (Australian Version) (World Health Organisation, 2000) is a well validated self report questionnaire which provides a measure of quality of life. The WHOQOL-BREF has been shown to have validity across a range of cultures (Skevington, Lotfy, & O'Connell, 2004). This scale was included because it is a brief measure of quality of life that is not based on experience of symptoms, and includes physical, psychological, social and environmental domains. In addition to the domain scores it contains a single item global scale (rating quality of life from 1= very poor, to 5= very good). It was developed for large epidemiological studies, however is also recommended for routine clinical work (Masthoff et al, 2006). It has been used in a recent clinical study of women with BPD undergoing DBT (Carter et al, 2010). The brevity of the WHOQOL-BREF was an additional reason for choosing this measure, as alternative measures of quality of life were found to be too lengthy to be practical in the time frame allowed.

In addition to the WHOQOL-BREF, three short measures of psychopathology were included, so that symptom measures could be compared to the clients' reported quality of life. These measures reflect those commonly used in clinical practice.

The Beck Depression Inventory (Second edition) (BDI-II) (Beck, Steer, & Brown, 1996) is a 21 item client self-report measure which measures depressive symptomology. It has good psychometric properties with internal consistency ratings of .89 to .94. The BDI-II is quick and easy to administer. It has test-retest reliability of .48 to .86 depending on the interval between testing. It has favourable content, concurrent and discriminant validity (Groth-Marnat, 2003).

The Beck Anxiety Inventory (BAI) (Beck & Steer, 1990) is a 21-item Likert scale self-report questionnaire measuring anxiety symptoms. It has excellent internal consistency, with psychiatric outpatients (alpha = .92 to .94). The BAI has demonstrated good

psychometric properties including internal reliability, discriminant validity and factorial validity (Kabakoff, Segal, Herson, & Van Hasselt, 1997).

Positive and Negative Affect Scale (PANAS) (Watson, Clark, & Tellegen, 1988), is a measure containing two mood scales, positive and negative affect. It is a brief self report measure. It has been shown to be highly internally consistent, and to have good test-retest reliability. The 10-item scales are internally consistent and have excellent convergent and discriminant correlations with other measures of mood factors. This scale was included because of DBT's focus on emotion regulation. The goal of therapy is not necessarily to increase positive affect and decrease negative affect (as might be measured by the BDI-II and BAI), but to increase the ability of clients to experience emotions (positive and negative) in a safe manner, and decrease fear or emotion. The PANAS was chosen over other measures which might have been chosen in context of DBT theory (for example those designed to measure emotion regulation) because the intention was to measure experienced emotion rather than ability to regulate emotion (under the 'quality of life' concept it was felt that measurement of emotional experience was more appropriate than ability to regulate).

Results

This section will present the psychometric results for each of the three participants, Sasha, Angela and Lisa. I will present the results from an empirical perspective, with the understanding that the scores represent changes in underlying constructs. In addition to this, at the end of each section I will briefly discuss alternative interpretations, taking a social constructionist perspective. It is important to note that this is not a qualitative-quantitative divide (interviews can also be read from an empiricist understanding as representing underlying constructs or states), but one of alternative conceptualisations as to the nature of reality and how this can be understood.

Case Study One – Sasha

134. *Sasha: you know when you walk into a swimming pool (.) and it's cold to start with*

Mel: yes

Sasha: and you sort of think ok and just sort of ease yourself in (1) well that's what I'm doing (.) just easing myself back into life (interview 2).

Sasha was very positive about DBT at both interview points. The above extract sums up Sasha’s approach, as she uses the metaphor of entering cold water to describe her acceptance of discomfort in pursuit of her goal of a better life. From an empiricist perspective the above quote could be seen as evidence of an underlying belief that she is gradually making progress. The next section presents Sasha’s responses on the two measures of mindfulness.

Mindfulness

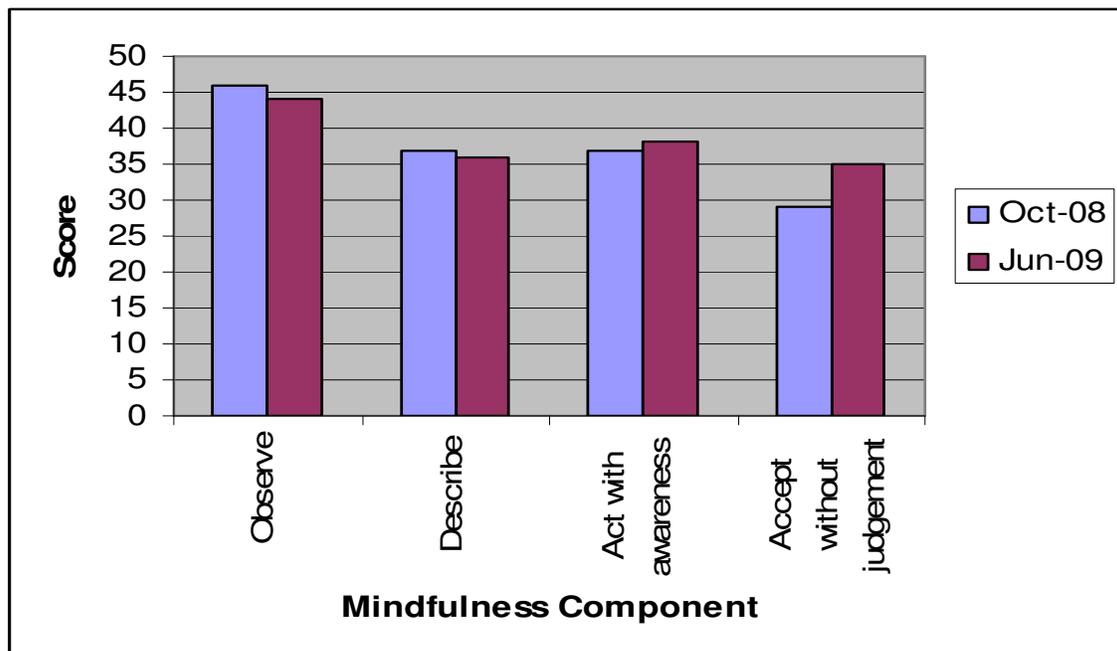


Figure 1: KIMS scores for Sasha

Sasha’s descriptions of herself as effectively mastering and using mindfulness in her life were congruent with the scores obtained on measures designed to examine the mindfulness construct. Her scores on the KIMS (see Figure 1) were within the normal range at both time points, compared to a student sample, and significantly above the scores found in a sample of people with BPD (see Appendix I for normative score ranges). There is little indication from her scores that there has been change in mindfulness skills between interviews, although there is some increase in her “accept without judgement” score, which fits with her description of acceptance of distress.

An important component of mindfulness, which has been found to be difficult for clients, was the ability to be compassionate and non-judgemental towards the 'self'. Sasha's scores on the Neff Self Compassion Scale showed an increase in overall self compassion between the two interviews, although her overall self compassion scores were within the expected range compared to a normative sample of female students at both interviews.

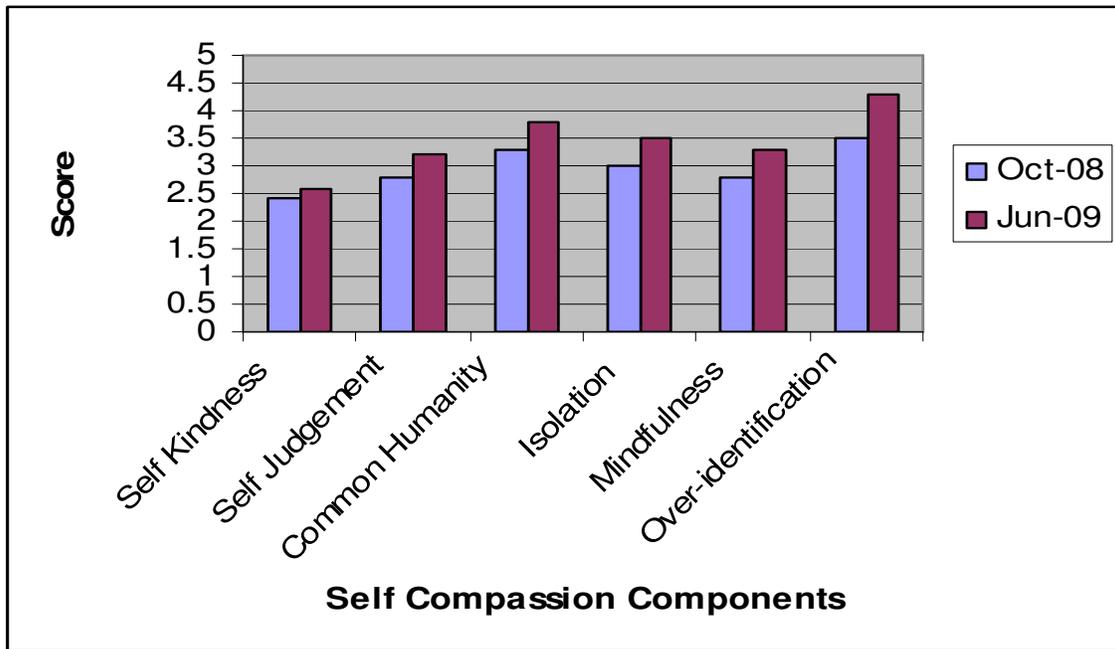


Figure 2: SCS component scores for Sasha

In looking at the individual component scores of the SCS it becomes apparent that nearly all of Sasha's scores are within the expected range compared to female students (see Figure 2). The only score outside this range was her score on 'over-identification', which was above the expected range. This suggests she is able to notice her thoughts and feelings in awareness, rather than over-identifying with them and experiencing them as fact. Sasha's scores on the SCS indicate slight improvement on every aspect of self compassion examined. This, as well as the consistency of the pattern of scores in relation to each other between time points, suggests that Sasha has responded in a similar manner at each time point (endorsing a slightly greater level of self compassion at the second interview).

The overall flavour of Sasha's responses on measures designed to examine mindfulness and self compassion was one of stability and of scores within the normal range, with a small increase in levels of self-compassion between the two interviews. The most obvious (empirical) response to these scores is to read them as valid reflections of improvement in Sasha's ability to be mindful and to accept and show compassion towards herself. This is congruent with her interview, as she presents herself as able to use mindfulness, and learning to accept herself.

From a social constructionist perspective the scores on measures of mindfulness can be read as Sasha's construction of herself as acting mindfully, and being compassionate towards herself – noticing thoughts and feelings rather than placing judgement on them. The actual questions and categories examined by the measures can be thought of as available resources (or even discourses) from which these scores can be created. Like the wider use of language the responses both construct a version of reality and are constrained by the resources available in the questionnaires. Sasha utilises descriptions of mindfulness and acceptance which construct her as utilising the skills, rather than alternatives options.

Sasha's results on quality of life measures are discussed next, again initially through and empiricist lens, followed by a social constructionist one.

Quality of life

This section discusses Sasha's responses on the WHOQOL-BREF, BDI-II, BAI and PANAS. Sasha's responses on the WHOQOL-BREF global scale, which is a single item scale (rating quality of life from 1= very poor, to 5= very good) indicate stability of overall 'good' quality of life between both interviews. This is consistent with her interviews, which present her as enjoying a good quality of life since beginning DBT.

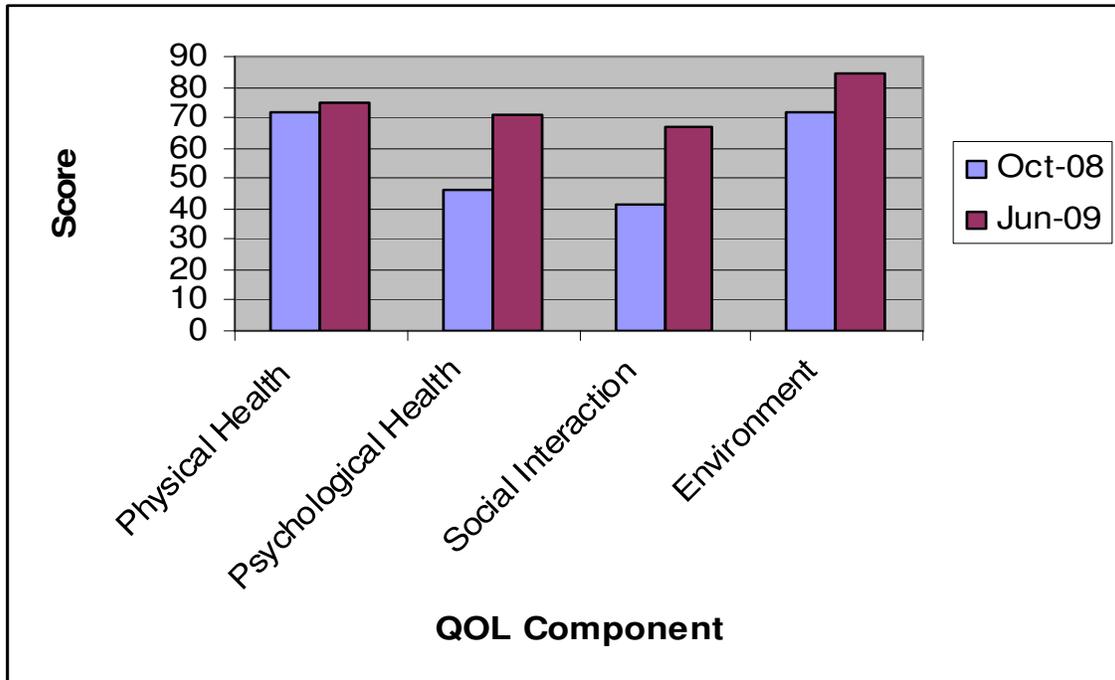


Figure 3: WHOQOL-BREF component item scores for Sasha

Figure 3 illustrates Sasha’s component scores on the WHOQOL-BREF, and these suggest an increase in all of the components examined. At the first interview, Sasha’s scores in psychological health and social interaction subscales were below expected when compared to an Australian population sample (see Appendix I for population norms), and these improved to the expected range at interview two. An improvement on psychological health and social interaction scores is to be expected given that these are areas targeted by DBT.

