EXPERIENCES OF IMPULSIVITY, SELF-HARM AND DBT GROUPS: A QUALITATIVE ENQUIRY IN A SECURE SETTING

Anna Caroline Whalen

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The University of Leeds
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Academic Unit of Psychiatry and Behavioural Sciences

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others

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ABSTRACT

Introduction

This study was developed from a recognition of the lack of research exploring experiences of self-harm, impulsivity and the group component of Dialectical Behaviour Therapy for women in low secure forensic setting. Psychological understandings and models proposed do not consider self-harm within particular contexts. It is important to gain an understanding of impulsivity and self-harm, within the context in which they occur, to develop models of understanding and ensure therapies offered are adapted for the specific needs of the population.

Method

Using a combination of purposeful sampling and snowballing, a sample of six women, who were detained in a low secure forensic hospital, were recruited. They participated in semi-structured interviews which were transcribed and then analysed using Interpretative Phenomenological Analysis. Individual transcripts were analysed and three levels of themes were identified for each participant. Individual themes were then used to develop the group themes.

Results

Two sets of results are presented. The first focuses on how women make sense of their experience of self-harm and impulsivity. Three levels of themes were identified, the first level consisted of '*I need you for safety but I fear you', 'I'm going round in circles and keep making the same mistakes', 'Living in a hostile world', 'A sense of losing and finding myself'*. The second set of results focuses on experiences of Group Based Skills Training component of Dialectical Behaviour Therapy Two levels of themes were generated, the first level consisted of '*Mistrust and vulnerability: denial and defences', Making sense of GBST: Is it worth it?, Tentative changes'.*

Discussion

The key findings of the study are linked to psychological theory, current models of understanding self-harm and previous research findings. The study adds to literature on experiences of self-harm and impulsive acts, in addition to, understanding the relationship between self-harm and impulsivity within forensic settings. It also adds to the minimal literature exploring the experiences of Group Based Skills Training for women within secure forensic settings.

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ABBREVIATIONS

DBT	Dialectical Behaviour Therapy
GBST	Group Based Skills Training
BPD	Borderline Personality Disorder
RCT	Randomised Control Trail
IPA	Interpretative Phenomenological Analysis
LD	Learning Disability
ASPD	Anti-social Personality Disorder
DSM	Diagnostic Statistical Manual
PTSD	Post Traumatic Stress Disorder
T2	Second transcript

CHAPTER ONE: INTRODUCTION

Mental health difficulties experienced by women detained in forensic settings tend to be complex (HMIP, 2014) with incidents of self-harm thirty times higher in female offenders compared with the general population of the UK (Hawton, Linsell, Adeniji, Sariaslan, & Fazel, 2014). Impulsive behaviours including, self-harm, suicide attempts and substance abuse are reactions to, and ways of coping with traumatic experiences (Langan & Pelissier, 2001), such as histories of sexual abuse, domestic violence, bereavement (Borrill et al., 2003; O'Brien, 2001). Self-harm has been understood in relation to past experiences, however, current understandings pay little attention to the particular context in which self-harm occurs despite self-harm being shown to serve different functions within forensic settings (Karp, Whitman & Convit, 1991). Impulsivity has been shown to be a risk factor for self-harm (Herpertz, Sass, & Favazza, 1997) and high rates of impulsive behaviours are found within forensic populations (Marzano, Fazel, Rivlin, & Hawton, 2011) Associations have been found, however, the relationship between self-harm and impulsivity remains unclear (Marzano, Fazel, et al., 2011). Understanding the complex nature of self-harm in relation to impulsivity within the context in which it occurs can support the development of interventions. Dialectical Behaviour Therapy has been shown to be an effective treatment for reducing self-harm and impulsivity. Initially designed for individuals within outpatient settings, DBT has been expanded to forensic populations. The group based skills component has been proposed to mediate reductions in self-harm and given limited resources within forensic settings, the cost effectiveness of delivering group therapy without the other components of DBT may be appealing. However, research highlights potential difficulties with this approach that require further examination. The voices of women in forensic settings have been neglected in research, highlighting a gap in the literature. Additionally, offering treatment that is not understood, has ethical implications.

In this chapter I begin with a review of the literature and understandings of self-harm. Understood as a risk factor for self-harm, I present theoretical perspectives of impulsivity and its relationship with self-harm. To deepen understanding, qualitative research will be discussed. I then introduce and discuss research examining the effectiveness of Dialectical Behaviour Therapy (DBT) within forensic settings, with a particular focus on the Group Based Skills Training (GBST) component of the therapy. Finally, an examination of the current literature exploring the experiences of GBST, will be discussed.

Literature review

Understandings of Self-Harm

What defines self-harm and the name given to this phenomenon has been debated for over 60 years. As yet, there is no universal definition of self-harm. Self-harm may result from the actual infliction of harm onto the self, for example, cutting oneself, or may be the result of neglecting the self, for example, excessive drinking or engaging in risky sexual practices (Bohn & Holz, 1996; Middleton & Butler, 1998). Sutton (2007) has defined self-harm as, "a compulsion or impulse to inflict physical wounds on one's own body, motivated by a need to cope with unbearable psychological distress, or regain a sense of emotional balance" (p.23). Self-harm can be intentional, accidental or committed through apathy, poor judgement or ignorance (McAllister, 2003). It is somewhat defined by what is socially acceptable within a given culture. Self-harm is usually carried out without sexual, decorative or suicidal intent (Shaw, 2001). However, research indicates that suicide and self-harm are not as clearly delineated from one another (Vivekananda, 2000). The term parasuicide has been used to describe suicide attempts or gestures where there is no result of death (Lofthouse & Yager-Schweller, 2009). Self-injury is seen as a sub category of self-harm and encompasses a range of behaviours such as, cutting oneself (Osuch, Holl, J & Putman, 1999). Functions of self-harm that bring about change within oneself or in the environment have been proposed and include; affect-regulation, anti-dissociation, anti-suicide, interpersonal boundaries, interpersonal-influence, self-punishment and sensation seeking (Klonsky, 2007). Categorisation of the functions of self-harm simplifies a complex phenomenon, however fails to explain how self-harm develops and is maintained. To develop understanding, theoretical perspectives of self-harm will be discussed.

Psychological Understanding of Self-harm

Psychological theories of self-harm consider earlier experiences, functions of self-harm and maintaining factors. As previously highlighted, women in forensic settings often have early experience of trauma and abuse. Experiences of child maltreatment and separation are associated with self-harm (Gladstone et al., 2004; Wagner, Silverman, & Martin, 2003). Although reliance upon retrospective reporting is open to bias, experiences of sexual abuse, domestic violence and bereavement are common for women within forensic settings (O'Brien, 2001). Attachment theory views experiences of abuse and neglect as precursors of attachment insecurities that may increase the risk of later self-harm (Stepp et al., 2008). Attachment is characterised by specific behaviours in children, such as proximity seeking with the attachment figure when threatened (Bowlby, 1969). Attachment can be understood within an evolutionary

context, whereby caregivers provide safety and security for the infant. If attachment figures are unavailable, unresponsive or insensitive, the individual does not experience a sense of security and safety. As a result, secondary attachment strategies are adopted. Deactivating strategies emerge when caregivers are perceived as rejecting, unavailable or who punish expressions of vulnerability or closeness. Activating strategies develop when caregivers may be responsive but are inconsistent in providing care. Adam (1994) proposed an attachment model of self-harm. Self-harm is viewed as an extreme attachment behaviour that has the purpose of avoiding separation, whilst at the same time, is a means escaping from distressing emotions. Reflecting a diathesis-stress approach to understanding self-harm, predisposing factors, such as abuse and neglect, contribute to increased vulnerability to self-harm and attachment insecurities. Precipitating factors are events within the current environment which reveal the underlying vulnerability. Experiencing loss, rejection or disappointment in the present is transformed into a crisis, resembling the behaviour of children following brief separation from their caregivers. During this crisis, individuals experience overwhelming distress that might lead to self-harm as a means of escape. This behaviour is in response to real or imagined loss of an interpersonal relationship. Correlational and cross-sectional studies have provided preliminary evidence of the associations between self-harm and attachment insecurities (Critchfield, Levy, Clarkin & Otto, 2008; West, Spreng, Rose & Adam, 1999; Wright, Briggs & Behringer, 2005). No longitudinal studies have been carried out which limits research as the reliance upon self-report measure and retrospective reporting are subject to bias. The studies were conducted among non-forensic clinical samples and may not generalise to forensic populations. There does not appear to be a simple linear relationship between attachment insecurities self-harm. Mediating influences have been found to be partially accounted for by distress arising from interpersonal interactions (Stepp et al., 2008). Further exploration of the particular interpersonal interactions which contribute to distress and mediate attachment and self-harm is required. The model highlights the role self-harm has as a form of seeking attachments and as an escape from unbearable distress. However, as highlighted by Klonsky (2007), self-harm has been found to serve many functions, which are not explained by this model, for example sensation seeking.

Distress associated with exposure to experiences of loss and rejection can be understood as a difficulty with processing past traumatic experiences. Linehan (2015) has proposed difficulties exist with inhibited grieving. Understood as a traumatic experience, psychodynamic perspectives propose that individuals are unable to forget the trauma, whilst at the same time are unable to speak of it, earlier trauma is repeated, communicated or symbolised through self-harm (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Traumatic memories are encoded in the form of vivid sensations and images, often in fragmented form and can be dissociated from all semantic-linguistic-verbal representation, instead they reflect images, bodily sensations

and emotions (van Der Kolk, 1998). It has been proposed that such images or memories may only be retrievable by non-verbal means (Richman, 2014). Trauma re-enactment is a way of 'telling without telling' (Calof, 1995). Bion's theory of container-contained (Bion, 1985) proposes that when the primary caregiver is unable to contain the experiences of the child, the child must find a way of 'holding himself together', for example, through excessive sensory stimulation (Emanuel, 2012). From this perspective self-harm can be understood as a means of sticking concretely to an object, such as self-harm (Ogden, 2004). Understood as a form of adhesive identification, a fear of separation and a difficulty of letting go is associated with mourning (Emanuel, 2012). The social perspective of self-harm agrees that self-harm is a response to earlier experiences but also highlights the role of the current context. Self-harm is understood as an understandable reaction to social factors. Without another to direct feelings of anger towards, they must be diminished through self-harm (Feldman, 1988). This contrasts with psychodynamic understandings. Self-harm is viewed as a form of self-punishment, a compulsion to re-enact the trauma and punish the body (Calof, 1995). Parkes & Freshwater (2012) found supporting evidence of the role of self-harm as a means of communicating distress associated with traumatic experiences and as a form of self-punishment, for women within a secure setting.

The Cry of Pain Model can be seen as an integrative model, recognising the impact of past traumatic events and interpersonal interactions in the present. It views parasuicide as the response (the cry) to a situation which has three components; defeat, no escape and no rescue.

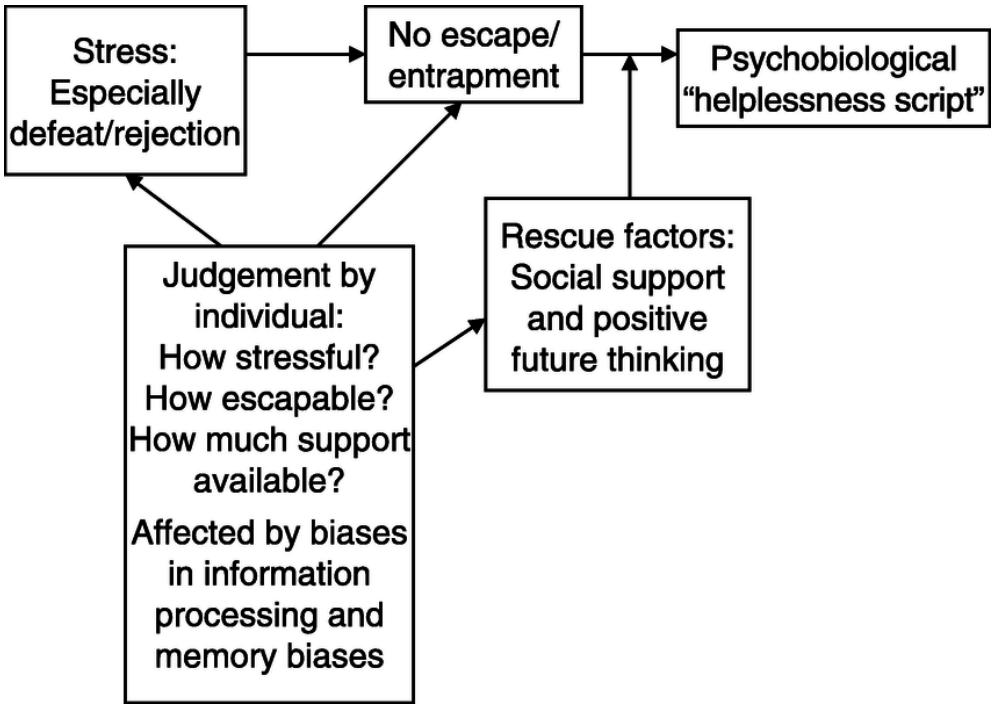

Figure 1: The cry of Pain Model (adapted from Williams, 2001)

Individuals who experience defeat and are unable to find a resolution or escape from the situation may use self-harm as a means of escape. Self-harm is seen to be a 'cry of pain' due to a wish to escape from an unbearable situation and communication is seen as a secondary function (Rasmussen et al., 2010). This differs from psychodynamic perspectives, where the primary function is communication. If others are interpreted as supportive, the motivation to escape through self-harm will fade. For those where self-harm has become repetitive behaviour, there is a lack of support when this is needed. This leads to the individual interpreting even neutral responses as potentially defeating and others as unsupportive. Cognitive processes limit the individual's ability to solve social problems. Traumatic events from childhood are recalled, whilst recall of experiences which could help to generate ideas to solve current problems are restricted. "Perceptual pop-out" occurs, where a stimulus, for example, humiliation or loss, appears to "jump out" from the environment. Indeed, research has shown the negative impact of trauma on social schema (Janoff-Bulman, 1989) and threat related attentional biases (Bar-Haim, Lamy, Pergamin, Bakermans-Kranenburg, & van IJzendoorn, 2007). Support for this model, has found higher levels of self-reported defeat and lower levels of escape potential in patients admitted to hospital after self-harming compared with controls reporting no history of self-harm. Participants who perceived that social support was available were less likely to report a history of self-harm. Limitations existed in the measures used, with only four items measuring defeat and two items measuring escape, potentially weakening the internal reliability of the scales (Pedersen, Rasmussen, Elsass, & Hougaard, 2010). A regression analysis carried out by O'Connor (2003) found support for the model, but rather than social support moderating self-harm, he found that the ability to generate positive future thoughts moderated the relationship between entrapment and self-harm. Cognitive processes appear to moderate the likelihood of self-harm from occurring.

The biosocial theory views parasuicide as a problem solving behaviour aimed at alleviating psychic distress triggered by negative environmental events, self-generated dysfunctional behaviours and individual temperamental characteristics. Emotional dysregulation is seen as the core dysfunction. Emotional dysregulation is the ability to respond to the ongoing demands of experience and emotions flexibility. Cognitive rigidity accompanies mood swings and is seen as a 'dialectical failure' where the individual is stuck in polarities unable to move to synthesis. As recognised previously cognitive processing is inhibited, leading to problems with problem solving. As a strategy parasuicide is maintained due to three factors. Poor coping resources include deficiencies in interpersonal problem solving, emotion regulation and self-management skills. Low distress tolerance motivates individuals to act in order to escape from intolerable emotions. Parasuicidogenic expectancies include consideration of the values and consequences,

whereby self-harm is viewed as the best solution (Linehan, 1987). Some of these perspectives of self-harm have been incorporated into the Experiential Avoidance Model (EAM) of self-harm, where self-harm is viewed as a negatively reinforced strategy for reducing or avoiding unwanted emotional experiences. Over time self-harm becomes an automatic conditioned response to emotional arousal (Chapman, Gratz, & Brown, 2006).

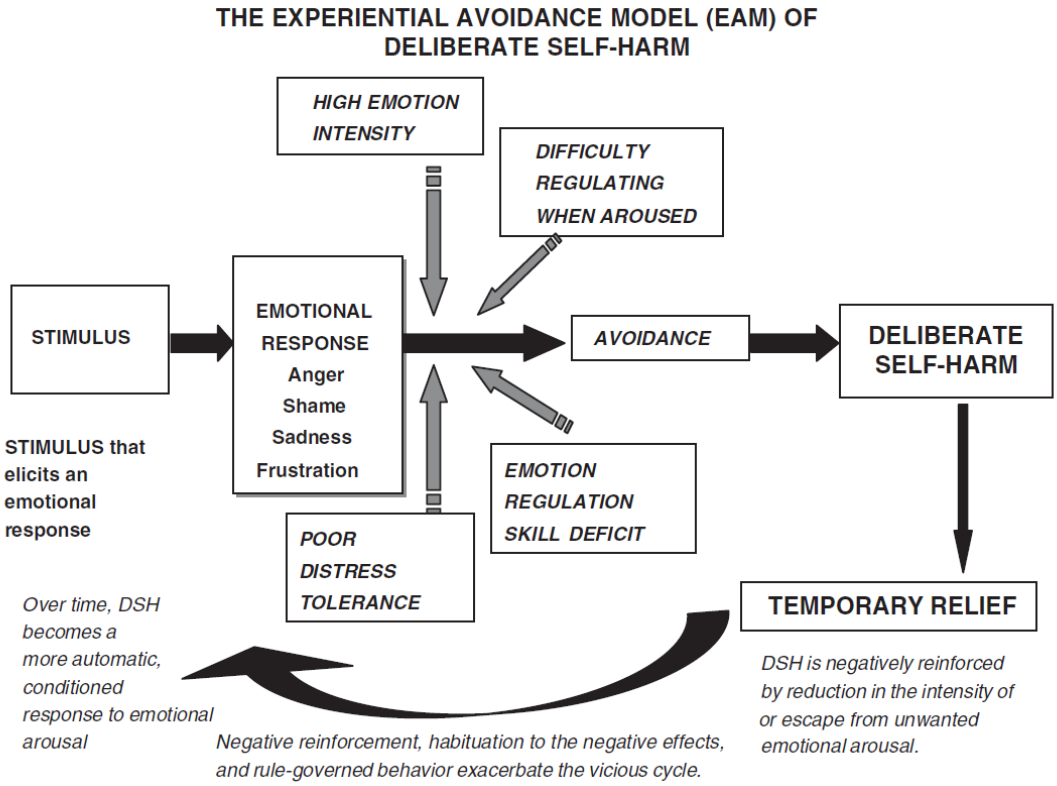

Figure 2: The Experiential Avoidance Model of Deliberate Self-Harm (Chapman et al., 2006).

The most frequently described function of self-harm is to relieve unwanted feelings (Briere & Gil, 1998; Chapman et al., 2006). Providing support for the view that self-harm provides negative reinforcement through the temporary relief of negative affect. Given the range of functions that self-harm has been found to serve, this model is limited in how it can explain functions of self-harm that relate to interpersonal functions. For example, as a communication that the person needs help (Briere & Gil, 1998). From this perspective, self-harm is largely intrinsic to the individual rather than occurring within context.

Borderline Personality Disorder (BPD)

When self-harm becomes a repetitive behaviour and is experienced alongside additional 'stable traits', a diagnosis of BPD may be given. Individuals meet criteria for diagnosis if they present with five out of nine stable traits which are present in an adult, for at least two years, and are maladaptive and distressing. These include self-harm, idealising and devaluing relationships, frantic efforts to avoid abandonment, labile mood, chronic emptiness, inappropriate anger, transient psychotic symptoms, an unstable sense of self and impulsivity (American Psychiatric Association, 2013). Prevalence rates of BPD are greater within forensic settings compared with the general population, 60%-80% and 0.2%-0.8% respectively (Blackburn, Crellin, Morgan, & Tulloch, 1990). High prevalence rates may reflect the severity of personality disturbance within this population. For individuals diagnosed with BPD, 70-75% have a history of at least one self-harm act (Clarkin, Widiger, Frances, Hurt, & Gilmore, 1983).