The comparison between Sasha’s stable global response rating of “good” quality of life at both time points compared to the apparent improvement on all the component scales suggests that even at time one, she regarded herself as having a good quality of life. It seems then that the component scales are measuring improvement which is not identified in the global scale. This could indicate that Sasha’s perception of overall quality of life can be separated from her current physical, psychological, social, or environmental quality of life. Sasha’s “good” rating on the global scale may indicate satisfaction with progress, or expectation of change; while the component scores indicate current functioning. Alternatively, Sasha may be measuring her good overall quality of life using something other than the component parts provided in the scale.

Sasha's results on the three measures of mood – depression, anxiety, and positive and negative affect are presented next.

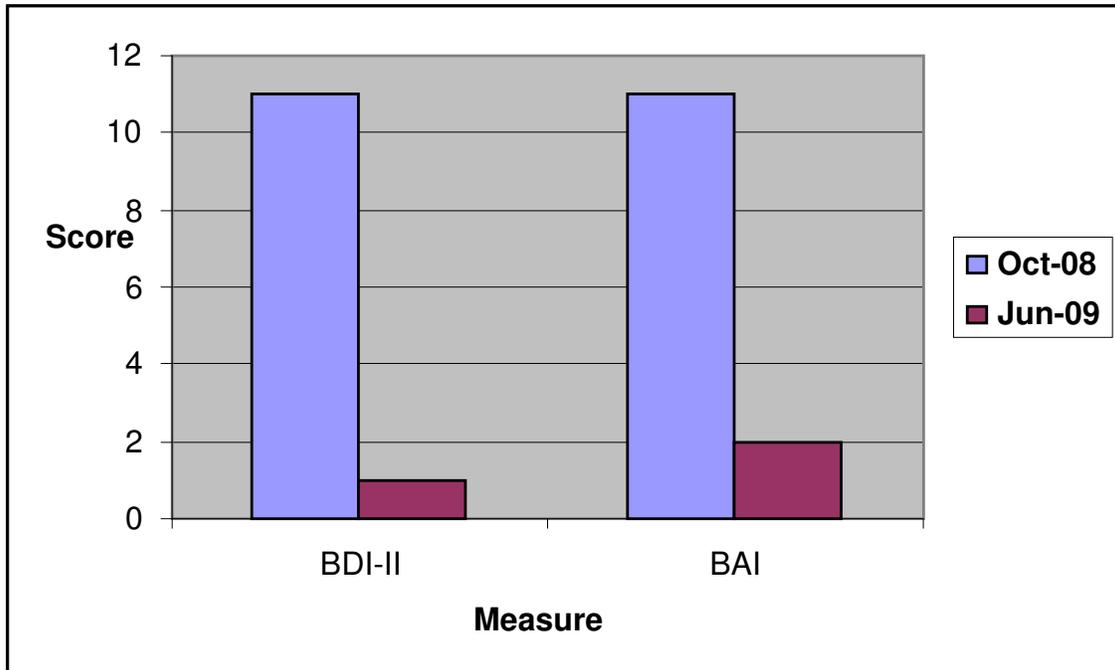


Figure 4: BDI-II and BAI scores for Sasha

Sasha's scores on the BDI-II and the BAI suggest a reduction in depressive and anxiety symptoms between interviews however it should be noted that her scores suggest minimal depression and anxiety at both time points (see Figure 4). These results suggest that Sasha was not experiencing depression or anxiety in the clinical range at either time point.

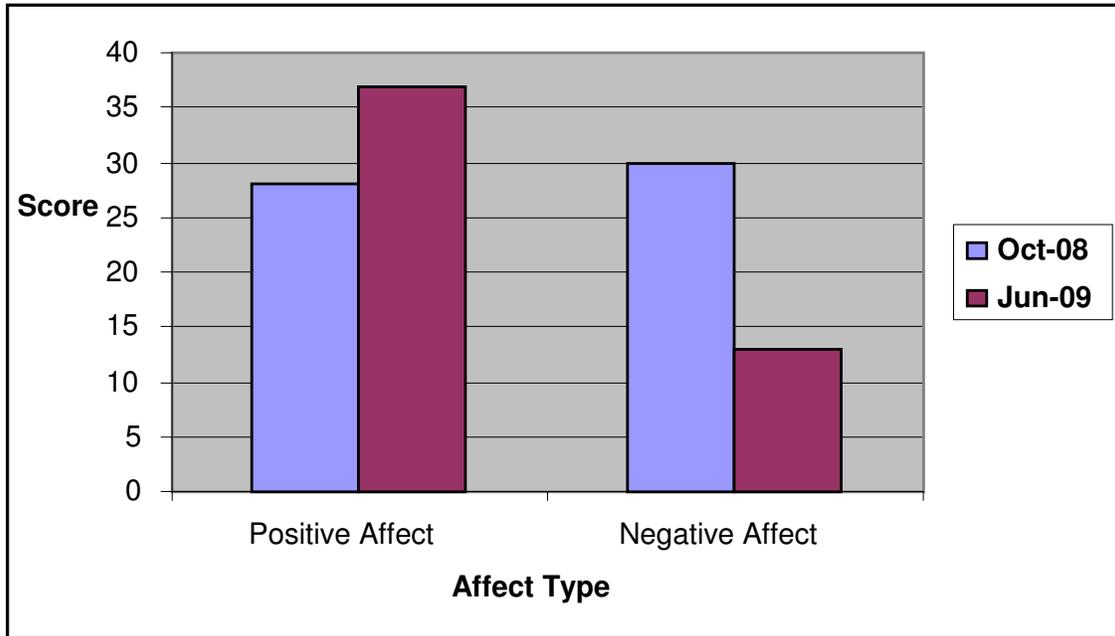


Figure 5: PANAS scores for Sasha

Figure 5 illustrates Sasha’s responses on the PANAS, showing an improvement between interviews. In particular, her endorsement of experiences of negative affect reduced from above the level expected for psychiatric inpatients at interview one, to expected levels compared to a sample of women at interview two (see Appendix I for population norms). Positive affect was reported at expected levels at both time points. These responses can be interpreted as indicating a reduction in negative emotional experiences. .

From a social constructionist perspective, Sasha’s scores may represent a wish to present herself as experiencing reduced negative emotional experiences, in order to be congruent with her construction of herself as happy, and able to enjoy her life following DBT. Sasha described DBT skills as ‘easy’ at both interviews, and utilised the discourse of skills deficit to describe her situation. She presented herself as breaking the cycle of skills deficit by ensuring her daughter benefitted from her new abilities (discussed in Chapter Eight, extract 100). As can be seen in extract 134 at the beginning of this section, Sasha used the skills deficit discourse to take responsibility for her actions, and to make progress. She constructs herself as tolerating distress in pursuit of her long

term goals, which becomes easier as she becomes more skilful (used to the temperature of the water).

Sasha's psychometric scores seemed consistent with her interview statements noting improvements in self compassion and quality of life, particularly psychological health and social interaction. The use of psychometrics in this way seems relatively straightforward in Sasha's case, because of this good fit between her psychometric results and her interview data (read from an empiricist perspective). There is no obvious discrepancy between Sasha's interviews and her psychometric scores which requires explanation. Whether the psychometrics and the interview data are measuring an improvement in underlying functioning or are social constructions of improvement seems from a pragmatic sense to be largely irrelevant, with the end result being improvement (or construction of improvement) in either case.

Case Study Two – Angela

135. Angela: I can definitely live with how I am at the moment whereas before like (.) it was just unbearable (1) so it's made a huge change (interview 2).

This section presents Angela's results on psychometric measures. As with Sasha's results, I will them first from an empirical perspective, and at the end of each section I will possible constructions from a social constructionist perspective. Angela was also very positive about her experience with DBT. Like Sasha there were more similarities than differences between the two time points. She talked about gradual improvement and increased quality of life since participating in DBT, in particular her ability to be more accepting of her own unwanted thoughts (extract 135). She described a progression in the goals she set for herself, as her life changed. This section describes Angela's responses on measures of mindfulness.

Mindfulness

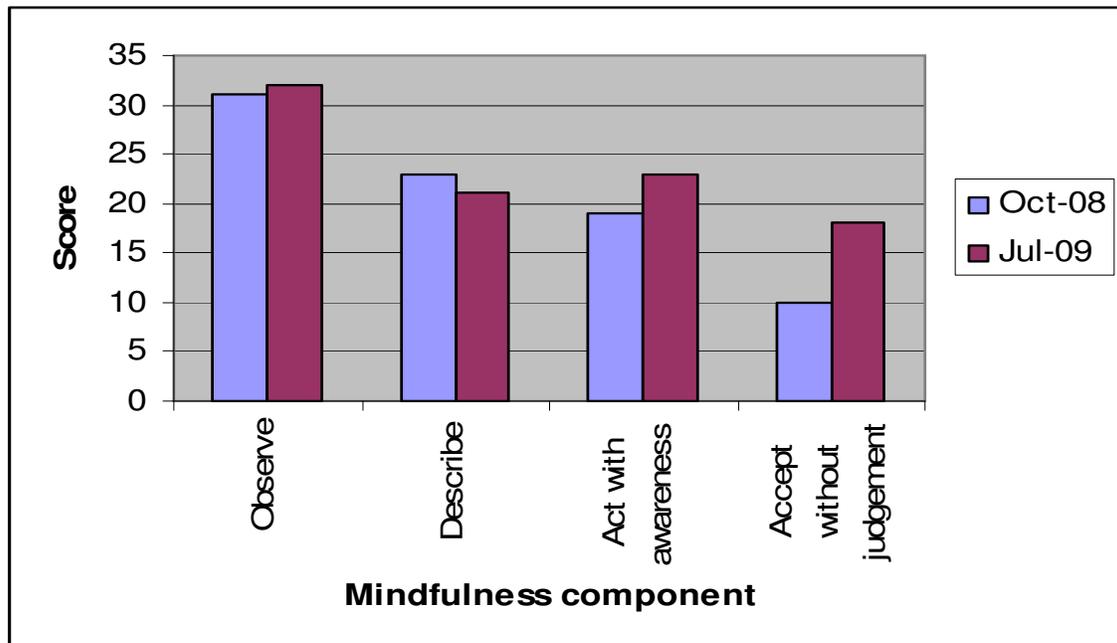


Figure 6: KIMS scores for Angela

Angela's scores on the KIMS (see Figure 6) suggest that her responses on this scale were relatively stable at the two time points. Her scores on the 'observe' and 'describe' subscales remained stable, and were within the expected level for both student and BPD population norms. Her score on the 'act with awareness' subscale was within the expected level compared to BPD norms at both time-points. The largest change was seen on the 'accept without judgement' subscale, with her score at interview one falling below expected compared to both student and BPD samples, improving to within expected levels compared to the BPD norms, remaining below expected levels compared to students. This change is congruent with her description of herself as becoming more self-accepting (extract 135). Further measures across time would be necessary to establish whether these changes represent part of an ongoing pattern of change, or represent random change in scores.

Angela's overall self compassion score for the Neff Self Compassion scale indicates an improvement in self compassion from below to within the expected range compared to female undergraduate students. This is congruent with both Angela's reports of increased self compassion in her interviews, and with the increase in 'accept without

judgement' score on the KIMS scale. This suggests overall improvement in self compassion.

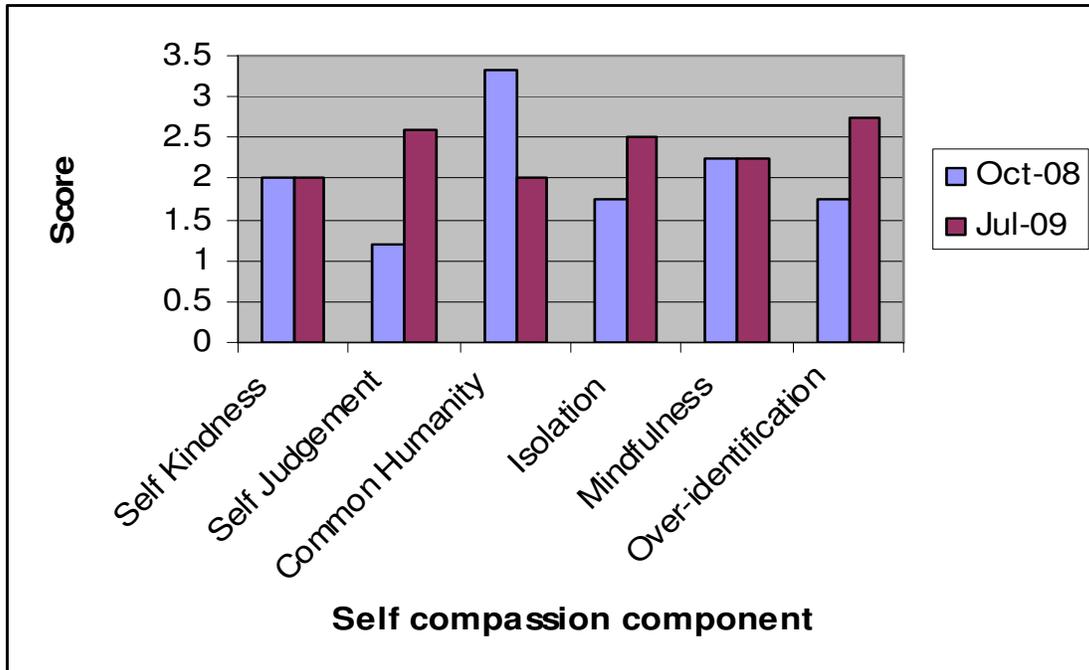


Figure 7: SCS component scores for Angela

Looking at the component scores of the SCS (see Figure 7) it is apparent that changes in Angela's responses on the SCS were far less consistent compared to Sasha's responses. Three subscales: 'self judgement', 'isolation', and 'over-identification' suggest improvement from below to within expected levels compared to female undergraduate norms. One subscale, 'common humanity', appears to show change in the opposite direction, falling to below expected levels at the second interview. 'Self kindness' and 'mindfulness' subscales remained stable, at somewhat below expected levels.

From an empiricist perspective, it is difficult to draw conclusions from Angela's scores on these two measures. The scores suggest some improvement in accepting without judging (KIMS) and in self compassion, however further measures across time would be necessary to establish any clear pattern.

A possible (empiricist) explanation for the drop in the SCS 'common humanity' subscale is that Angela continues to experience a sense of difference at the second interview even though she describes this as not recognisable by others. In extract 136 (below), her statement "I would never have picked any of these people out" seems to suggest this – as she notes other group members are different from 'normal' even though this cannot be immediately observed. In this case, Angela's perception of herself as different from 'normal' may have increased rather than decreased (which is reflected in the SCS scores), while at the same time she is much less judgemental of herself.

136. Mel: yeah um (3) ok so (.) you've learned a lot about skills (1) have you learned (1) are there other important things that you have learned?

Angela: (cough) excuse me (1) um (.) I guess to (.) it sounds kind of (.) like um (.) obvious but (laughter) I'm just to accept I am the way I am (.) you know like I think being in the group setting with the other people (1) and seeing them I never would have picked out that they had what they have and they made me to sort of accept who I am like people don't (.) won't look at me and think oh she's got a mental illness you know (.) like I thought people could see it immediately (.) by looking at me (.) um but I would never have picked any of those people out (Interview 2)

From a social constructionist perspective, Angela's scores on the KIMS and interview data can be seen as examples of Angela's construction of self, particularly her construction of herself as now accepting who she is as a person, which is reflected in her responses to the items constituting the 'accept without judgement' scale. For example item 4 on the KIMS ("I criticise myself for having irrational or inappropriate emotions") was endorsed as "very often or always true" at time one, and as "sometimes true" at time two. In choosing an available option on a self report measure, similar work is done as occurs in the interview data, the presentation of improved self-acceptance.

In extract 136 (from a social constructionist perspective) Angela constructs herself as able to be more accurate in her assessment of herself. She does this by providing evidence that she was unable to identify mental disorder in other group members, and therefore her previous understanding of herself as able to be identified (by others) as mentally disturbed must have been wrong. She utilises the illness discourse to construct

herself as having a ‘mental illness’ and at the same time rejects the associated idea that this ‘illness’ must define her or is necessarily recognisable to others. She constructs this as a change in attitude for her. This narrative seems to fit well with her responses on the KIMS and SCS.

The next section presents Angela’s results from the measures of quality of life, again first from an empiricist and then from a social constructionist perspective.

Quality of life

Angela’s scores on the WHOQOL-BREF global scale indicate an improvement in overall quality of life and health between the two interviews. At interview two she described her quality of life as ‘good’, compared to interview one when she reported it as “neither good nor bad”.

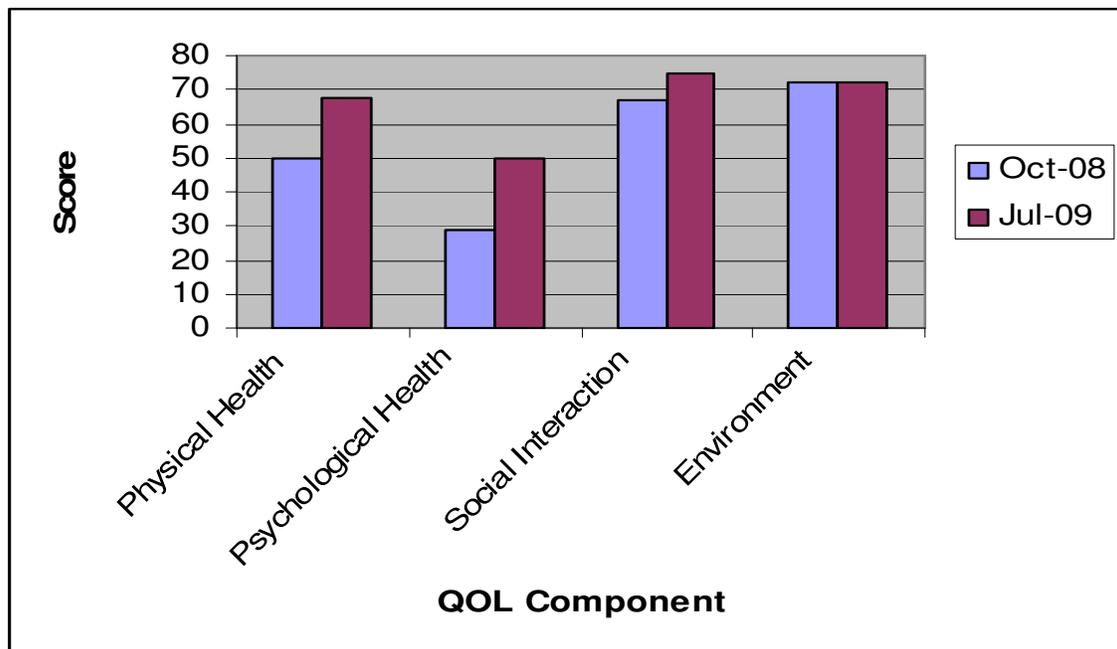


Figure 8: WHOQOL-BREF component scores for Angela

The biggest increase in WHOQOL-BREF component scores, not unexpectedly, appears on the subscale measuring psychological health, improving from below to within expected levels compared to outpatient norms, although it remains below the level

expected for community norms (see Appendix I). These scores are congruent with her interview data and reports of improvement in daily life.

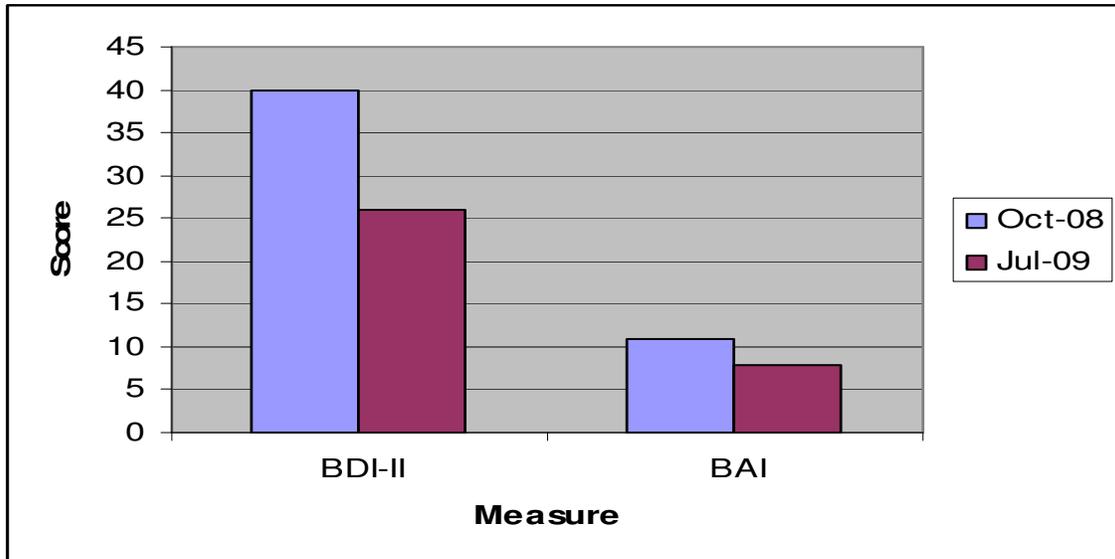


Figure 9: BDI-II and BAI scores for Angela

Angela's scores on the BDI-II and the BAI are shown in Figure 9. They show a decrease in depression, with the scores suggesting severe depression at interview one, and moderate depression at interview two. These scores matched with Angela's reports of improved wellbeing at interview two. Anxiety levels were measured as minimal at both time points.

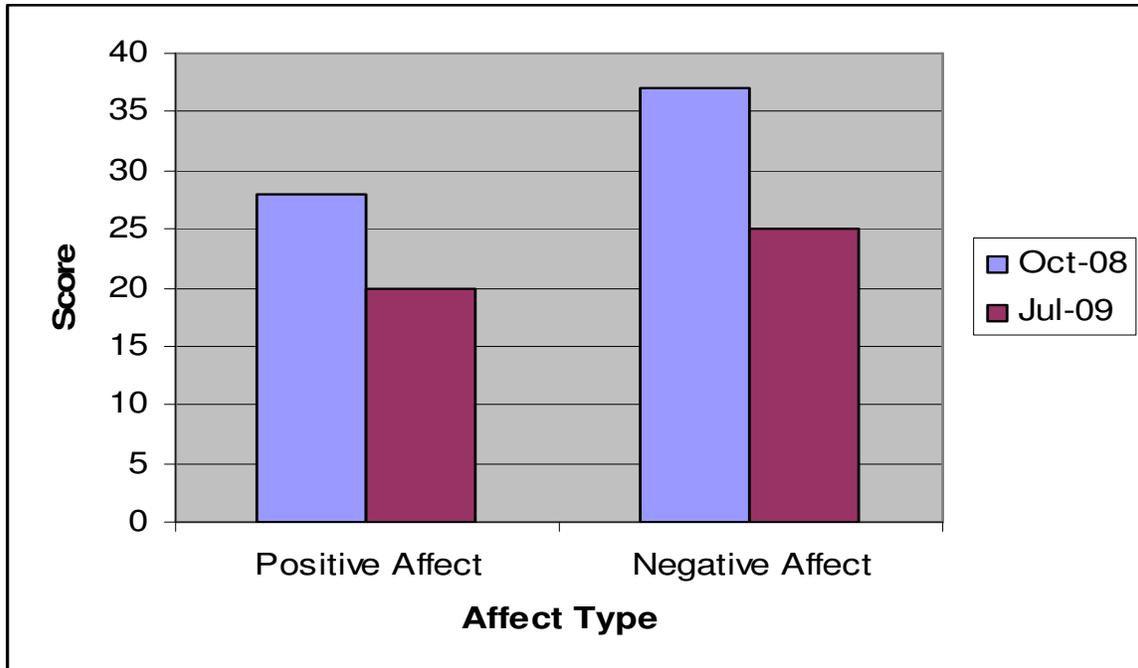


Figure 10: PANAS scores for Angela

Angela's scores on the PANAS suggest a decrease in both positive and negative affect (see Figure 10). Positive affect scores at both time points were below the expected range when compared with normative populations of women and psychiatric inpatients (see Appendix I for population norms). Negative affect scores were above the expected range compared to both normative groups at time one, and above the expected range for women at time two.

This decrease in both positive and negative affect in Angela's scores is a different pattern to Sasha, whose scores showed an increase in positive and a decrease in negative affect. Angela's results seem to suggest an overall decrease in reporting of emotional experiences, rather than a differentiation in the type of emotion experienced. Again it is possible to interpret Angela's scores in a multitude of ways. One possibility is that Angela had increased emotional experiences (positive and negative) prior to the first interview compared to the second. This could be due to increased stressors at that time, or due to a change in her response to distress or construction of distress. Another possibility is that she has improved in her ability to regulate emotion – which is a target of DBT, and therefore no longer experiences such a high degree of emotional reactivity.

Angela's psychometric scores on mindfulness provide some indication that she was expressing higher levels of self compassion at the second interview compared to the first. Her scores on the quality of life measures seemed to suggest improvement in psychological health, anxiety and depression. Again further testing would be necessary to confirm this.

Angela's scores are in line with her description of increased ability to identify and modify levels of emotion before they reach high intensity. In extract 137 she describes this ability using an example of anger. From an empiricist perspective this extract can be read as evidence for increased control over (and reduced experience of) anger.

137. Angela: just being mindful (.) like to my emotions and um (.) that's helped in (.) now that I can sort of predict like say for example I'm getting angry (.) I know sort of what level my anger's getting

Mel: yeah

Angela: or is (.) and then I can do something to stop it or (1) just prevent it from getting higher so I don't get really angry and do something silly (interview 2, p. 3)

From a social constructionist perspective, Angela's scores are congruent with her interview, and constructions of herself as now living a life which is meaningful while continuing to anticipate improvement and progress. In the above example she utilised the DBT providing skills discourse, when she reports that she can now recognise her anger (mindfulness) and has the skills to do something to stop her anger escalating. Her scores match her construction of herself as becoming more skilfull.

Both Sasha and Angela's scores on the measures were relatively congruent with their constructions of improvement in their lives. The third case study, Lisa, will be discussed in the next section.