The diagnosis of BPD is debated and has been defined as 'a controlling classification' that explains away the strategies women have used to survive trauma, including abuse and oppression (Appignanesi, 2009). The current classification system appears to capture the core concept of the disorder however results in 151 possible variations of BPD (Leichsenring, Leibing, Kruse, New & Leweke, 2011). BPD is not marked by one interpersonal style, there is heterogeneity across individuals diagnosed with BPD. Both the DSM and ICD fail to recognise the importance of trait dimensions of personality (Tyrer et al., 2011). Not all women diagnosed with BPD offend. Indeed, BPD symptoms have not been found to correlate with offending behaviour. Particular interpersonal factors have been associated with offending behaviours, for example, impulsivity has been associated with hostile interpersonal processing in BPD within forensic settings (Ansell, 2012). Women within forensic settings are often given multiple diagnosis, such as, Anti-Social Personality Disorder (ASPD) and Learning Difficulties (LD). Viewing individuals through the lens of diagnostic criteria does not address the problem of overlapping criteria. (Tyrer et al., 2001). Given the complexity of presentations within forensic settings, the adoption of a dimensional approach to research seems more appropriate and essentially will support the individuation of individuals who would be categorised by crude diagnostic demarcations (Tyrer et al., 2001). Impulsivity is the most frequently included criteria across diagnosis (American Psychiatric Association, 2013) and a focus on this construct may be more helpful for a population who present with complex, co-morbid difficulties.

Impulsivity

Impulsivity is a risk factor for self-harm (Herpertz et al., 1997). Additionally, self-harm has been associated with other impulsive behaviours, such as absconding (Hunt, Windfuhr, Swinson, Shaw & Appleby, 2010), substance abuse (Pickard & Fazel, 2013) and violence (Hawton, Rodham, Evans & Weatherall, 2002). Reflecting the need to explore constructs which span presenting difficulties, such as impulsivity, rather than research which categorises individuals within diagnostic labels.

Impulsivity is a multi-faceted construct which describes a variety of behaviours. Vohs & Baumeister (2011) have defined impulsivity as "the tendency to act on immediate urges, either before consideration of possible negative consequences or despite consideration of likely negative consequences". Impulsivity has been viewed to have two sub-constructs: state impulsivity and trait impulsivity (Spielberger, Krasner & Solomon, 1988). State impulsivity refers to a transitionary state, which occurs at a particular time, in response to a particular event. Ainslie (2001) would argue that an act is seen as impulsive if the decision the person has made is not stable over time. Trait impulsivity refers to an enduring personality characteristic, relatively stable, and approximately normally distributed within the general population. Common definitions of impulsivity include, attentional impulsiveness, whereby there is a diminished ability to focus on the task at hand. Motor impulsiveness, the inability to persevere with tasks. Non-planning impulsiveness, which reflects a tendency to act on spur of the moment without regard for consequences. Hyper or hypo-sensitivity to reward and punishment with a diminished ability to delay gratification. Poor response inhibition is the inability to suppress behaviour that is no longer required. Increased passive avoidance is the inability to inhibit punished responses. Finally, "urgency" reflects a diminished ability to regulate emotions (Moeller et al., 2001; Patton, Stanford & Barratt, 1995). Self-report measures have been used to measure the core constructs of trait impulsivity (EI: Eysenck, Pearson, Easting, G & Allsopp, 1985; BIS: Patton, Stanford & Barratt, 1995; UPPS: Whiteside, Lynam, Miller & Reynolds, 2005). Impulsivity is also measured using behavioural measures (Dickman, 1993; Dougherty, Moeller, Steinberg, Marsh, Hines, 1999; Matthys, van Goozen, de Vries & Cohen-Kettenis, 1998). Attempts to operationalise impulsivity reflects theoretical and empirical disagreements regarding the most appropriate categorisation of the constructs of impulsivity, ranging from two (Reynolds, Ortengren, Richards, & de Wit, 2006) to five distinct dimensions (Meda et al., 2009). This is further complicated by evidence for both relatedness (Bornovalova et al., 2005; Reynolds et al., 2006) and independence (Smith et al., 2007) between dimensions. The lack of interrelatedness between dimensions has led some to argue that impulsivity is a "misnomer" and call for the constructs of impulsivity to be separated into distinct tendencies (Cynders, 2015).

Associations between Self-harm and Impulsivity

Given the proposition that impulsivity may reflect distinct tendencies literature has explored the relationship between different constructs of impulsivity and self-harm. An extensive literature review revealed no known studies exploring the associations between self-harm and the core constructs of impulsivity within forensic settings. Within community samples impulsivity has been found to be significantly associated with self-harming behaviours. (Marzano, Hawton, Rivlin, & Fazel, 2011) when self-report measures are used, but not on behavioural measures of impulsivity (Janis & Nock, 2009). McCloskey, Look, Chen, Pajoumand & Berman (2012) highlight that behavioral measures are used during a specific time, within a particular context and within a set of task demands, including an individual's emotional state. Results on behavioral tasks that are not in context may not show how somebody would respond given that context. Wingrove & Bond (1997) found that trait impulsivity showed little correlation, if any, on behavioral tasks. They proposed that people who become aware that they are likely to behave impulsively compensate by slowing down their responses but this may only be in situations with low temptation. These findings highlight the complexity of the association between impulsivity and self-harm, difficulties with measuring impulsivity and indicate that individuals can exhibit a degree of control when the context requires it or does not relate to situations which they may find 'tempting'.

Qualitative Research on Self-harm

Alder and Alder (2011) explain, "many scholarly portraits of self-injury are analytical, detached, and impersonal. They objectify and externalize an act that is, at its essence, about feelings. Comprehending self-injury requires a close, densely textured examination of how this act is carried out, felt, and interpreted by the people who perform it" (p. 66). Contradictions within the quantitative research discussed so far indicate a need to understand impulsivity and self-harm within context and over time. Exploration of qualitative research can develop our understanding of self-harm and impulsive behaviours within 'real world' settings, in particular forensic settings.

Baker et al (2013) used thematic analysis to explore the experiences of five women who self-harmed within a medium secure forensic setting. Six themes emerged. The 'traumatised individual' included past experiences of trauma and how these experiences impacted on the present, including difficulty with trusting others. Which is consistent with the attachment model and cry of pain model of self-harm. It builds on this further by identifying trust as a challenge for individuals who self-harm. 'Interrupted maturational process' reflected participants appearing younger in age and having the experience of finding distress difficult to articulate.

Which has been proposed within psychodynamic understandings of self-harm. Self-harm functioned as a way to elicit the response of others. 'The hidden experience' reflected the private nature of self-harm experiences and a sense of alienation. 'Crossing the line' represented the decision making process and control. A number of emotions were spoken about alongside a sense of relief following self-harm. This finding is consistent with the view that self-harm functions for reducing or avoiding unwanted emotional experiences as proposed by the EAM model of self-harm. 'Individual and systemic repercussions' echoed a struggle to answer what might be helpful in terms of assistance for self-harm which links to the cry of pain model in relation to perceptions of support and the likelihood of self-harm occurring. Distraction and having someone to talk too were experienced as helpful. Physical treatment was described as poor and punitive. 'Nascent potential protection' emulated narratives that had the potential to provide future protection. Quotes reflected a wish to change and be treated as "normal". Without alternative means of coping, communicating and relating to others, participants struggled to change. The authors noted the uniqueness of the narratives shared by each participant and that 'one size does not fit all' indicating a need for services to develop individualised formulations and target interventions. Of interest are the ways in which models may explain different parts of the process of self-harm but overall not one model explains the whole process.

Increasing numbers of individuals with learning disabilities are entering secure settings (Fergus & Ashwin, 2011). Some participants within this research project have a diagnosis of learning disability therefore it is important to consider the experiences of people with learning disabilities. Harker-Longton & Fish (2002) adopted a case study design to explore the experiences of a women with mild learning disabilities within a secure forensic setting. Themes identified included; self-punishment, control, frustration and communication. Preventative strategies utilised by staff were experienced as punitive, echoing the themes found by Baker et al., 2013. This study is limited as there was a clinical relationship between the researcher and participant, leading to potential bias in the results. Extracts from the interview also indicated closed and suggestive questioning. James & Warner (2005) explored experiences of self-harm for women in a secure setting for adults with intellectual disabilities. Q methodology was used and self-harm was seen in the context of coping with powerlessness and abuse, controlling emotional distress and blame. It is difficult to differentiate which themes emerged from staff and which emerged from service users. Both of these studies emphasise the impact of current context and relationships within individuals' experiences of self-harm. It has been argued that understandings of self-harm have developed predominantly from white, middle class individuals within outpatient settings (McAllister, 2003). Despite limitations, this research begins to highlight the unique experiences of self-harm in context. The cultural context of forensic

settings differ from outpatient settings for example, choice can be limited and there is greater control exerted upon the individual.