Case Study Three – Lisa

138. Mel: what about the way that you think about how you behave (1) has that changed?

Lisa: (3) yeah I suppose it has (2) um (1) I'm more accepting of myself

Mel: mm

Lisa: to a certain degree (3) um (2) but I can still be really hard on myself as well (Interview 2, p. 9)

Lisa, like the other participants, was enthusiastic about DBT, and talked of DBT as having greatly improved her life. Again the similarities between both interviews were greater than differences, with the key difference being an increase in acceptance of her emotions and behaviour in the second interview. She did not negate her earlier descriptions of events, but chose to turn the focus away from these earlier events. As with the previous two case studies the results are discussed first from an empirical perspective followed by a brief comment from a social constructionist perspective.

Lisa's psychometric scores were interesting because some of them appeared to contradict the positivity about her progress evident in her interviews. Her scores on the mindfulness measures are presented next.

Mindfulness

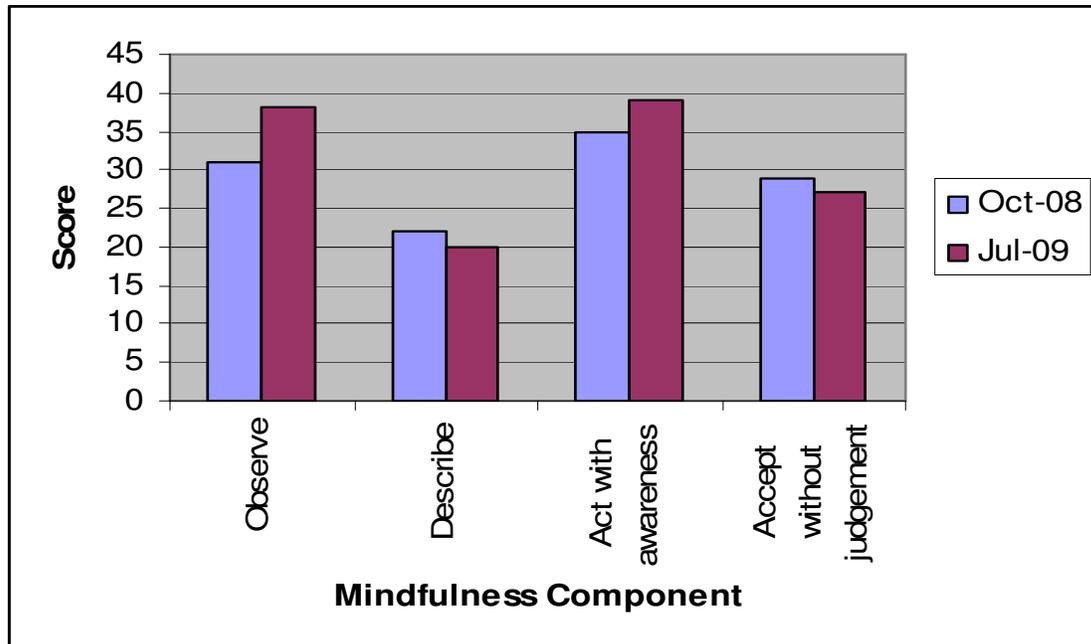


Figure 11: KIMS scores for Lisa

Lisa's scores on the KIMS were at or above the expected range compared to normative values using a BPD sample at both time points (see Figure 11). Overall there was little

change identified by the measure, with scores improving slightly on two subscales ('observe' and 'act with awareness') and worsening on two measures ('describe' and 'accept without judgement'). The scores on the KIMS correlate reasonably well with her interview data – and descriptions of effective use of mindfulness - given that they represent a good level of mindfulness, with only the 'describe' component slightly lower than the others.

Lisa's responses on the Neff Self Compassion Scale seem to indicate reduced self compassion at the second interview compared to the first. Her overall score remained within the expected range at both time points, although a reduction in the score is apparent. This seemed to contradict her interview reports of being more accepting of herself.

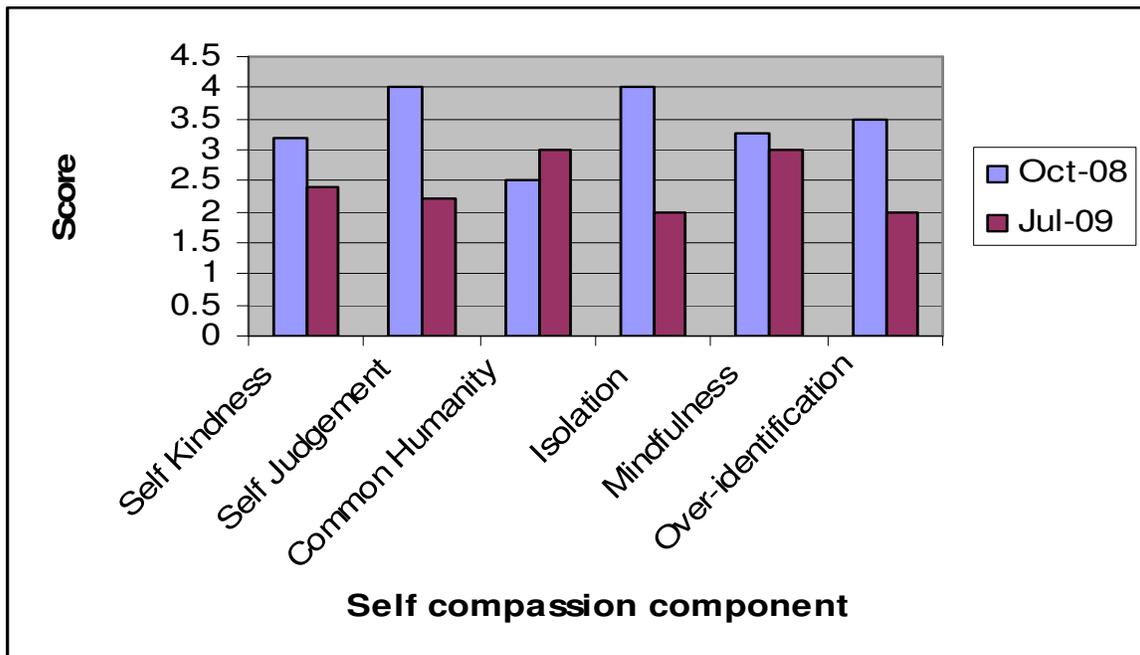


Figure 12: SCS component scores for Lisa

Looking at the individual components that make up the self compassion score, it is apparent that three of these components fell below the expected range at the second interview (see Appendix I for population norms). These are scales measuring self judgement, isolation, and over-identification. The way that the SCS is scored means that higher scores indicated greater self-compassion (less self judgement, isolation and over-identification). This suggests that Lisa was more judgemental towards herself at

the second interview, and felt more isolated from other people. This contrasts with the descriptions of herself present in her interview.

There are several possible interpretations for Lisa's scores on mindfulness and self compassion. One is that the measures are in fact reflecting a slight decrease in her level of compassion towards herself. It is possible that the measures are collecting information which is different from that collected by interview, and that (from an empiricist perspective) an underlying level of self compassion has reduced, despite her reports to the contrary. This seems unlikely, given that the measures were both self-report measures, and given the conscious and effective use of mindfulness that Lisa reported.

A more likely (and still empiricist) explanation is that Lisa is now actively observing and describing underlying emotions (as she describes herself doing) and is therefore presenting a more negative appraisal of herself because she is now noticing emotions she previously avoided. This is congruent with increased observation and acceptance of such things as judgemental thoughts and isolation from others. In extract 138 which opened this section - although Lisa describes herself as more accepting, she still notes that she can be judgemental. From this perspective the increase in judgemental thoughts shown in her scores makes sense.

139. Lisa: you know um (.) I basically locked myself away um (1) and because I have isolated myself (.) and it (.) still been (.) I'm still in that position (1) of being isolated because of (.) just sort of the work I do (2) and that um (2) I no longer work from home (.) I actually have (.) shifted my office (.) into the office at the workshop (Interview 2)

Similarly in extract 139 Lisa describes herself as having been isolated from others, and outlines steps she is taking to overcome this. Her responses on the SCS are congruent with increased awareness of this sense of isolation. If this hypothesis is correct then the SCS is measuring awareness of isolation – or even acceptance of that awareness, rather than isolation per se.

From a social constructionist perspective, Lisa's responses represent constructions of experience. It is possible that the measures provided her with a range of more negative constructions to choose from, that did not appear comfortably in the interview setting (due to context, expectation, or discourses utilised within that interview that may have suppressed more negative understandings). As discussed at the beginning of this research, from a social constructionist perspective meaning occurs in social interactions, complete with context and history. It is inevitable that context will enable some potential understandings and suppress others. In this way the interview situation and the completion of psychometric measures can be thought of as context, influencing Lisa's constructions of events and availability of discourses. Lisa's scores on measures of quality of life and psychopathology will be discussed in the next section.

Quality of life

Lisa's score on the WHOQOL-BREF global scale indicates that her quality of life remained unchanged between the two interviews. Lisa rated herself as having a 'good' overall quality of life at both time points. Despite Lisa's descriptions of significant stressors and events in her life, this result was congruent with interviews, where she presented as rapidly improving and hopeful for the future.

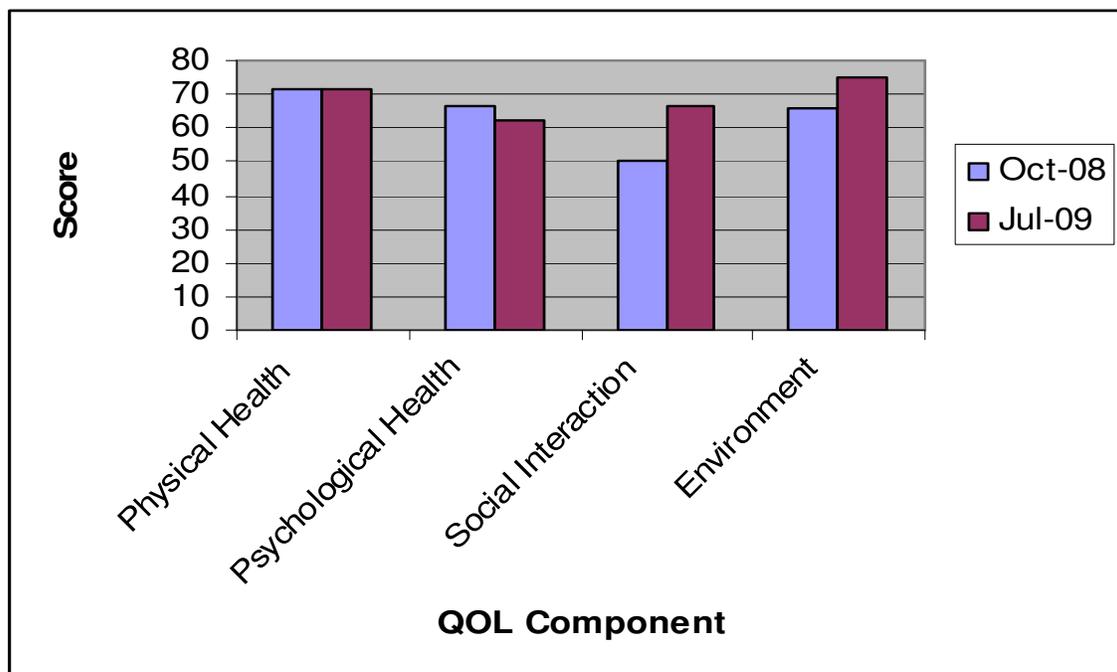


Figure 13: WHOQOL-BREF component scores for Lisa

Figure 13 shows Lisa's scores on different aspects of quality of life also suggest that there has been little change in physical, psychological or environmental components. Her score on the social interaction subscale at the first interview was below expected when compared to Australian community norms, however within the expected range for both outpatient and inpatient psychiatric norms. This improved to the normal range compared to the community sample at interview two. Overall these scores are congruent with her reports at each interview.

The scores on the WHOQOL-BREF seem to suggest good quality of life in all domains, including psychological health, as reported by Lisa. This provides an important comparison to her scores on the BDI-II, BAI and PANAS.

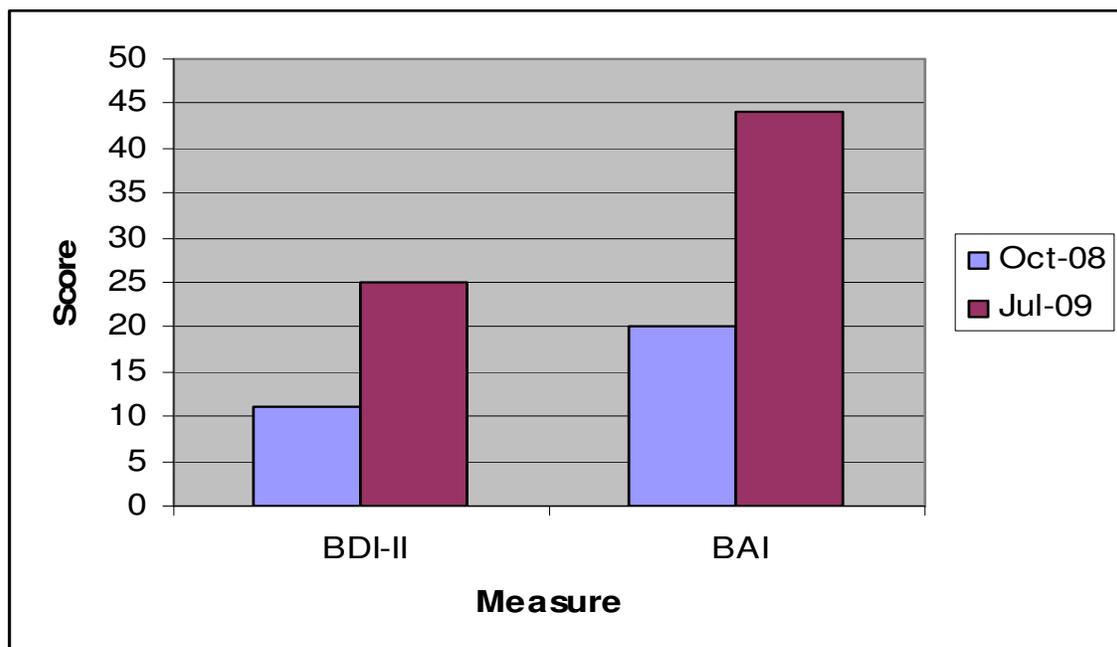


Figure 14: BDI-II and BAI scores for Lisa

Lisa's scores on the BDI-II and BAI appear to show an increase in both depression and anxiety symptoms between the two interviews. Her scores on the BDI-II suggest her depression has increased from the minimal to the moderate range and her BAI scores suggest her anxiety has increased from the moderate to severe range (see Figure 14). This is incongruent with her reports of improved well-being and ability to manage emotions. There are again several possible interpretations for these scores.

It is important to note that the BDI-II and BAI are both designed to measure current levels of depression and anxiety and the client is asked to reflect on a short period of time when completing them, rather than consider a general level of depression or anxiety. The increases shown at interview two could reflect an increase in distress in response to stressful events occurring at the time of the interview. Lisa did report significant stressors in the days and weeks preceding both interviews, and these could have impacted differently on the symptoms she experienced.

The increased scores could reflect an increase in underlying depression and anxiety which is not apparent in the interview data, however similarly to her self compassion scores, this is considered unlikely given her interview responses. At the second interview – the same time as scoring in the severe range on the BAI, and the moderate range on the BDI-II – she described herself as ‘fine 98% of the time’ (see extract 140, below), which suggests she is not experiencing ‘severe anxiety’ as indicated by her BAI score.

140. Mel: mm (3) and are you fine?

Lisa: (3) most of the time (laughter)

Mel: great

Lisa: probably 98 (.) percent of the time (Interview 2)

It is also possible that the increase in scores reflects an increased willingness to recognise and label negative emotions and experiences, which were therefore endorsed at a greater rate at the second interview. Lisa may be now more accurately observing and describing her symptoms, and accepting the presence of these symptoms. This is congruent with her interview responses. From this perspective her presentation as experiencing an increased level of distress is not necessarily negative, and could indicate progress.

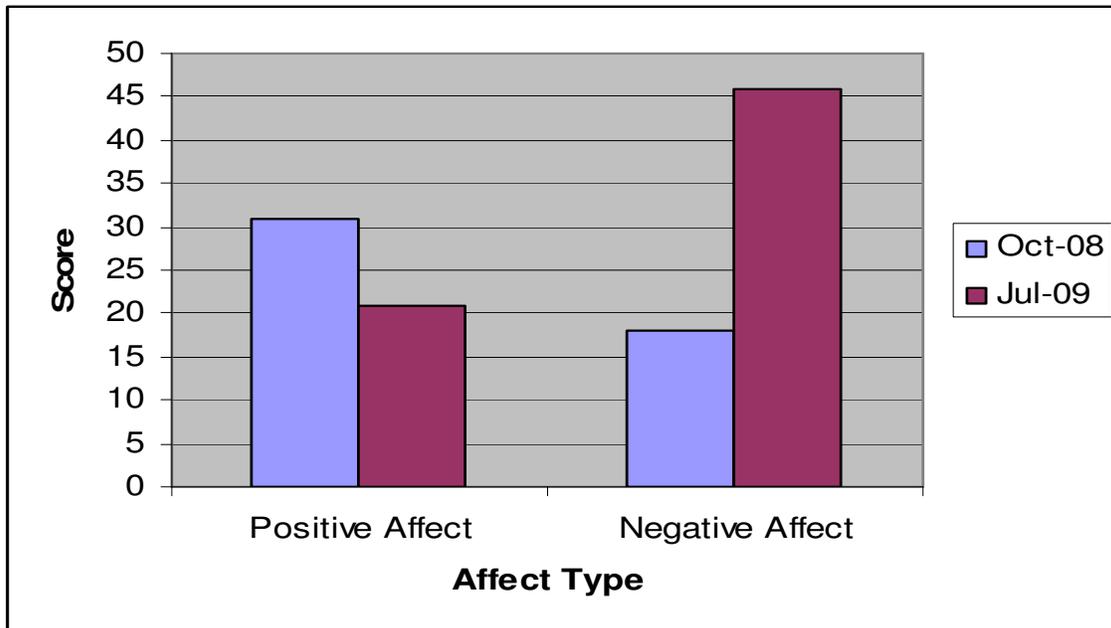


Figure 15: PANAS scores for Lisa.

Lisa's scores on the PANAS also seem to indicate increased distress (see Figure 15). She endorsed fewer positive emotions and more negative emotions at the second interview compared to the first. In particular she endorsed a very high level of negative emotions at the second interview. In interpreting these scores, similar arguments apply as for the BDI-II and the BAI, in that it is a self report measure designed to measure the level of emotions present over a short time period, rather than a more general level. Lisa may have experienced more stress in the week prior to interview two compared to interview one. She may also have been paying more attention to negative emotions, and therefore endorsed them to such a high level (above the expected level for psychiatric inpatients). From a DBT – emotion regulation perspective, Lisa's increased scores may indicate reduction of emotion phobia.

From a social constructionist perspective, Lisa constructed herself in her interviews as able to use mindfulness more easily to notice emotions. She constructed herself in both interviews as functioning well, and with good quality of life. It is possible that at the second time point she utilised the 'BPD as skills deficit' discourse when completing the psychometric measures, with associated construction of tolerating negative experiences as being evidence of skilful behaviour. She may not have had access to these discourses at the earlier time point, and therefore did not wish to present herself as

disordered – so endorsed positive emotions. If this is the case, then the new discourse of ‘BPD as skills deficit’ (acquired through participating in DBT) may have changed the meaning of items on the measures for Lisa. Whereas at time one endorsement of symptoms carried meaning of disorder – at time two – endorsement of symptoms carried meaning of skills use.

Summary

The responses on psychometric measures varied between the three participants involved. This variation encouraged me to consider what the reasons for this might be. Although I had initially administered the psychometric questionnaires with a view to examining the scores as representations of an underlying level of construct (mindfulness or quality of life), the inconsistencies between the interview constructions and the scores suggested that there were a number of potential explanations for the data, and instead of looking for one answer, perhaps a clinician working with clients would be better advised to keep a number of possibilities in mind.

One possible explanation from an empiricist perspective was that the questionnaires were not necessarily measuring what they were designed to measure, or that the interview data was inaccurate. The most obvious example of this was Lisa, who scored highly in anxiety, depression and negative affect at the same time as stating in her interview that she felt good 98% of the time (extract 140). This potential for scores to be misleading is well known to clinicians, who wisely administer psychometrics as an adjunct to a clinical interview.

The use of quantitative measures in this study can not be regarded as providing accurate information about what is occurring for each client. This is because insufficient data has been collected, for example there has been no repeat measures which may have established a stable baseline, and no follow-up measures following completion of treatment, which could have provided information about ongoing change (Martin & Pear, 2003). However the scores provide additional information in combination with interview data, and in the case studies reported above the measures provide evidence of stability and perhaps improvement in mindfulness and quality of life.

The psychometric results can be read in several ways – even within empiricist tradition. Despite this there are some commonalities which should be commented on. With regards to the mindfulness measures, the clients reported relatively high scores on mindfulness at both time points. This is potentially because mindfulness skills are taught early in DBT, and clients may have already acquired some mindfulness skills even very early in therapy, and before the first interview. Some clients may have studied mindfulness in individual therapy while waiting for inclusion in a DBT group. The relative stability of mindfulness measures may reflect this learning. Additional research measuring mindfulness in clients before they have access to DBT or individual therapy, and following a longitudinal design would clarify this.

There appear to be many positive indicators in the data, particularly that clients were more accepting of themselves. Sasha and Angela's scores indicated reduction in self-judgement. While Lisa's scores seemed to indicate the reverse, it should be noted that her initial self-judgement score on the SCS was much higher than the others (meaning that she presented herself as less judgemental), which perhaps suggests initial denial of judgemental thoughts. Lisa's talk, in which she describes herself as 'more accepting' (extract 138), also provides evidence that contradicts her SCS score.

Attention should also be paid to the WHOQOL-BREF global quality of life scale, which, with its simplicity perhaps provides the clearest indication of the clients' perception of quality of life. Sasha and Lisa reported unchanged 'good' quality of life at both interviews, while Angela reported improvement from 'neither good nor bad' to 'good'. These scores suggest clients were happy with their quality of life at both time points, although in their interviews it was clear that this had not always been the case. These results indicate that improvement in quality of life may occur early in therapy. Perhaps merely beginning therapy is enough to influence perception of quality of life.

The above discussion should not be taken to mean there should be no attempt to utilise psychometric measures. What this study has done is identify a need to consider possible alternative reasons for scores, and if possible to supplement these with qualitative data from participants. From a pragmatic perspective, absolute measurement in psychology is impossible. Psychology by definition examines human experiences, which are not easily translatable into numbers (Botella, 1998). If there is an underlying

entity to be measured, we can still only measure a conceptualisation of this, situated in context, or a construction of what we think might be there. Even the language of empiricism recognises this, using the word 'construct' to identify what is measured.

The changes in psychometric scores in the above case studies add information which could not be obtained from interviews, and which, with measurements at additional time points could identify stability of changes over time. From an empiricist perspective this could identify changes in underlying states (mindfulness, self compassion, quality of life, psychopathology). From a social constructionist perspective this could identify changes in use of available discourses, and integration of new understandings into participants' constructions of their world.

Chapter 12: Discussion

The previous chapters have described four studies – a discourse analysis of literature, clinician interviews and client interviews, and data from psychometric questionnaires. The data illustrated different constructions of BPD (the diagnosis given to the treatment target group), and of DBT and the experience of participating in the therapy.

BPD

The construction of BPD as an illness and individual pathology was apparent in all of the studies, although most apparent in the literature and client studies (in the clinician study it was described as utilised by clients). This understanding underpins the creation of a diagnostic label, and as such is inevitable and possibly unremarkable, however it is worth highlighting this meaning because the term BPD is also utilised by those who argue alternative viewpoints, for example feminist discussions of BPD. The use of the term BPD becomes problematic when the dominant illness discourse is not recognised and countered (if appropriate). Shaw and Procter (2005) suggest the act of giving a diagnosis decontextualises the experience of distress, locating the disorder within the individual. Yet without use of the label, authors, clinicians and clients have no term to represent the experience they wish to discuss. More than this, if there is to be any possibility of alternative meanings being heard by those involved, then a shared vocabulary is required. The use of the BPD term without an understanding of the possible meanings attached to the label creates potential for increased confusion, distress, and – as discourses are created and maintained in a social environment – maintenance of discourses which present people in a pejorative manner.

In these studies, a discourse of 'stigma' emerged, which was utilised by clinicians and clients to express meanings of hopelessness and negativity contained within the BPD label, and largely comprised of judgement statements about BPD. This discourse was also apparent in the literature study, in the form of a construction of 'difficult client' as an acknowledged meaning contained within the diagnosis. This construction of difficulty was also strongly represented in the clinicians' study – in particular in their discussions of pre-DBT experiences working with clients. Clinicians positioned themselves as aware of, but not now in agreement with, this discourse.

The above illness and stigma discourses were present in all three studies, and were described as contributing on the understanding of receiving a BPD diagnosis, or working with clients. These discourses remained active (despite efforts to avoid them) and were clearly available and understood by all the participants. An example of this recognition of meaning can be seen in Tony's statement that he would not like to be diagnosed with BPD (see Chapter Seven, extract 48), which utilises the stigma discourse.

The stigma and illness discourses function to position clients with a BPD diagnosis as impossibly difficult to work with for clinicians, and with little hope for improvement. The fact that clinicians openly discussed their difficulties working with clients (in the interview) suggests an acceptance of these particular meanings. The discourses function to maintain dominant ideas about BPD, and to ensure that the blame for lack of progress is placed onto the clients rather than mental health system. Any treatment failure can be attributed to the diagnosis, rather than problems with the treatment, or treating clinician. The discourses also function to validate negative clinician experiences, and, when taken as fact by clients and clinicians, have the potential to damage therapeutic relationships, worsen behaviours – as the client takes on expected ways of being, and to reduce hope. Alternative discourses can function to counter accepted understandings and make room for new meanings, and DBT provides some alternative meanings.

The 'making sense' discourse presented the BPD diagnosis as providing information, which could inform conceptualisation of the client's difficulties and guide treatment. Clinicians mentioned this as a positive aspect of BPD. Clients also utilised this discourse, and described the diagnosis as assisting them to understand their experience. This could be a positive and a negative influence. Positive aspects were the sense of not being "crazy" identified by the clients, and a link to a possible treatment for their difficulties. Negative aspects of 'making sense' included taking on illness meanings which could shift responsibility for change to treatment providers, encouraging a sense of helplessness for clients.

The term 'emotion dysregulation' was preferred over 'BPD' by clinicians, perhaps in an attempt to avoid some of the negative meanings associated with 'BPD'. This is congruent with the conceptualisation of BPD contained within DBT theory. In utilising

this discourse clinicians positioned themselves as 'making sense' of their clients' difficulties, while avoiding the stigma attached to the term 'BPD'.