Due to the lack of research specifically exploring women's experiences of self-harm within forensic settings the literature review was expanded to include both sexes. Self-harm has been understood as a means of turning anger in oneself and gender socialisation can affect how males and females manage anger, where women are not encouraged to express their anger overtly (Dittmann, 2003). Mixing genders, within research, may mask potential differences in experiences of self-harm between men and women. Brown & Beail (2009) found three theme using Interpretative Phenomenological Analysis to explore the experiences of nine men and women who lived in a secure service for adults with intellectual disabilities. The first theme 'self-harm in an interpersonal context' highlighted participant links with self-harm and interpersonal relationships in both the past and present. Self-harm was experienced as an alternative to aggression and therefore offered protection to others. This finding builds on previous theoretical assumptions that anger is turned in on the self but also indicates that within forensic settings this is done in order to protect others. The second theme, 'Self-harm as an emotional experience' reflected emotions prior to, during and post self-harm. This process appeared to reflect negative emotions prior to self-harm, a catharsis during and positive emotional effects. However, post self-harm participants described feelings of guilt and regret. This finding is consistent with the EA Model of self-harm whereby self-harm provides negative reinforcement through the reduction of negative emotions. However, emotions were experienced as released rather than reduced, which may reflect a different emotional experience. These findings also show that self-harm results in positive emotions, which are not accounted for by the EA Model of self-harm. In addition, the experiences of guilt and regret following self-harm may serve to maintain the circularity of self-harm, whereby participants again experience negative emotions. Although it is not clear if these emotions contribute to further self-harm. The third theme, 'managing self-harm' reflected participant's management strategies to control their self-harm, including internal and external interventions. Duperouzel & Fish (2008) explored staff and patient experiences of self-harm within a secure forensic setting for individuals with learning disabilities. Participants felt that staff did not understand their actions and needed more training. In addition, they felt that they should be allowed to harm themselves, and that there was a tension between support and control. As common themes were reported, it was not clear if these themes emerged from service users or staff. These findings, together with the findings by Brown & Beail (2009) indicate that models of understanding self-harm that do not take into account relational experiences may be limited in their application within forensic settings. Duperouzel & Fish (2008) noted that some of the emergent themes also related to a number of other problem behaviours which challenge services. The authors suggested further

research to explore why some engage in self-harm whilst others engage in externalising behaviours, for example, impulsive aggression. Indeed, as previously discussed, separating out behaviours into discrete phenomena for research purposes may mask the underlying experiences that unite them. Participant accounts within the following studies, illustrate how self-harm and impulsive behaviours become associated.

Given that some women have experienced imprisonment before entering secure forensic settings a literature review included self-harm within a prison context. Smith (2015) used Interpretative Phenomenological Analysis to explore experiences of self-harm for 17 male and 3 female prisoners. Themes were presented in a chronological order; 'antecedents to the self-injury event', 'during the self-injury event' and 'post self-injury', reflecting the process of self-harm. Antecedents to self-harm were experienced as personal losses and loss of control of negative affect, including feelings of rejection and hopelessness. Self-harm was a means of alleviating psychological pain. Again these findings link to the cry of pain model and attachment model of self-harm. Experiences, within the prison, replicated earlier childhood experiences of control. Punitive responses to self-harm, such as isolation, promoted feelings of abandonment and hopelessness. Participants made a commitment to themselves to never be victimised again, which contributed to acts of self-harm and violence. 'During the self-injury act' reflected feelings of rage, self-hate, agitation and irritability. Images of childhood abuse were experienced. This finding can be seen to reflect experiences observed within Post Traumatic Stress Disorder (PTSD) where the perception of current threat is accompanied by intrusions and emotional responses (Ehlers & Clark, 2000). Participants increased their surveillance and storage of items with which to self-harm, whilst trying not to be caught by staff. At the same time, self-harm served as a means of upsetting staff. During self-harm participants experienced a release of emotions and a "high". 'Post self-injury' related to feelings of guilt, shame and embarrassment in relation to scars.

Brown & Beail (2009) recommended that research explore why some people engage in internalising behaviours, whilst others engage in externalising behaviours. A literature review was carried out to explore the experiences of impulsive behaviours, including substance abuse, fire setting and aggression, within forensic settings. Only two papers were found exploring the experiences of individuals detained within secure settings, highlighting limited research in this area. Although individuals within forensic settings may engage in both externalising and internalising behaviours, which can be seen in the literature discussed.

Qualitative Research on Impulsivity

Fire setting is one of the most common precipitants of admissions for women to secure forensic hospitals. Cunningham, Timms, Holloway, & Radford (2011) recruited nine women from a medium secure hospital. To minimise heterogeneity individuals with learning disabilities were excluded from the sample. Distress associated with both early and current life events was experienced prior to fire setting. Several participants had also used self-harm and substance abuse as a means of coping with distress. This demonstrates the link between self-harm and other impulsive behaviours and their common association with earlier life events. There was a progression towards fire setting, where these behaviours were 'no longer enough' and had failed to elicit support. Fire setting was a means of gaining containment, such as being detained in a place of safety without a need to ask. Fire setting symbolised strength, whilst asking for help was a sign of weakness. Reflecting the systemic nature of difficulties and the need for safety from others and the system around them.

Experiences of aggressive behaviour in high secure forensic settings was explored using focus groups and analysed using content analysis (Meehan, McIntosh, & Bergen, 2006). Participants included 22 males and 5 female clients. Eighty-five percent of participants had received a diagnosis of schizophrenia. Themes reflected the impact of the environment upon aggression, for example, lack of personal space, boredom and controlling behaviour by staff. Indicating that systems which do not meet individual's needs are responded to with aggression. The over representation of males, within this research, may mask the particular experiences of the women. High numbers of participants with a diagnosis of schizophrenia were included in this research, which although potentially an over-representation, does reflect the complex co-morbid mental health difficulties of this population.

Summary of literature on self-harm and impulsivity

Within research, women's understanding of impulsivity and self-harm is underrepresented and further research is required. Findings are consistent with current theoretical perspectives and models of self-harm, however, address different elements of self-harm across the process. As generic models, they do not consider the unique experiences of the forensic context.

Research that has explored experiences of impulsive behaviours indicates an overlap with self-harm. Impulsive behaviours also occur in response to overwhelming emotions and serve the function of communication and eliciting support. At the same time self-harm and violence served as a means never to be victimised again and as a means of upsetting staff. The role of past traumas are reflected in themes across both self-harm and impulsive behaviours. The experience of being detained within a forensic setting contributed to an expression of these

behaviours. Participants spoke of a wish for change, but without alternative means of coping, communicating and relating to others, they were unclear how to make changes.

The fragmentation of behaviours into discrete entities is reflected in the fragmentation of treatments offered within forensic settings, for example, self-esteem, assertiveness, anger, index offence (Aitken, 2006). Some have argued that a narrow reliance on particular approaches, or techniques, may reproduce structures of domination and exploitation, in socialising women to tolerate the oppression of the institution (Kendall, 2000). Psychotherapeutic approaches exist, which target the proposed underlying 'deficits' or issues common across impulsive behaviours. Two main psychotherapeutic approaches are used to 'treat' individuals diagnosed with BPD. Mentalization based therapy comes from psychoanalysis, attachment theory and developmental psychopathology. Dialectical behaviour therapy grew out of failed attempts to apply standard Cognitive Behavioural Therapy with individuals presenting with complex difficulties (Dimeff & Linehan, 2001) and synthesises acceptance based approaches, behavioural science and dialectical philosophy (Swenson & Choi-Kain, 2015).

Dialectical Behaviour Therapy (DBT)

DBT is based on the biosocial theory and was originally designed to treat problem behaviours, such as self-harm and suicide attempts within outpatient settings. The focus of DBT is on recognising, accepting and moderating emotional responses (Linehan, Schmidt, Dimeff, Craft, Kanter & Comtois, 1999) which contributes to the alleviation of problem behaviours. DBT is a multi-model, staged treatment that targets the dysfunctional patterns of instability in emotional regulation, self-image, interpersonal relationships and impulse control through a combination of individual psychotherapy, group based skills training (GBST), telephone coaching and a therapist consultation team. The dialectical philosophy recognises relationships between and within systems and the complexity of causal connections. Five functions are delivered across the therapeutic modalities and include, enhancing client capabilities, enhancing client motivation, ensuring generalisation, structuring the environment and enhancing therapist capabilities. The three distinctive features of DBT are behaviourism, Zen and dialectical philosophy. Dialectical philosophy synthesizes the contrasting perspectives of cognitive-behavioural approaches and Zen practice with a focus on acceptance vs change. The programme outlines a hierarchy of stages of what to treat and when to treat it. Pre-treatment addresses assessment, orientation and commitment. Dependent upon their difficulties, clients can enter at one of four stages. Those with a diagnosis of BPD tend to enter at stage one. Stage one focuses on stabilising the client and achieving behavioural control. This stage aims to reduce life threatening behaviours, including suicide attempts and self-harm, and therapy interfering behaviours, such as missing treatment and refusal to engage in steps required for change. Group

based skills training is included in this stage to increase skilful behavioural strategies which can replace maladaptive behaviours (Swales & Heard, 2009).

Overview of the Evidence for Dialectical Behaviour Therapy

Acknowledging that differences exist between outpatient and forensic settings is important. DBT has been found to be effective within outpatient settings for reducing self-harm behaviours (Carter, Willcox, Lewin, Conrad, & Bendit, 2010; Verheul et al., 2003), suicide attempts (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Hubert, 1993; Linehan, Tutek, Heard, & Armstrong, 1994; Verheul et al., 2003) and impulsive behaviours, for example substance abuse (Linehan et al., 2002; Linehan, Schmidt, Dimeff, Craft, Kanter & Comtois, 1999). The application of DBT within forensic settings may require adaptions to the programme. In addition, cultural and organisational differences may impact on the effectiveness DBT. Fox, Krawczyk, Staniford, & Dickens (2015) examined the effectiveness of DBT within a low secure setting. Eighteen women with a diagnosis of BPD who completed one year of adapted DBT, took part. A statistically positive change was found in risk behaviours, self-reported symptoms of BPD, current mood and symptom experience. Staff observations noted reductions in aggression, including self-harm, and for verbal and direct aggression directed towards objects and people. It is often the case that multiple programmes are offered in forensic settings, therefore research that utilises a within subjects design, cannot attribute changes to DBT alone. Of relevance to the current study, the authors recommended that future studies look at patient perceptions of DBT being delivered in a low secure setting. Due to the lack of research exploring DBT within low secure settings, the literature search was expanded to include high secure settings and prisons. Low et al (2001) assessed the effectiveness of DBT in a high security hospital. Ten Female patients, who met the diagnosis of BPD and exhibited self-harm, completed a one year programme of DBT. There was an overall reduction in self-harm over the 18 months whereas measures of impulsivity fluctuated over time with no significant difference found between baseline measures and 18 month follow up. The lack of a control group means that it is not possible to say, conclusively, that the positive results found were due to DBT. Two patients, who dropped out of the programme, had limited cognitive abilities, highlighting a need to explore the experiences of patients who have cognitive difficulties.