The construction of difficulties as a skills deficit was associated with the conceptualisation of BPD as emotion dysregulation. This discourse presented clients as lacking in skills in how to regulate their emotions, rather than suffering from an illness. This worked to negate the 'illness' discourse. This positioning of difficulties as skills deficit provides the opportunity for change to occur, as skills can be learned (compared to a disorder inherent in the person). This is most clearly reflected in Sasha's comments that she missed out on learning skills as a child, yet is now making up for this and ensuring that her own daughter learns the skills (see Chapter Nine, extract 100).

The construction of agency or choice, and who is responsible for the behaviours is central to the decisions made about the nature of BPD. The illness discourse includes the notion that the person is not responsible, and must seek treatment in order to recover. The skills deficit discourse emphasises that the individual is not necessarily choosing to behave the way they do, however he or she has the responsibility to gain new skills and reduce the unwanted behaviours. The 'stigma' discourse on the other hand presents an image of clients deliberately producing unwanted behaviours. Throughout these constructions runs the idea that there are 'normal' ways to behave, think and feel which people with BPD deviate from. In this way they are constructed as 'other' or different, and deviant, and the problem is located in the individual. All of the studies contained examples which illustrated these ideas. The constructions of BPD as containing elements of illness, and elements of deliberate choice, mirror the confusion identified by Wirth-Cauchon (2002) who presented it as situated on the border of madness and sanity, and at the limit of psychiatry.

Associated with discourses, are subject positions. For example, the illness discourse is linked with the idea of a client being someone who is unwell, and receives treatment with hopefully beneficial results. Behaviours connected with this might be seeking help, attending a doctor or therapist appointment, and following the advice of the 'expert' clinician. The acceptance or rejection of such subject positions is part of the process of identity creation. Gottschalk (2000) describes the creation of self as a process occurring through relationships with other people, in an interactive process. Gottschalk states that

the creation of an acceptable identity is dependent on a positive response from others. People justify their positions through language and obtain validation through interaction.

The tension between discourses of illness and non-illness (particularly the presentation of clients as deliberately choosing distressing behaviours contained in the 'stigma' discourse) results in the need for clients to position themselves in such a way that they defend against unwanted meanings. This was most obviously illustrated in Lisa's attempts to justify her position as both out of control, and deliberate in her use of self harming behaviour to obtain help (see Chapter Nine, extract 109). In this example, from a dialectical perspective, there is some validity to both positions and Lisa's talk vacillates between the two. As Billig (2001) identifies, the examination of argument can reveal what is taken as common sense and understood by all parties – hence Lisa's need to defend her position, highlights the existence of both the illness and absence of disorder discourses. Another example of this awareness – and rejection – of dominant discourses was also described in Chapter Seven (extract 51) as Rachel described clients' negative reactions to receiving the BPD diagnosis because of associated unwanted meanings.

Dominant discourses are maintained by their use and acceptance by participants (Mehan, 2001). The ongoing use of the BPD diagnosis in context of mental health services requires continuation of the illness discourse, because the mental health service is founded on the understanding that its function and purpose is 'treatment' of 'illness'. The above discussion has identified tensions in the meanings attached to BPD, and attempts by clients and clinicians to negotiate helpful subject positions within the mental health service, resulting in sometimes confusing use of opposing discourses. DBT, with its overt acceptance of more than one viewpoint, seems to have been somewhat effective in enabling a shift towards alternative, and potentially more helpful ways of conceptualising difficulties.

DBT

The most obvious outcome of this research is the construction of DBT as a worthwhile, helpful and effective therapy, which can offer hope for people with BPD. Clinicians reported that their clients found DBT useful in managing difficulties in their lives. Clients described themselves on a journey towards recovery, with goals that they had never

thought possible. The clients spoke of a sense of security that came with the commitment of their DBT therapist and support of the group and talked of a new willingness to take risks and believe that they could have the capacity to succeed. They recommended DBT for others experiencing similar difficulties. This endorsement of DBT is in line with research literature, which suggests DBT is an effective therapy for people with BPD. Implicit in this is hope for improvement for people with BPD.

The ability of the 'skills deficit' discourse to construct clients as able to change (and enable clinician hopefulness) is an important finding of this research. Research on clinician experiences working with people with BPD has identified that this work has been regarded as difficult and distressing for clinicians. These findings were also reflected in Study One the 'difficult client' discourse, and Study Two the 'stigma' discourse. DBT seemed to provide a framework which enabled clients and clinicians to work together. It is clear that in this small sample at least, clinicians and clients were able to develop a conceptualisation of the clients' difficulties – which was acceptable and helpful to both. DBT appeared to provide a shared vocabulary, acceptable to both clients and clinicians, which allows for the possibility of positive change.

The construction of DBT as providing skills was an important discourse associated with DBT. Clients' descriptions of DBT were similar to those found in a study by Cunningham, Wolbert and Lillie (2004), which reported clients describing DBT as giving them tools to manage real life situations. This discourse appeared to function to increase the acceptability of DBT for clients, and reduce a sense of being 'attacked' which previous attempts to change their behaviour had induced. The discourse worked to externalise the clients' difficulties and allow therapy to be perceived as non-threatening, because the aim of therapy is to provide skills rather than change underlying personality. Skills are presented as 'tools' available for use by anyone, and therefore their use does not have to mean acceptance of unwanted illness or pathology labels.

In using DBT language, clinicians constructed their clients' behaviours as understandable in the context of their lives and histories. This is likely to have increased the acceptability of these constructions for clients. The clients also spoke of the importance of clinicians treating them as 'human'. Although this presentation of clients

and clinicians as essentially the same (human) was largely absent from the journal articles, it is congruent with DBT theory, which notes that clinicians and other people in the client's environment are influenced by the same behavioural principles underlying DBT theory (Linehan, 1993). Linehan also notes that clinicians are likely to respond with empathy when this commonality is accepted, and that was certainly reflected in a positive regard for clients in the clinicians' talk.

Although clients talked about DBT as a set of skills, they also presented themselves as changing in fundamental ways, which removed the possibility of returning to their former (difficult) lives. The construction of changing identity over time, and the difficulties associated with that are most clearly seen in the client interviews. The process of undertaking a therapy aimed at improving quality of life, and learning new skills to replace problematic behaviours such as self harm was seen by clinicians and clients as positive. Clients and clinicians also constructed this change as difficult for clients. Angela spoke clearly of her discomfort in giving up the safety of her identity as a self harmer, describing this in terms of losing what little of herself she knew (see Chapter Ten, extract 123). The clinicians also described the process of change as difficult for clients. Anne described her client's sense of frustration that skills could not be 'un-learned', meaning that the client now had a responsibility to behave in the new skilled manner (see Chapter Eight, extract 83). The risk that clients take in leaving behind old and comfortable (if dysfunctional) behaviours is constructed by clients and clinicians as an important part of the recovery process, requiring encouragement and support. Recognition of this risk taking, and the fear associated with the 'DBT as changing identity' discourse, is likely to enhance treatment of BPD, and may (along with the skills-deficit discourse) work to de-pathologise unwanted behaviours, because the behaviours can be constructed as fear-driven rather than deliberate or malicious.

The impact of a therapy on clinicians rather than clients is not often identified as an outcome of therapy research. A major advantage of DBT (as identified in the clinicians' study), was the construction of professional safety and security offered to clinicians by the DBT framework. This was described as enabling clinicians to feel safe and confident in their practice. The sense of safety draws on earlier discourses of difficulty and hopelessness working with clients, identified in all the studies, for without the presence

of these discourses there would be no need for the provision of safety, or defence against the risk of working with BPD.

The construction of DBT skills as useful in clinicians' own lives was strongly apparent in the interviews. Understanding of difficulties as skills deficits works to depersonalise the skills – enabling clients to accept them without the sense of being attacked or pathologised that could occur with an understanding of pathology located in the individual (as with the illness discourse). This depersonalisation possibly also works to allow clinicians to practise the skills in the same way as their clients, without threat to their sense of self as a person or as a clinician.

In comparison to the fluidity of identity in the clinician and client studies, the dominant idea in the articles study was on presenting a stable theory of BPD and DBT, and therefore presenting the research as valid, and in most cases objective. There was little indication that these constructions (of BPD) would be likely to change over time, despite recognition of the variety of meanings associated with the construct (including BPD as an illness, and the clients as difficult, unlikeable, and choosing difficult behaviours). This is likely to reflect the empiricist background of the journals, and privileging of empiricist knowledge and importance of empiricist research. The discourses of DBT as well researched and based on theory function to maintain the position of the journals as offering important and scientifically sound research.

Discourses associated with the BPD diagnosis included an illness discourse, a stigma discourse and a making sense discourse. For clinicians, the term BPD was largely replaced by the alternative 'emotion dysregulation', which appeared to function to classify clients (and explain their behaviour) while maintaining distance from the illness and stigma discourses. Associated with this was a skills deficit discourse, which was prominent in all three studies. DBT itself was presented as based on sound theory and research, as providing skills, and as both a coherent whole and containing functioning parts. It was constructed by clinicians and clients as 'the best' treatment, and was promoted as changing clients' lives for the better, and in providing useful skills and professional support for clinicians. The use of discourses in action and the subject positions created through language hints at unspoken assumptions and what is regarded

as 'common sense', in this case the unwritten expectations for subject positions for client and clinician.

This research has some 'take home' messages, which add to a knowledge base for people working with BPD. The first of these is the continued prominence of illness and stigma discourses associated with BPD, which function to maintain clients (and clinicians) in a position of hopelessness. The first step in countering such discourses is to recognise their existence, so that there can be openness to alternative constructions. This is difficult within a mental health service which assumes 'illness' as eligibility criteria for DBT.

Secondly, DBT seems to provide a shared vocabulary, which can begin to counter the negative meanings associated with BPD, and shift agency and control (and responsibility) towards clients, while maintaining acceptability within the structure of the mental health service. This is an important feat, when the entrenched nature of illness and stigma discourses is recognised.

A third important finding is the level of the risk taking and fear involved in establishing new (and hopefully more functional) ways of being for clients. The clients spoke of a sense of losing what sense of identity they had, as they abandoned old behaviours. Within the DBT as changing identity discourse they constructed themselves as not simply replacing behaviour with a new skill – instead they talked of facing difficult situations without recourse to old strategies, and not yet secure in new ways of responding. The courage involved in such a step is significant, and recognition of this by clinicians and others may ensure encouragement and support.

Finally the studies identified that DBT provided discourses which enabled clinicians to also utilise the DBT skills within their own lives, and to construct themselves as professionally safe. Perhaps this sense of security is a necessary base from which clinicians are able to let go of some of the responsibility inherent in the construction of the 'clinician' role – and encourage their clients to take risks – in pursuit of progress, however with potential for failure.

Validity and reliability

The validity and reliability of discourse analysis studies can not be assessed by the same criteria that apply to studies with an empirical design, because of differing theoretical underpinnings. Potter and Wetherell (1987) propose four criteria for ensuring validity of discourse analysis research: coherence, participant orientation, generation of new problems, and fruitfulness. Coherence is the extent to which the analysis creates a complete and coherent explanation of the data. Participant orientation reflects the idea that research should reflect the viewpoint of the participants, or creators of discourse (Sherrard, 1990). Generation of new problems refers to the extent to which the research generates new questions and stimulates further research. Fruitfulness refers to the ability of the analysis to explain discourse in new ways. Research is valid if it generates new solutions to problems (Potter & Wetherell, 1987).

I believe that this research has met these criteria. The constructions identified in literature, clinician and client interviews complemented one another in such a way that each enhanced understanding of the other. The discourses identified were common in each interview or journal article, increasing the likelihood that these represent available discourses. Attempts to justify a position involving rejection of alternative constructions (for example Lisa's defence against the perception that her self harming behaviour was unreasonable) also support the coherence of the analysis. The findings of the client study closely paralleled those found by Cunningham, Wolbert and Lillie (2004), which provides evidence that other researchers have identified similar discourses.

Participant orientation was achieved in part by the sharing of transcripts with each participant, so that there was an opportunity for editing. To some extent the creation of the interview data itself was a shared undertaking between myself and each participant, as the interview progressed. Of course the analysis itself involved my own interpretations of the data and as such the participants may not always agree with my interpretations. The inclusion of participants in the data analysis phase would have potentially produced different readings of the data.

The third criterion, generation of new research questions, is also met by this study. Perhaps future research using discourse analysis could extend the case study design to a longitudinal approach, examining changes in the use of available discourses by an

individual over time. There is a need for research into constructions used by clients who did not persist with DBT – maybe their stories would contain different constructions. Similarly clinicians who do not use DBT are likely to have used alternative constructions. This is relevant because these non-DBT clinicians usually provide the (clinical) background environment from which DBT clients are referred. Some of the clinicians in this study identified that simply having something to offer had made clients with BPD seem less daunting – and there is room for research looking at how the introduction of a DBT programme impacts on clinicians (and clients) within the wider mental health service. Discourse analysis is fundamentally a work of meaning making, and it is important that researchers from different disciplines and theoretical backgrounds undertake research, so that the potential impact of the researcher on the data can be better understood. There is therefore room for this study to be repeated by others.

The final criterion identified by Potter and Wetherell (1987) is fruitfulness. I believe that this study has provided reflection on the nature of psychotherapy research, and that this reflection meets this criterion. Discourse can be examined as representative of underlying states, or as constitutive of reality. Clinical psychologists are aware of their clients' stories, and often reflective on their own stories. They know of the importance of context, background and history. At the same time they value knowing that the therapy they recommend has been tried before, and achieved positive results for clients. They often understand reality as both real and constructed at the same time.