Reductions in self-harm and suicidal ideation have been found when DBT has been implemented within prison settings (Gee & Reed, 2013). However, high dropout rates were observed, with only 29 from the original 62 clients completing one module or more. Client experiences of the programme were reported via questionnaire. Feedback reflected mixed experiences of the programme; 64% reported an improvement in their perception of their lives,

whilst 24% reported a deterioration in their perceptions of their lives. In relation to perceptions of improvements in their mental health, 56% reported an improvement. This research highlights a need for further examination of the issues that keep women engaged or lead to drop out. Reports of deterioration highlight the importance of exploring women's idiosyncratic experiences of DBT to ensure ethical treatments are offered.

Later research has explored the necessity of the GBST component of DBT for reducing suicidal behaviours within outpatient settings. Linehan (2015) carried out a randomised controlled trial to explore the importance of the GBST group by comparing skills training plus case management (DBT-S), individual DBT plus activities group (DBT-I) and standard DBT. All three conditions were comparably effective in reducing suicide attempts, suicide ideation, and medical severity of self-harm. Interventions including GBST (Standard DBT and DBT-S) were more effective at reducing self-harm acts than interventions that did not include GBST (DBT-I). Linehan proposed that the results indicate that increasing DBT skills mediates reductions in self-harm. Delivering a single component of DBT may become an attractive proposition for services with limited resources.

Group Based Skills Training

The aim of the weekly GBST is to help individual's change emotional, thinking, behavioural and interpersonal patterns which contribute to problems in life. Behavioural strategies are didactically taught and are aimed towards replacing strategies which are either ineffective or contribute to individual's overall difficulties. There are both acceptance based modules; mindfulness and distress tolerance and change based modules; interpersonal effectiveness and emotion regulation. Within each module, there are a number of separate skills that are taught in sequence. Group Skills training runs weekly for 6 months and modules are covered three times each (Linehan, 2015, pp27).

Table 1: Modules taught in Group Based Skills Training

Session 1	Orientation to skills training. To introduce group members and staff, orientate to structure, BDP and goals.
Session 2	Core Mindfulness skills
Session 3-7	Specific module skills: Interpersonal effectiveness training targeting Interpersonal chaos.

	Emotional regulation training targeting labile affect. Distress tolerance training targeting Impulsiveness.
Session 8	Last session

Individuals with traumatic abuse histories, struggle to tolerate negative feelings without acting on them and to reflect on experience as it is occurring. This increases the likelihood of impulsive risk behaviours, such as self-harm, substance misuse, suicide attempts and violence (Witharana & Adshead, 2013). Mindfulness has been negatively correlated with borderline personality traits (Yu, Mabel and Clark, 2015), including impulsivity (Erisman, Upton, Baer, & Roemer, 2011), indicating that increasing mindfulness, may reduce impulsive acts. The aim of mindfulness is increasing awareness of internal and external events without acting on them. The effective use of skills depends largely on the mastery of mindfulness (Linehan, 2015). A number of mechanisms of mindfulness have been proposed. Firstly, learning theorists have proposed that exposure to previously avoided thoughts, emotions and sensations leads to a weakening of the original conditioned stimuli. Mindfulness may establish an internal context that maintains the extinction of unwanted responses and promotes the development of new responses. With practice, the association between emotionally evocative stimuli and mindfulness may become dominant, therefore, providing the opportunity for new associations with stimuli that elicit emotional pain to develop (Wright, Day, & Howells, 2009). Secondly, theorists have emphasised the importance of appraisals and meanings as mediators between emotion and automatic response tendencies, as proposed by the cry of pain model and indicated within the research discussed. Mindfulness may function by changing the behavioural response tendency, for example, rather than act, observe instead. Mindfulness may not reduce the overall intensity of the emotion but may change the sense meaning and behavioural response to that emotion (Lynch, Morse, Mendelson, & Robins, 2003). Thirdly, mindfulness may develop metacognitive awareness thereby breaking down the literal belief in thoughts. Mindfulness may also support individuals to disengage from emotional stimuli. Turning attention away from streams of thought or emotions may lead to shorter, more tolerable emotions (Teasdale, 2003).

Individuals with emotional dysregulation often experience difficult interpersonal relationships, which can be marked with fears of abandonment and associated feelings of anger, shame and jealousy. The interpersonal effectiveness training module aims to help clients to develop skills,

such as, assertion training which reduce the intense distress experienced within perceived unstable relationships (Linehan, 2015; Swales & Heard, 2009).

Individuals may experience difficulties with recognising, describing and labelling emotions. They may emotionally avoid and struggle to know what to do when they experience feelings. The emotion regulation skills training module focuses on enhancing the control of emotions. For example, within this module a technique is taught called opposite action. It is believed to work through exposure. Opposite action involves exposure to an emotionally evocative stimulus whilst engaging in behaviour that is incompatible with the action tendency. This weakens the association between the stimulus (CS) and the now, unjustified, emotional response (UCR) (Lynch et al., 2003).

Individuals with emotional dysregulation often exhibit patterns of behaviour dysregulation and problematic impulsive behaviours, such as self-harm and substance misuse. These behaviours are viewed as maladaptive problem solving behaviours which result from an individual's struggle to tolerate distressing emotions long enough to pursue more effective solutions. The distress tolerance training module aims to teach clients to accept, find meaning and tolerate distress by learning more adaptive and effective distress tolerance skills to reduce impulsive behaviours (Linehan, 2015; Swales & Heard, 2009).

Structuring Group Based Skills Training Sessions

GBST differs to other psychotherapy groups, rather than change coming from the group process (Karterud, 2015), change comes from practicing skills. Linehan (2015), however, does recognise the importance of group dynamics and defines the stages of implementation and considerations needed for running a group. "Pre-treatment" refers to discussions between clients and providers which identifies if DBT is an appropriate treatment approach. During this stage, a collaborative commitment to engage is reached and orientation to the skills training. There is a recognition that positive, collaborative relationships are important. DBT strategies are designed to enhance the "expert" leader to enhance credibility and increase hope and motivation in clients. Leaders are also encouraged to tell group members about times, in the past, when skills have been helpful for clients. Issues of trust and confidentiality are also addressed in the DBT skills training manual (Linehan, 2015). Protecting group members and maintaining confidentiality are ways in which DBT facilitators can increase trust.

Some of the guidance highlighted by Linehan (2015) relate to Yalom's therapeutic factors in groups. Yalom proposed that therapeutic change within groups occurs through an intricate interplay of eleven "therapeutic factors" (Yalom & Leszcz, 2005).

Table 2: Yalom's therapeutic factors in groups (Yalom & Leszcz, 2005)

Therapeutic factor	Description
Universality	Meeting others allows for recognition of shared experiences and feelings.
Installation of hope	When members are at different stages of recovery, others are inspired by stories of coping from others in the group.
Imparting information	Advice and guidance given from either the therapist or the group members.
Altruism	The process of helping others gives rise to benefits of the 'helper'.
Corrective recapitulation of the primary family group	Transference occurs when group members re-enact critical family dynamics with group members which enables correction.
Development of socialising techniques	The group take risks by expanding their repertoire of interpersonal behaviour, improving social skills.
Imitative behaviour	Observation of other group members' exploration enables the development of social skills through a process of modelling.
Interpersonal learning	Members gain greater self-awareness about their interpersonal conflict through feedback provided by others.
Group cohesiveness	Belonging to a group with similar problems, promotes group cohesion. It is an essential requirement to promote acceptance and encourage risk taking in sharing experiences.
Catharsis	The group space allows the opportunity to express difficult emotions without fear of negative consequences.
Existential factors	Members accept responsibility for life decisions.

Within GBST, the installation of hope is assumed to come from the expert leader and stories of recovery. Universality appears to be assumed within GBST, where group members meet others, like themselves, and offer validation to one another. Linehan (2015) also recognises that this may not occur and additional support from the facilitator is required. Imparting of information could be seen as coming, primarily, from the skills taught. Group cohesiveness also appears to be seen as important, with group facilitator's taking a key role in managing tensions that arise, focusing on individual group members and having awareness of their own role within the group. Pressures on forensic services to 'treat' and reduce the risk posed by poorly functioning patients, reduces the ability of therapists to select clients for therapy on the basis of suitability

therefore group dynamics may be complicated. Karterud (2015) has proposed that the focus of GBST on skills, rather than on group process, may overcome issues of splitting and projective identification which are observed within BPD.

Group Based Skills Training as a Stand-Alone Treatment in Forensic Settings

Linehan (1993) recommends that all components of DBT are required to bring about change. However, as previously highlighted, delivering one component of the programme within a group format, may be attractive to services with limited resources. This may be reflected by the higher number of studies assessing the effectiveness of GBST as a stand-alone treatment within prison settings compared with secure settings. Following engagement in GBST within secure settings and prison significant reductions on measures of impulsivity and risk have been found. Alongside measures of impulsivity and self-harm, measures of coping ability have been taken to assess if there is a correlational change. Sakdalan, Shaw, & Collier (2010) carried out a pilot study evaluating adapted GBST for forensic clients with intellectual disabilities. Nine participants were included, seven males and two females who had previous convictions for violent crimes. Two participants were residing in a medium secure facility and seven resided in supported accommodation. A significant decline in levels of risk was found but no significant difference was found in coping or adaptive skills. Limitations to the study weaken validity of the results, no control group mean that it is not possible to know if the results are due to the GBST intervention. The small sample size limit the generalisation of the findings. To explore participant perceptions of the GBST. Feedback was gathered via a questionnaire. All participants indicated they enjoyed the programme and had learnt a lot however, reporting of feedback was limited. It was not clear which elements of the course participants enjoyed or what they had learnt. Participants recommended more support with completion of homework tasks, more visual information and to further simplify the information provided in handouts. Similar results were found within Lemmon (2008). Utilising a randomised control trial to assess the effectiveness of GBST among women in prison, significant reductions in measures of impulsivity were observed pre and post treatment within the group and between groups. No significant differences were found between groups on measures of coping ability. Shelton, Sampl, Keston, Zhang & Trestman (2009) adopted a non-equivalent control group design to assess the effectiveness of an adapted GBST for reducing impulsive aggression, impulsivity and psychopathology within a prison. Both adult males and females and adolescent males took part. A significant reduction in measures of psychopathology was found, whilst no significant difference was shown of measures impulsive aggression. No significant difference was found between groups, indicating that GBST was no better than treatment as usual. These disjointed

findings indicate that reductions in impulsivity may not be due to increases in coping ability and that other factors account for changes in impulsivity and risk behaviours.

In contrast when measures were taken of specific skills taught within GBST, significant improvements were observed in mindfulness, alongside a significant decrease in anger expression and borderline symptomology, within a prison population (Wahl, 2012). Significant differences between groups were also shown, indicating an overall effect of treatment. Methodological concerns exist regarding the reliability and validity of measures used as they had not been normed for this population. In addition, participants volunteered to take part in the programme. It is possible that these participants differ significantly to those in the control condition limiting causal inferences.

Exploring the effectiveness of GBST for reducing suicidal and self-harming behaviours, Eccleston & Sorbello (2002) assessed the outcome of an adapted version of GBST within a prison. Adaptions made, included simplification of materials and 'warm up' exercises to promote engagement. A trend towards a reduction in suicidal and self-harm behaviours was found but statistical significance was not reported. Participants were included from different units and outcomes varied between the units. The authors proposed that this may reflect different populations between units, for example, participants at different units had more or less experience of groups. Some participants withdrew due to experiencing discomfort in groups**.** This finding is shared with research which has explored barriers to engaging in GBST within outpatient settings. Barnicot, Couldrey, Sandhu, & Priebe (2015) found that key barriers to learning skills included anxiety during the skills groups. Eccleston & Sorbello (2002) utilised qualitative methods to follow up the quantitative findings, analysing facilitator therapy notes. High motivation for the group and group cohesion was reported to have occurred. Feedback from participants was reportedly positive. However, analysis of the data is not presented, weakening the internal validity of the results and potential difficulties with researcher bias. A need for more rigorous research of participant experiences is required.

How do Women Engaged in GBST Experience Group Based Skills Training?

Qualitative research is important when considering the complex nature of groups as it supports an in-depth exploration of phenomena that might elude quantitative methods (Watkins, 2014). Within some of the studies previously discussed further exploration of the experiences of GBST were sought. Rigorous methodology was not adopted and therefore a further literature review was carried out to identify research which explored women's experiences of GBST within forensic settings. Following on from an extensive literature review, no known studies exploring experiences of GBST, in any setting, could be found. The literature review was expanded to

include experiences of DBT within forensic settings. Again qualitative exploration was used to follow up quantitative research findings that had disparities in findings. Two such research studies will be discussed. Pol (2013) carried out a mixed method design to explore the effectiveness and participant experience of a pilot implementation of DBT within a forensic secure hospital. Outcomes revealed that little or no visible changes in symptoms occurred. Some participants who completed the programme did show a reduction in self-harm. Of the six participants who took part, four discontinued DBT. Participants were interviewed following engagement, although it is not specified how many of the participants took part in the interviews. Data from the interviews was described but not subject to analysis. Participants reported that initially the GBST was found to be the most difficult component. Fear of speaking out was experienced. As time passed, participants got to know one another and felt a "connection". They could seek support from one another and found alternative ways of coping which reduced aggressive outbursts. The mindfulness exercises were also described as difficult. Participants reported that instructions were not given clearly and they felt unable to find the peace of mind they needed. A lack of commitment from patients was reported as a challenge for therapists. Barnicot et al (2015) explored barriers to engagement in GBST within outpatient settings. A thematic analysis of 40 participants' experiences, found key barriers to learning skills were, anxiety in groups and difficulty understanding the material. Barriers to using skills included overwhelming emotions. Participants overcame challenges to using skills through support from other skills group members, group therapists, friends and family. Those who dropped out of treatment were more likely to report anxiety in groups and were less likely to report overcoming barriers to using skills. Nee & Farman (2007) asked for feedback from participants who had engaged in GBST. Mrs A reported that GBST made her behaviours and emotions understandable to her. The structure and regular sessions helped her to build her trust in relationships. Ms K found some techniques such as 'wise mind' and interpersonal effectiveness skills particularly helpful. Although feedback is limited, both participants reported the impact of GBST on relationships.

Rationale

Research has neglected the voices of women within forensic settings. When research has explored the experiences of women, unique accounts of self-harm, within context, have been found. These accounts cannot wholly be explained by current models of self-harm. Research has dissected exploration of impulsivity and self-harm, however, research indicates that these two phenomena are inter-related. Impulsivity has been largely understood from an expert discourse and limited research has been carried out into the views of women in forensic settings of their 'impulsive behaviours'. Robust research exploring the experiences of GBST for women in

secure settings is limited. Research that does exist indicates difficulties in engagement and unique differences in what participants experienced as helpful. It has been proposed that GBST mediates reductions in self-harm, however, research was conducted within outpatient settings. Research exploring the relationship between coping skills and outcomes within forensic settings have no found support for this hypothesis. Further research is required to explore the relationship between self-harm and GBST, to ensure ethical treatments are offered.

Research questions

The aim of this research is to explore the following questions:

1. How do women engaged in Group Based Skills Training in a forensic setting make sense of impulsivity and self-harm?
2. How do women experience engaging in Group Based Skills Training?
3. How do women describe the impact of Group Based Skills Training on their impulsivity and self-harm?

CHAPTER TWO: METHODOLOGY

Section 1: Theoretical methodology

Qualitative or Quantitative

Clinicians' decisions regarding treatment are influenced by guidelines and legislation. These decisions have an impact on client outcomes and experiences of therapy (Barkham, Hardy & Mellor-Clark, 2010, pg 3). Guidelines and legislation are informed by evidence based practice which imposes a hierarchy of trustworthiness. The randomised controlled trial (RCT) is observed as the highest in the hierarchy followed by other forms of evidence. RCTs include large samples and control variables, allowing the data to be generalised. However, within the clinical population, such limits and homogeny rarely exist. Qualitative data can give individuals a voice and enable researchers to share the 'insider's view' (Barkham, Hardy & Mellor-Clark, 2010, pg 66). Where quantitative research presents numbers, qualitative research provides the words and context to the numbers.

Why Qualitative?

As discussed in the introduction, contradictions exist in the quantitative research literature. Evidence for the effectiveness of DBT comes from RCTs which have been carried out in out-patient settings. Research exploring the components of DBT are limited and highlight particular challenges for the application of DBT within forensic settings. It is important to understand the experiences and processes involved within GBST for women within forensic settings to inform clinical practice and consider adaptions that may be required. RCTs do not allow us to understand the processes within therapy which bring about change (Persons & Silberschatz, 1998). A qualitative methodology will allow for exploration of the 'how' and 'why' questions which are important when informing clinical practice.

Section 2: Method

Design

The aim of this study was to explore women's experiences of self-harm, impulsivity and GBST groups therefore this study used a qualitative design employing semi-structured interviews to collect the data. Interviews were analysed individually and then as a whole using IPA.

Participants

Defining the Sample of Interest

Women who were under section at a private secure hospital in the North of England were identified as potential participants. I aimed to recruit individuals who attended the group based skills training component of DBT. Those who attended had a diagnosis of Borderline Personality Disorder. Many of the women also had co-morbid diagnosis. It was decided to include women with co-morbid diagnosis otherwise the sample would be limited and not representative of those attending GBST in real-life clinical settings.

Recruitment Criteria

Inclusion criteria consisted of the following:

• Able to give informed consent (assessed by the responsible clinician and Clinical Psychologist).

• Women aged 18+ who had attended GBST within the last 3 months.

• Women detained under the Mental Health Act.

Exclusion criteria consisted of the following:

• Unable to give informed consent (determined by the responsible clinician and Clinical Psychologist).

• If staff believed exclusion was necessary due to risk to self or others.

Assessing capacity to provide informed consent was important to ensure that participants' mental health was considered and participants were protected. Participants who expressed an interest in taking part in the research were assessed by the responsible clinician and Clinical Psychologist, prior to signing informed consent, to determine if they were able to provide informed consent. Part of the outcome of the assessment was influenced by participant's current mental health and their ability to understand the process of engaging in the research and the outcome of the results, for example results would be shared with staff and published. It was important to consult with staff regularly throughout the research process to consider if there were any negative effects of participants taking part and to address these if issues arose. Only women who had attended GBST within the previous three months were considered. This was deemed important so that events and the impact of GBST were more easily recalled. All of the women were detained under the Mental Health Act.

Recruitment Procedure

Posters introducing the research were placed on notice boards on the units in the hospital. An independent advocate was available should participants wish to seek independent advice about the research. To promote the research, the researcher visited the units to introduce the research and respond to questions or comments. All women who lived within the units were able to comment. Being open and allowing all to take part in discussions was deemed appropriate and important, to build trust. Potential participants were offered the opportunity to take part in the design of the research. When potential participants expressed an interest the Psychiatrist, as the responsible clinician and Clinical Psychologist assessed if they were able to provide informed consent.

Consultation groups were offered to discuss and gather ideas about how the research could be developed. Rather than attend consultation groups the potential participants' chose to have individual 1-1 meetings with the researcher to discuss the research. The researcher met with the women up to three times on an individual 1-1 basis. They were provided with the participant information sheet (See Appendix III), consent form (See Appendix IV) and were then given two weeks to decide if they wished to take part. In this time, the researcher did not visit the secure hospital to minimise any pressure in taking part. The independent advocate was available for those who wished to ask any questions or sign their forms with her. I re-visited the women after the two weeks and met with them individually to reflect on the information sheet and answer any questions. The consent form had either already been signed with the support of the independent advocate or the women chose to sign it with the researcher following our meeting. We then arranged interviews at participants' convenience.