Limitations

All research has limitations, and these must be acknowledged. There are issues related to the methodology and these include the responsibility to interpret other people's stories and the subjectivity of the researcher. There are also issues arising as research progresses, such as participant recruitment and selection.

Discourse analysis conceptualises the language, or text as the subject of study – not the person speaking, and not underlying beliefs that person may or may not hold. In theory, this makes sense – in practice it is difficult not to read a person's statements as representative of them as a person. In particular the process of identity creation occurs through language, and there is an ethical obligation not to produce research which further imposes unhelpful ways of speaking about already marginalised groups. This

recognises that discourse analysis is inherently political in nature, as identified by Parker (1990).

The subjectivity of the researcher inevitably influences research, particularly research examining creation of meaning such as discourse analysis. This means that a study such as this, with only one analyst, is limited by that researcher's background, goals, political understandings, and interpretation (and creation) of the data. This is acknowledged as far as possible, so that readers consider these aspects of the research. My background in mental health, my relationship or perceived relationship with participants, and my position as a graduate student all necessarily impacted on both the creation and reading of the data.

The number of participants included in these studies was small. This means that only five clinicians and five client participants were interviewed. This may have limited the extent to which a full range of possible discourses was recognised. A larger number of participants may have included people who utilised different discourses of BPD and DBT.

In this research, recruitment of client participants was difficult. This is likely to be because the nature of problems experienced means these people were already experiencing high levels of distress, and often difficulties relating to others, making participation in a research interview a daunting prospect. It is possible that those who did participate were different as a group compared to those who did not. Perhaps their experience of DBT was more positive, and they wished to share this. Perhaps their difficulties were different to those experienced by other participants. Or there may be another reason for non-participation. There are also people who do not complete DBT, or who are offered it but do not participate. These people also have stories of DBT which were not heard on this occasion. My position as a clinician within the service, albeit not within the DBT programme, may have influenced what clients felt able to say, or impacted on the manner they wished to present themselves.

Participation by clinicians similarly may have been biased towards those who wished to share a positive experience of DBT. The voices of clinicians who work with clients with BPD – but who do not use DBT – were also not included in this study. As researcher I

was known to clinician participants as a registered nurse, or as intern psychologist, and there may have been a wish to help me achieve my degree. There may have been a wish to present the new DBT programme as succeeding and to construct themselves and their DBT colleagues as effective clinicians.

With regards to the psychometric component of the case studies, there were an insufficient number of measurement points to obtain valid data from an empirical standpoint, as there was no stable baseline or follow-up obtained. There were insufficient numbers of participants to allow comments about the changes in psychometrics of the group over the course of the programme. Instead I chose to examine them qualitatively, and from a discourse analysis perspective. Larger samples and obtaining stable baseline and follow-up measurements would have allowed for more meaningful comments from an empirical understanding as well.

Reflexivity

In completing this research it is important to acknowledge that the research itself is an example of construction, and represents my own reading of the interviews and journal articles. It is inevitable that all research is to a large extent influenced by the researcher, because from conceptualisation to data collection and analysis, decisions are made which profoundly influence the findings of research. In this research, I was present both as a researcher/participant (as my contribution to the interviews is part of the analysis) and analyst. I was also present as a clinician (although I was not working clinically with participants) and my background as a clinician also profoundly influenced the questions I came to, and undoubtedly contributed to the progress of the interviews, and the interpretations that followed. My experience as a new clinical psychologist increased my interest particularly in the clinicians' descriptions of DBT in their own lives, and this was likely reflected in the interview process.

The combination of social constructionist and empirical data in the same study can be problematic, because the information is understood in differing ways. From an empiricist perspective, scores on psychometric testing, or comments in an interview, provide clues as to an existing underlying truth about what is occurring. From a social constructionist perspective, both responses on psychometric testing and the use of language in an interview are examples of a creation of meaning occurring within a historical and social

context. Although my intention was to report Study Four as an empiricist outcome measures study, the small number of participants, and difficulty recruiting them resulted in my focus being more on the use of psychometrics as a snapshot in time, linked with the ways in which clients constructed their progress in interviews. I found myself thinking in social constructionist terms and looking at the use of psychometric measures as one avenue through which clients could construct their experience, and convey this to others.

“...we psychologists are encouraged in a hierarchy of intellectual snobbery. We gaze admiringly towards our betters in the natural sciences, while disdain the poverty of truth to be found in the humanities. The path to truth is paved with correct methods. Those psychologists who question the accepted techniques are not made welcome: They are seen to challenge the very activity of psychology itself.” (Billig, 1996, p.6)

I have included the above quote by Billig because it seemed to construct the position of psychology as a discipline, as somewhere between searching for an empirical truth (as in natural sciences) and the creation of meaning through culture and art (as in the humanities) - always uncomfortable with the position of not being clearly 'scientific' (or clearly not). Through the process of conducting this research I think it is useful to take a dialectical perspective, and look for the truth (the pragmatic truth – or useful truth) in both. DBT, and the concept of dialectics, provides a useful framework, with its overt search for truth in both sides of an argument. In doing so it is profoundly accepting of different ways of thinking.

As a researcher and clinician (albeit not a DBT clinician) this study has affirmed my leanings towards a social constructionist understanding of reality, and the power of language to create, maintain, and also resist understandings across time. The problematic nature of labels such as BPD is heightened when different meanings are not recognised. This is important for therapy, so that unhelpful or stigmatising discourses can be countered. It is important for research to acknowledge assumptions and ways of thinking that influence study. Perhaps the most useful way to approach clinical research is, as Birgden and Ward (2003) state, to make the goal of research to identify useful understandings that can solve practical problems for individuals or groups, or to take

what is useful from different sides. As Linehan (1993) reports, the conflict is resolved when the existence and validity of both positions is recognised.

As I reflect on the undertaking of this research, the most prominent feeling is a profound sense of privilege, to have been able to hear the participants' stories. I find their words coming to mind when I am faced with a client in my clinical practice, for whom DBT may be an option. In the process of this research I have become much more aware of the interplay between available linguistic resources (discourses) and an individual's attempts to create their own meanings. This process both influences and has been influenced by my clinical work, and I can only predict that it will continue to do so in the future.

Appendix A: Study One – list of journal articles

- Brassington, J., & Krawitz, R. (2006). Australasian dialectical behaviour therapy pilot outcome study: Effectiveness, utility and feasibility. *Australasian Psychiatry, 13*, 313-319.
- Bray, S., Barrowclough, C., & Lobban, F. (2007). Social problem-solving skills of people with borderline personality disorder. *Behavior Research and Therapy, 45*, 1409-1417.
- Comtois, K.A., & Linehan, M.M. (2006). Psychosocial treatments of suicidal behaviors: a practice-friendly review. *Journal of Clinical Psychology, 62*, 161-170.
- Conason, A.H., Oquendo, M.A., & Sher, L. (2006). Psychotherapy in the treatment of alcohol and substance abusing adolescents with suicidal behavior. *International Journal of Adolescent Medicine and Health, 18*, 9-13.
- Durrant, C., Clarke, I., Tolland, A., & Wilson, H. (2007). Designing a CBT service for an acute inpatient setting: A pilot evaluation study. *Clinical Psychology and Psychotherapy, 14*, 117-125.
- Frederick, J.T., & Comtois, K.A. (2006). Practice of dialectical behavior therapy after psychiatry residency. *Academic Psychiatry, 30*, 55-62.
- Harned, M.S., Banawan, S.F., & Lynch, T.R. (2006). Dialectical behaviour therapy: An emotion-focussed treatment for borderline personality disorder. *Journal of Contemporary Psychotherapy, 36*, 67-75.
- Hazelton, M., Rossiter, R., & Milner, J. (2006). Managing the 'unmanageable': Training staff in the use of dialectical behaviour therapy for borderline personality disorder. *Contemporary Nurse, 21*, 120-130.
- House, A.S. (2006). Increasing the usability of cognitive processing therapy for survivors of child sexual abuse. *Journal of Child Sexual Abuse, 15*, 87-103.
- Huss, D.B., & Baer, R.A. (2007). Acceptance and change: The integration of mindfulness-based cognitive therapy into ongoing dialectical behaviour therapy in a case of borderline personality disorder with depression. *Clinical Case Studies, 6*, 17-33.
- Jacobo, M.C., Blais, M.A., Baity, M.R., & Harley, R. (2007). Concurrent validity of the Personality Assessment Inventory Borderline Scales in patients seeking dialectical behavior therapy. *Journal of Personality Assessment, 88*, 74-80.
- Koons, C.R., Chapman, A.L., Betts, B.B., O'Rourke, B., Morse, N., & Robins, C.J. (2006). Dialectical behaviour therapy adapted for vocational rehabilitation of significantly disabled mentally ill adults. *Cognitive and Behavioral Practice, 13*, 146-156.
- Kirby, J.S. & Baucom, D.S. (2007). Treating emotion dysregulation in a couples context: A pilot study of a couples skills group intervention. *Journal of Marital & Family Therapy, 33*, 375-391.
- Kroger, C., Schweiger, U., Sipos, V., Arnold, R., Kahl, K.G., Schunert, T., Rudolf, S., & Reinecker, H. (2006). Effectiveness of dialectical behaviour therapy for borderline personality disorder in an inpatient setting. *Behaviour Research and Therapy, 48*, 1211-1217.
- Levy, K.N., Meehan, K.B., Kelly, K.M., Reynoso, J.S., Weber, M., Clarkin, J.F., & Kernberg, O.F. (2006). Change in attachment patterns and reflective function in a randomized control trial of transference-focussed psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology, 74*, 1027-1040.

- Lew, M., Matta, C., Tripp-Tebo, C., & Watts, D. (2006). Dialectical behavior therapy (DBT) for individuals with intellectual disabilities: A program description. *Mental Health Aspects of Developmental Disabilities, 9*, 1-12.
- Linehan, M.M., Comtois, K.A., Murray, A.M., Brown, M.Z., Gallop, R.J., Heard, H.L., Korslund, K.E., Tutek, D.A., Reynolds, S.K., & Lindenboim, M. (2006). Two-year randomized controlled trial and follow-up of dialectical behaviour therapy vs. therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry, 63*, 757-766.
- Lynch, T.R., Chapman, A.L., Rosenthal, M.Z., Kuo, J.R., Linehan, M.M. (2006). Mechanisms of change in dialectical behaviour therapy: Theoretical and empirical observations. *Journal of Clinical Psychology, 62*, 459-480.
- Lynch, T.R., Cheavens, J.S., Cukrowics, K.C., Thorp, S.R., Bronner, L., & Beyer, J. (2007). Treatment of older adults with co-morbid personality disorder and depression: A dialectical behaviour therapy approach. *International Journal of Geriatric Psychiatry, 22*, 131-143.
- McFetridge, M., Morton, C., & Berg, J. (2006). Traumatic memory: Is it all in the mindfulness? Therapeutic Communities: *International Journal for Therapeutic and Supportive Organizations, 27*, 171-191.
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Appendix B: Information Sheet for Participation in Research on Dialectical Behaviour Therapy (Clinician)

Hello/ Tena koe

You are invited to take part in this study about Dialectical Behaviour Therapy (DBT), because I understand that you are involved in delivering a programme of DBT at XXDHB.

My name is Melanie Simons and I am a graduate student in psychology at Massey University studying towards a Doctor of Clinical Psychology degree. I am also employed at XXDHB as a psychiatric nurse and you may already have met me in that capacity. A requirement for my studies is the completion of a piece of research, which is relevant to clinical practice. My supervisors for this project are Associate Professor Keith Tuffin and Dr Joanne Taylor, both of whom are senior members of staff in the Massey University psychology department. I am interested in clinicians' perspectives of DBT, and your views on your clients' experience of the therapy.

If you agree, I will ask you to participate in one interview with me, at XX DHB. The interview will take approximately 30 minutes to one hour and will be audiotaped.

In the interview I will ask you about your experiences of the DBT therapy, and about your clients' behaviour and contact with mental health services. I will transcribe the interview and the transcript will be kept in a locked filing cabinet at Massey University, accessible only to myself, and will not be used for any research other than this study. You will be provided with a transcript of your interview to edit, prior to any analysis taking place.

Your participation is entirely voluntary. If you agree to take part you are free to withdraw from the study at any time, without having to give a reason. You can refuse to answer any question at any time. You can ask that the tape recorder be turned off at any time during the interview.

On conclusion of the study, you will be provided with a summary of the overall findings, and will have an opportunity to discuss this with the researcher. The findings of the study may be submitted for publication in journals in New Zealand and internationally. No material which could personally identify you or your clients will be used in any reports on this study. To ensure this is the case, gender neutral pseudonyms will be used, any unusual client behaviours will be reported as 'dangerous actions' or similar, and demographics will be given as a summary of the group from which participants are drawn.

If you agree to take part in this research you will need to sign the enclosed consent form. A second copy of the consent form is for you to keep for future reference. Please return the consent form to me within two (2) weeks in the reply paid self-addressed envelope that is provided for your convenience. The consent forms will be sent to me care of Keith Tuffin at the School of Psychology, Massey University. Your consent form and all information will be kept in a secure filing cabinet there at all times for five years after the research has been completed, it will then be destroyed.

The consent form is included for you to fill out. If you have any questions about this project, or require further information, please contact me, or Keith Tuffin at Massey University (see the following contact details).