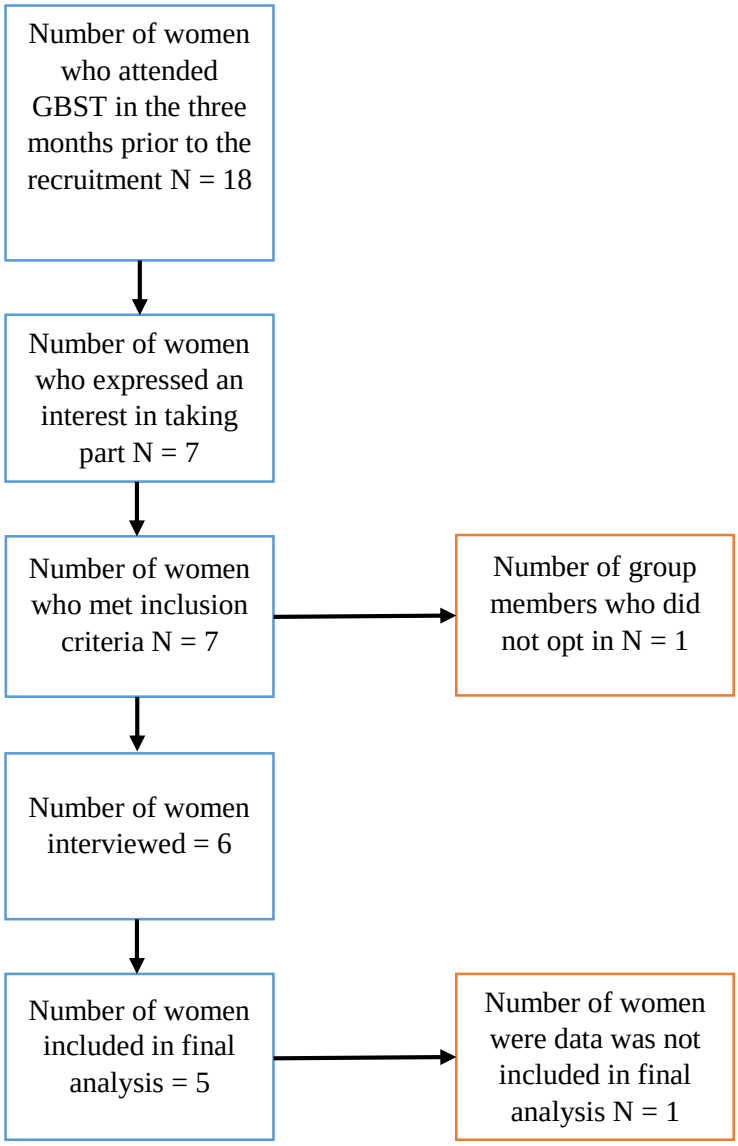

Figure 3: Participant recruitment flowchart.

From the 18 women who had attended GBST within the three months prior to recruitment, 7 expressed an interest in taking part in the research. All were assessed as being able to provide informed consent. One participant chose not to take part in the research following provision of further information on publication. Six participants signed to provide informed consent and took part in interviews. Of those six interviews, five interviews had enough information for analysis. The first interview was ended before interview questions were asked, due to the researcher and participant deciding that the participant's mental health on that day was not conducive to an interview. At the next interview, the participant again struggled with the interview process, appearing to become anxious when the recording equipment was switched on. The data from

this interview was subsequently deleted due to a researcher error. As a result, data from this participant has not been included in the group analysis. She was contacted, by letter, to ask if she still wished to continue taking part, she did not respond and was not contacted again, until participants were asked to quality check themes. All participants were offered the opportunity for a second interview, one participant chose to be interviewed again.

Sampling and Homogeneity

To develop a rich account of peoples lived experiences a small sample size is recommended. Although there are no formal guidelines regarding sample size, between four and ten interviews are advised for doctoral level research projects (Smith, Flowers & Larkin, 2009). Given the demands of the process and limitations of time, a larger sample size may limit the development of relationships with participants and weaken the richness of the data. For these reasons the researcher aimed to recruit between 4-6 participants.

Group based skills training (GBST)

Two versions of GBST ran for 6 months, including an adapted version. Both followed the group based skills training manual outlined by Linehan (1993). The adapted version used simplified language and had been adapted by the facilitators of the GBST. Women who attended the adapted version were deemed to have learning difficulties. The facilitator was an Occupational Therapist who had received external accredited training in the delivery of GBST. The co-facilitator was an Assistant Psychologist, with no external training in GBST. Participants were engaged in the full programme of DBT, with individual psychotherapy and a therapist consultation team. Telephone coaching was replaced by keyworkers who worked with participants on the units.

Section 3: Ethical considerations

Participant and interviewer wellbeing

Given the sensitive nature of the topic being explored, the vulnerable nature of the client group and the setting, participant wellbeing was considered throughout the process. To minimise distress and safeguard as much as possible support networks were put in place. Support was offered from the psychology team, staff and advocacy. Contact details of the supervisors of this research were provided. To reduce distress during the interview the researcher spent time developing relationships with participants prior to interview and participants were able to choose a member of staff to be with them during the interview, if they wished. The researcher was supported by her supervisors should she require any support.

Consent

The responsible clinician, who was the Psychiatrist and the Clinical Psychologist at the secure hospital were asked for their opinion and assessment of potential participants' ability to provide fully informed consent. To ensure fully informed consent was provided, participants were given the participant information sheets and staff supported them to read through if required. Participants were given two weeks to reflect and think about participating. Following the two weeks participants either provided informed consent, which was taken by the advocate or requested a further meeting to discuss the study with the researcher, who took informed consent. Prior to the interview, the researcher and participant reviewed the participant information sheet again reviewing their rights to withdraw from the study and confidentiality.

Confidentiality

To protect participant identity, participants chose pseudonyms. In addition, all names and place names were changed or blanked out within the transcripts and the documentation. The researcher chose not to attend GBST to maintain neutrality as a researcher. Participants were advised that confidentiality would be broken if information shared indicated a risk to themselves or others. For two interviews, the Clinical Psychologist from the service, stayed during the interviews. On one occasion to minimise risk to the researcher and on another, because it was requested. The same confidentiality agreement, which was outlined within the participant information sheet, was extended to the Clinical Psychologist. The transcriber signed a confidentiality contract and all transcribed data was anonymised.

Payment

To reduce the likelihood of cohesion and increase the likelihood that the women were taking part of their own free will, no payment was offered to participants. Participants did receive thank you cards and certificates to acknowledge their participation in the research.

Ethical Application

Ethical clearance for this study was provided by the NRES Committee North West (REC reference: 14/NW/1349 (See Appendix VI). As the study aimed to involve participants in the design of the interview schedule, this was not available at the time of application for ethical approval. Ethical approval was provided on condition that the interview schedule be sent once this was finalised. The interview schedule was sent on the 9th March 2015 and was accepted as a minor amendment.

Section 4: Theoretical considerations

Qualitative Methodological Approach

Interpretative Phenomenological Analysis (IPA) has arisen from theoretical frameworks including, phenomenology, hermeneutics and ideography. It is a method which explores lived experience and how we make sense and meaning from experiences (Smith, 2004).

Phenomenology

IPA is a version of the phenomenological method. The aims of phenomenology are to examine the things themselves, that is the 'experiential content of consciousness'(Husserl & Heidegger, 1927). Our tendency for order means that we too quickly place our experiences within our pre-existing categorisation systems. Experiences present themselves differently depending upon our context, location, angle of perception and mental orientation (desires, wishes, judgements, emotions, aims and purposes); this is referred to as intentionality. IPA accepts the impossibility of gaining direct access to an individual's lived experience. The phenomenological analysis is always an interpretation of that individual's experience (Smith, Flowers & Larkin, 2009).

Hermeneutics

Hermeneutics has a philosophical underpinning for the interpretation on text. It is concerned with questions such as, what are the methods and purposes of interpretation itself? Is it possible to uncover the original meanings of the author? Within hermeneutic theory, there exists the idea of the hermeneutic circle, whereby there is a dynamic relationship between the part and the whole at a series of levels. Incorporation of this theory within IPA means that the process of analysis is iterative. Rather than working with the data in a step wise fashion, we may move back and forth and our meaning of the data can be made at a number of levels, which relate to one another (Smith, Flowers & Larkin, 2009).

Ideography

Ideography makes claims at the group or population level. It makes general laws of human behaviour and is interested in the particular on two levels. Firstly, exploration of the detail and therefore analysis of the detail is viewed as important. Secondly, IPA is interested in the way experience has been understood by the individual in a particular context. IPA uses small, purposely- selected and carefully-situated samples. It is also recognised that experience is also a relational phenomenon. This offers us a more complex picture of an 'individual' as they are also embedded within relationships and a world of things. However, an individual can give us a

perspective of their relationship to the phenomenon of interest. IPA connects these underlying theories by concerning itself with a detailed account of human lived experience, allowing this to be expressed in its own terms. It recognises that researchers can only interpret experience. It places individuals within their context (Smith, Flowers & Larkin, 2009).

Interpretation of the data involves a double hermeneutic. The researcher attempts to make sense of what is said by the participant which allows phenomenon to appear, through a process of interpretative engagement. Reflecting on any preconceptions they hold regarding the data and bracket these off. By doing this the researcher moves around the circle to join the participant and the focus is on them. Having done this, there is movement back around the circle back to their own pre-conceptions and experience. However, these have been changed by the interaction with the participant. Returning again to the conversation with this new knowledge and experience. The participant is making sense of their experiences and the researcher is making sense of the participant's experiences. Given this, the researcher reflects on their own assumptions, bias, experiences and knowledge throughout the interpretative analytic process (Smith, 2004).

Alternative Approaches

Alternative approaches fit within a contextual constructive framework. These are described and a discussion and rationale regarding the approach taken is presented.

Thematic Analysis

Thematic analysis is a method which aims to identify 'themes' across a data set. It is not wedded in any theoretical frameworks. It can be an essentialist, constructionist or contextualist method. As an essentialist method, it reports the experiences, meanings and reality of participants. As a constructionist method it examines the ways in which events, realities, meanings and experiences are the effects of a range of discourses operating within society. Thematic analysis can sit between these two extremes, as a 'contextualist' method, recognising the ways in which individuals make meaning of their experience and the way in which society impacts on those meanings. It also accounts for material and other limits of society (Braun & Clarke, 2006).

Grounded Theory

Grounded theory is concerned with generating theories. Theories are specific to the context in which they emerge rather than relying on analytical constructs from pre-existing theories. The method of grounded theory involves the progressive identification and integration of categories

of meaning from data. Unlike thematic analysis, it is theoretically driven. Guidelines are provided on how to identify categories, how to make links between them and how to establish relationships between them. The outcome is an explanatory framework in which to understand the phenomenon under investigation. A major criticism of grounded theory is that it does not take into account the role of the researcher. A further limitation is its focus on uncovering social processes rather than psychological processes (Willig, 2001).