Researcher: Melanie Simons
Supervisors: Keith Tuffin
 Joanne Taylor

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Advocate:

0800 42 36 38 (4 ADNET)

This study has received ethical approval from the Central Ethics Committee. If you have any concerns about the conduct of this research, please contact the Central Region Ethics Committee:

Thank you for taking the time to read this information sheet, and considering participation in this study. Your contribution is highly valued and I and hope that you will consider taking part in this research.

Appendix C: Information Sheet for Participation in Research on Dialectical Behaviour Therapy (client)

Hello/ Tena koe

You are invited to take part in this study about Dialectical Behaviour Therapy (DBT), because I understand that you are beginning a programme of DBT at XXDHB.

My name is Melanie Simons and I am a graduate student in psychology at Massey University studying towards a Doctor of Clinical Psychology degree. A requirement for this degree is the completion of a piece of research, which is relevant to clinical practice. My supervisors for this project will be Dr Keith Tuffin and Dr Joanne Taylor, both of whom are senior members of staff at Massey University psychology department. I am interested in the effectiveness of DBT. I am particularly interested in hearing how the therapy may influence the way in which people think about their behaviour and contact with mental health services. There is very little research on DBT in New Zealand, and no research that examines how DBT influences the way people think about their behaviour.

If you decide to participate, I will ask you to come to XXDHB for an interview, which will be tape recorded, and some psychological assessment questionnaires. These assessments should take approximately 1 ¼ - 1 ¾ hours to complete (30 minutes to one hour for interview, and 45 minutes for questionnaires). I will ask you to return for the same assessment procedure again after six months of the therapy, and again after one year. This is so that I can compare the assessments and track your progress.

In the interviews, I will be asking you about your experiences of the DBT therapy, and about your behaviour and contact with mental health services. You can choose to refuse to answer any question at any time. You can ask that the tape recorder be turned off at any time during the interview. The interviews will be transcribed by the researcher (Melanie Simons). The transcripts from the interview will be kept in a locked confidential place at Massey University. The transcripts will not be made available to clinicians, and

will not be used for any research other than this study. You will be provided with a transcript of your interview to edit, prior to any analysis taking place.

There will be some short pencil and paper questionnaires to complete. If you agree, I will make the results of the psychological questionnaires available to your psychologist, and these will be kept at XXDHB with your psychology file.

Your participation is entirely voluntary (your choice). If you do agree to take part you are free to withdraw from the study at any time, without having to give a reason and this will in no way affect your continuing health care. Participation in this study will be stopped if you, the researcher, or your therapist decide that it is not in your best interests to continue. Therapist A has agreed to be available to you following the assessments, should you experience any distress as a result of your participation.

On conclusion of the study, you will be provided with a summary of the overall findings, if you would like one, and will have an opportunity to discuss this with the researcher. The findings of the study may be submitted for publication in journals in New Zealand and internationally. No material which could personally identify you will be used in any reports on this study.

If you agree to take part in this research you will need to sign the consent form that says you would like to take part in this study. A second copy of the consent form is for you to keep for future reference. The consent form will need to be returned to me within two (2) week in the reply paid self-addressed envelope that is provided for your convenience. The consent forms will be sent to me (Melanie Simons) care of Keith Tuffin at the Psychology Department, Massey University. Your consent form and all information will be kept in a secure area there at all times and destroyed after the research.

The consent form is included for you to fill out. If you have any questions about this project, or require further information, please contact me, or Keith Tuffin at Massey.

Researcher: Melanie Simons
Supervisors: Keith Tuffin
Joanne Taylor

DBT Coordinator: Therapist A

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Advocate:

0800 42 36 38 (4 ADNET)

This study has received ethical approval from the Central Ethics Committee. If you have any concerns about the conduct of this research, please contact the Central Region Ethics Committee:

Thank you for taking the time to read this information sheet. I appreciate your thoughts about your treatment and hope that you will consider taking part in this research.

Appendix D: Consent form

Evaluation of Dialectical Behaviour Therapy for New Zealanders.

CONSENT FORM

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF TWO (2) YEARS

REQUEST FOR INTERPRETER

English	I wish to have an interpreter	Yes	No
Maori	E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhaka pakeha korero	Ae	Kao
Cook Island	Ka inangaro au I tetai tangata uri reo	Ae	Kare
Fijian	Au gadreva ma dua e vakadewa vosa vei au	lo	Sega
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu	E	Nakai
Samoaan	Out e mana'o ia I ai se fa'amatala upu	loe	Leai
Tokelaun	Ko au e fofou ki he tino ke fakaliliu te gagana Peletania ki na gagana o na motu o te Pahefika	loe	Leai
Tongan	Oku ou fiema'u ha fakatonulea	lo	Ikai

I have read and understood the information sheet dated _____ for volunteers taking part in the study designed to examine client perspectives of Dialectical Behaviour Therapy. I have had the opportunity to discuss this study. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time.

I have had this study explained to be by Melanie Simons

I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study.

I understand that taking part in the study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my continuing health care.

I understand that participation in the study is confidential and that no material which could identify me will be used in any reports on this study.

I understand that the investigation will be stopped if it should appear harmful to me.

I have had time to consider whether to take part.

I know who to contact if I should have any side effects to the study.

I know who to contact if I have any questions about the study.

I consent to my interview being audiotaped. YES/NO

I consent to my psychometric questionnaires being made available to my psychologist, and kept with my psychology file. YES/NO

I consent to the use of psychometric questionnaires for both this Research project and my treatment. YES/NO

I wish to receive a copy of the results
YES/NO

I _____(full name) hereby consent to take part in this study.

Date:_____

Signature:_____

My contact details:_____

Researcher: Melanie Simons.

Email:

Telephone:

Supervisor: Keith Tuffin

Email:

Telephone:

Project explained by:_____

Signature:_____

Date:_____

Appendix E: letter accompanying transcripts.

Dear

Thank you for participating in an interview on

Here is the transcript of your interview. I would be grateful if you would take the time to have a look at it and make any changes you would like. You are welcome to cross anything out, or add anything you would like.

Even if you make no changes to the interview I will be attempting to maintain your anonymity and that of your colleagues and clients as much as possible. For example I will be deleting any names, places or designations (e.g. nurse, social worker, or psychologist) that could identify you or others.

To assist you in reading your transcript, I have used the following notation: Pauses are indicated with two brackets (). A short pause is represented as (.) and longer pauses have the time inside the bracket, e.g. a three second pause is written as (3). Overlapping speech is written inside square brackets [...]. Words with distinct emphasis are underlined. I have not included any other notation.

When you are happy with the interview, please return it to me in the envelope provided.

Thanks again for you time and thoughts!

Best wishes

Melanie Simons

Appendix F: Interview schedule clients

Part A Behaviour

How did you come to do the DBT group?

Tell me about your experiences of mental health services before DBT

How would you explain your experiences to someone who does not have the same problems you have?

Tell me about being diagnosed with BPD, what do you think about that diagnosis?

Why do you think you have (or had) the difficulties that led you to try DBT?

Have you changed the way you behave at all since DBT?

Have you changed how you think about what you do? Tell me about that

Part B DBT Programme

How have you found the DBT programme?

Does your experience of DBT match your expectations?

Tell me about one of the group sessions, what happens?

What was it like being in the group?

What are the most useful skills?

Tell me about the individual therapy

What are the most important things you have learned?

Is DBT helping you in your everyday life? Can you describe an example?

What did/do you like most about DBT?

What don't you like about DBT?

Do you think DBT will continue to help you? If so how?

Can you think of anything you would change about the programme? How would you change it?

Have you got any ideas for future DBT groups or individual therapy?

Appendix G: Interview schedule clinicians

Clinician's view of clients experience and behaviour

- Tell me how you decide who is enrolled in the DBT group?
- Tell me about the people who want to have DBT. What are their problems? Why do you think they have these problems?
- Tell me about borderline personality disorder, what do you think about the diagnosis?
- How do the clients find the treatment? How does it compare to their previous experiences?
- What aspects of DBT do the clients like most/like least?
- Is the treatment helping your clients in their everyday life?
- (If yes) How is it helping? What are the most useful things?
- Can you describe an example of when DBT helped someone?
- Has the way your clients behave changed at all since DBT? Tell me about that.
- Have you changed how you think about how your clients' behaviour? Tell me about that. Have clients changed the way they think about their behaviour?
- Do you think DBT will continue to help your clients? If so, how?

Clinician's own experience

- What lead you to DBT? What previous experience have you had with DBT?
- What aspects of DBT are you most involved with?
- Tell me about the individual/group/telephone coaching/consultation group (your experience)
- Tell me about one of the sessions, what happens?
- What do you like about DBT? (can you give example?)
- What don't you like about DBT?
- Does your experience of DBT match your expectations?
- Are there aspects of DBT that stand out for you? Tell me about these.
- Have you made any adaptations to DBT to fit the situation here? Would you suggest changes? What difficulties have you experienced implementing DBT?
- How has DBT changed your practice? What has changed?

Appendix H: Feedback sheet for participants

Dear participant

Thank-you very much for participating in my research about client and clinician experiences of DBT. In doing this research I hoped to identify how you talked about your experiences, and look at the influence of language on the way you talked about yourselves and your work with DBT, either as a client or as a clinician.

The results

The language used suggested that the borderline personality disorder diagnosis carries several broad meanings or 'discourses'. Discourses can be thought of as building blocks for language, in that they are commonly understood ways of thinking or talking about experience. These will be listed below:

- An illness discourse – constructed people with BPD as unwell. Associated with this idea was a need to be treated (by others) and a lack of responsibility for behaviours, which were seen as symptoms.
- A pathology or stigma discourse – contained negative and judgemental aspects of the diagnosis, including the idea that people with BPD are difficult to deal with, and are disliked by clinicians. This discourse was notable in client and clinician descriptions of their pre-DBT experiences with mental health services.
- A 'making sense' discourse was utilised by clinicians in assisting them to conceptualise their clients with BPD in order to assist them.
- An emotion dysregulation discourse – conceptualised people with BPD according to DBT theory, and behaving in certain ways because of difficulty managing emotions, and fear of emotion. This can also be seen as an attempt to utilise the 'making sense' aspect of the BPD diagnosis while avoiding the negativity of the pathology discourse.

With regards to DBT itself, there were also a variety of discourses identified:

- DBT as providing skills – this was the most prominent idea, and was associated with thinking about BPD as being an emotion regulation difficulty because of a skills deficit. Talking about using DBT in this way allowed clinician and clients to express hope for improvement, and worked to avoid the negativity of the pathology discourse, and the powerless position of clients within the illness discourse. Both clients and clinicians spoke of effectively utilising DBT skills to manage distress in their lives.
- DBT was described as a coherent whole, and also as divisible into component parts such as skills training and individual therapy. While skills were generally the topic of conversation, the relationship with the therapist, and commitment to therapy were also presented as fundamental. The DBT group provided support and also confrontation because clients were faced with others experiencing similar problems.
- An important finding was the presentation of DBT as providing professional support and safety for clinicians. The clinicians described feeling safe in knowing that they were able to deliver the best care possible based on current knowledge. They expressed confidence and interest in working with clients with BPD. This is important because of the earlier difficulties in this area described by clinicians and clients alike.
- The process of change for clients included confronting the possibility of choosing new identities, for example losing the status as a self harmer. This could be a difficult and scary process for some people and the clients described losing a former sense of identity or 'who am I'. Clients talked of using skills, and maintaining a strong connection with their individual therapist as helping them manage this.
- DBT was strongly endorsed as helpful and effective by the clients and clinicians (yourselves).

I intend to publish findings from this study in academic journals, which will enable these results to be read by others interested in DBT. I will also make a copy of the thesis

available to the DBT group at XXDHB, which you can access through the DBT coordinator should you wish. This is likely to be around August-September 2010.

I would like to thank you very much for your time and sharing of your experiences. This research would not have been possible without your generosity and openness. It has been a privilege to hear your stories. If you would like further information, please contact me on the contact details provided. I will be happy to hear from you.

Best wishes

Melanie Simons

Appendix I: Population norms for measures

Neff Self Compassion Scale (Neff, 2003)

Female Undergraduate Students N=225	
Self Compassion	17.72 (3.74)
Self Kindness	3.0 (0.75)
Self Judgement	3.24 (0.77)
Common Humanity	3.03 (0.76)
Isolation	3.09 (0.90)
Mindfulness	3.27 (0.76)
Over-identification	3.25 (0.90)

WHOQOL-BREF (WHO, 2000, p.33)

Australian population norms			
	Community n=396	Outpatient n=334	Inpatient n=266
Physical	79.00 (17.05)	61.47 (22.50)	51.55 (23.11)
Psych	72.63 (14.16)	65.37 (18.03)	64.04 (18.34)
Social	72.15 (18.53)	62.89 (23.53)	63.36 (21.02)
Env	74.83 (13.72)	67.93 (16.81)	66.99 (15.96)
Item 1	4.31 (.75)	3.87 (.91)	3.65 (1.01)
Item 2	3.64 (.93)	2.88 (1.03)	2.62 (1.19)

Kentucky inventory of Mindfulness Skills (Baer, Smith & Allen, 2004)

	Student Sample n=205	BPD Sample n=26
Observe	36.61 (6.92)	36.77 (7.92)
Describe	27.61 (5.77)	22.25 (6.57)
Act with Awareness	28.89 (5.40)	24.09 (5.45)
Accept without Judgement	30.11 (6.01)	21.50 (7.49)

PANAS (Watson & Clarke, 1994):

	Women n=115	Psychiatric Inpatients n=117
Positive Affect	33.9 (5.1)	32.4 (8.1)
Negative Affect	14.2 (4.1)	25.5 (10.0)

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