Discourse Analysis

Discourse analysis has its roots in social constructionist epistemology. It refers to a group of methodologies assuming that when people talk they construct their social and personal world. Discourse analysis can take a 'bottom up' or a 'top down' approach. The latter explores how discourses position people, with a focus on power and resistance (Foucauldian position). A 'bottom up' approach explores how people position themselves through language (Potter & Wetherell, 1987)

Methodological Stance Taken; IPA and why?

Epistemological Position Taken

The research aims reflect a contextual constructionist framework. Exploration of women's lived experiences considers subjectivity and a person's context. It is also willing to consider that there are many 'realities', whilst a realist approach would not allow for such variability in 'realities'. A radical constructionist position would focus on the cultural and social constructions. As this research is interested in individual's experiences, it would not fit well with the research aims.

The aims of this study are to explore the lived experiences of impulsivity, self-harm and the GBST component of DBT. Thematic analysis does explore experiences however, it has been criticised for allowing too much flexibility and not outlining a thorough process of analysis. This may allow for the biases of the researcher. Grounded theory aims to reduce researcher bias by providing step by step guides to analysis (Strauss & Corbin, 1990). However, as we have discussed, it is concerned with generating theory and its focus is on uncovering social processes rather than psychological processes, which are of interest to this study. Discourse analysis explores the ways in which language constructs phenomenon, which is not of interest for this research study. IPA maps onto the research aims and provides a framework for analysis. In addition, it recognises that the researcher will influence interpretation and takes this into account. IPA assumes an epistemological position. Through careful and explicit interpretative

methodology, it becomes possible to access an individual's cognitive inner world (Smith, Jarman & Osborne, 1999). IPA has been selected as the most appropriate methodology for this study.

Service User Involvement

As discussed previously, there are themes of power and confusion for those who have been diagnosed with BPD. A reflection of this can be seen in the accounts of women who engaged in DBT with the process involving lack of choice and knowledge about DBT (Hodgetts, Wright & Gough, 2007). A co-operative enquiry method was considered. Co-operative enquiry emphasises participation. This fits with IPA as the person is not being directed or determined by the researcher. Co-operative inquiry moves through four stages of reflection and action. Phase 1 involves co-researchers (previously named researchers and participants) coming together to discuss the area they wish to explore. Phase 2 involves reflection through recording the process and outcomes of their own and each other's experience. Phase 3 allows for freeing up of preconceptions. Understandings are elaborated and deepened. Phase 4 involves a return to the original questions. Co-operative enquiry can be a demanding and lengthy process, however, this approach will support the development of relationships with a group of individuals who may experience difficulties with trusting others (Smith, Harre & Langenhove, 1995).

A full co-operative approach was not possible. To gain ethical approval the research questions and area of interest were predetermined, prior to meeting participants. Phase one was attempted, whereby I offered several opportunities for 'co-researchers' to come together to discuss the research within a meeting room away from the units. From feedback, it appeared that at times meetings were not recorded within the diaries on the units or there was not the available staff to escort participants to the meetings. At that time participants had only met with me when I had visited to introduce the research and I had not met them individually. From the one participant who did attend the meeting away from the unit, our conversation appeared to reflect suspicion of the research. Another participant recalled a Care Programme Approach meeting whereby her wishes were not accepted. It may have been that participants had previous experiences of group meetings which they recalled as negative. Rather than meet as a group, particpants' requested to be seen on a 1-1 basis and I met with participants individually up to three times. We spoke about the research, considerations, such as how to support them to discuss the topic and the types of questions I should ask. Through this process I was able to bracket off my initial ideas about the areas of study and hold in mind the women's experience of being involved in research often for the first time. Phases 2 to 4 were loosely implemented, whereby I recorded my reflections on the process of meeting

participants and considered their views of the types of areas I could enquire about. For example, participants spoke about the importance of considering the context that surrounded self-harming behaviours. I also asked participants to think about any questions they thought were important for me to ask and let me know the next time I met with them, if they were unable to consider this at the time of the meeting. Participants often asked me to review my reflections the next time we met, so they could recall what we had spoken about. This process supported me to include questions on the interview schedule which mirrored and attempted to expand the narratives of participant's sense making.

The final stage of service user involvement, included a discussion of the outcomes of the analysis and served as a means of quality checking the data. I returned to participants with the findings and asked for their reflections. This process involved 1-1 meetings which individually lasted up to one hour. Participants were responsive to this approach and vocalised when they felt themes did and did not apply to them. This process also helped the development of some theme names, for example "I'm going round in circles and keep making the same mistakes" was a direct quote from a participant at this time and led onto the amendment of the structure of some of the themes. For some participants they reflected on their experiences of self-harm, impulsivity and GBST since meeting me and we reflected together if their experiences matched the themes. In addition, I also shared the pen pictures which were written from information gathered through hospital records and staff views and asked participants if they wished to contribute.

Data Collection

A range of data collection methods were considered in relation to the research questions and method of data analysis. A good qualitative research design is one in which the method of data collection generates data that are appropriate to the method of data analysis. Different qualitative data collection methods produce different kinds of data. Some methods produce data that can be analysed in a number of different ways whereby some methods of data collection produce data that are not compatible with some methods of data analysis (Willig, 2001). The range of data collection methods will be considered

Focus Groups

Focus groups allow multiple voices to be heard in one sitting. A number of participants come together and the researcher facilitates discussion through the interview schedule. The data are influenced by the dynamics of the group and interpretation must consider the context of the group interaction (Millward, 1995). The researcher introduces group members to one another

and takes on the role of moderator, steering the discussion and prompting group members to respond to issues raised by others, highlighting agreements and disagreements. The focus of the group is introduced by the researcher and limits to the discussion are set, such as the beginning and end. Participants should ideally respond to one another as they would do outside of the research context. To allow for active participation by all, focus groups should contain no more than six participants. Focus groups can be homogenous, where participants share features or heterogeneous, where participants are different. Focus groups may bring together pre-existing groups or participants who are not familiar to one another. Groups may be concerned with the same subject matter or may not share the same concerns (Willig, 2001).

Interviews

An alternative to a focus group method are in-depth interviews. Interviews support participants to share their world with you. As an explorative process a researcher can either use a schedule to provide structure, as in semi-structured interviews or can use single core interview questions, as in unstructured interviews (Smith *et al*, 2009).

Unstructured Interviews

The single core question will be used at the beginning of the interview, how the interview flows after this will be dependent upon how the participant answers. The benefits of this approach are that the interview is less likely to be affected by the researcher's prior assumptions and interests. This method also limits the potential data of the analysis merely reflecting the questions asked. However, caution has been given to those new to qualitative research using this method, as it takes time and experience to gain these skills (Smith *et al*, 2009).

Semi-structured Interviews

The semi-structured interview enables the researcher to ask about a particular aspect of experience. Questions are framed to allow for the facilitation of open discussion regarding the area of interest, unlike structured interviews, whereby the interviewer does not deviate from the questions. A balance is struck whereby a semi-structured interview allows for a loose agenda framed around the questions, addresses the research questions and also enables interviewers to follow up on deviations from the original question which may enrich the data further. In addition, semi-structured interviews can facilitate rapport. Using an interview schedule has the benefit of providing a guide for a novice interviewer (Smith *et al*, 2009; Willig, 2001).

Chosen Method of Producing Data

The strength of focus groups is that it allows for an interaction between people, mobilising responses and comments to one another's comments. This can enrich the data by extending or developing statements. The researcher can ask questions about the way in which ideas are developed and changed. As the focus group provides a setting that is more likened to a natural setting, the data generated is more likely to have high ecological validity (Smith, Harre & Langenhove, 1995). However, being part of a focus group may mean that it is more difficult to hear individual's experiences and this method may lend itself better to discursive analysis. Those within the group may take positions and may directly evaluate GBST. Specifically, within this proposed research a focus group may restrict women from sharing their experiences as they may also be in the same GBST and living in the same unit. A number of factors highlighted the strength of using semi-structured interviews. The importance of developing rapport with women who experience interpersonal difficulties could be facilitated using a semi-structured interview as this allows for flexibility. As the researcher was new to qualitative research and so a semi-structured interview provided a framework which could facilitate the gathering of richer data. Importantly, during consultation participants chose to be interviewed individually.

Material

To promote the research, a poster was placed on notice boards on each unit within the hospital (See Appendix II). Potential participants were provided with a participant information sheet providing details of the purpose behind the study, what would happen if they decided to take part and who would be available to speak to about the research (Appendix III). A consent form was also provided (Appendix IV).

Interview Schedule

To facilitate the interview and to enrich the data, an interview schedule was developed and informed by potential participants as part of the consultation process (See Appendix V). Firstly, I met with potential participants regarding the important points to consider during the interviews and areas which were important for me to ask about in the interview. The consultation process lasted for two months and I met with each of the women on at least two occasions, prior to conducting the interviews, both as a group and individually for up to 45 minutes. Staff were also consulted to consider areas of importance that neither I nor the women may have considered.

Transcription

The transcriber was recruited privately and had experience of transcription within the legal system. Five interviews were transcribed by the transcriber. I transcribed two interviews. The transcriber signed a confidentiality agreement (Appendix VII) and agreed to replace any identifiable information with pseudonyms or alternative place names. The process of transcribing allowed me to immerse myself in the data. I listened to all recordings alongside the transcripts to ensure accuracy. I also added to the transcript relevant sounds or actions I had noted in the interview but may not have been known by the independent transcriber. Although this is not a requirement of IPA it was included to enrich the data. Standard writing conventions were employed in all transcriptions (See Table 3).

Table 3: Writing conventions

(laughs)	Describes participant's behaviour
{What happens?}	Question from interviewer
[ ]	Information added to make extract more understandable
…	Short pause
……	Long pause

Section 4: Data Analysis

Process of Analysis

The data was analysed following the steps recommended by Smith *et al* (2009), which are outlined in Table 4.

Firstly, during the interviews I noted any non-verbal communications that coincided with speech to enhance meaning or used to replace speech, where it was difficult for participants to articulate in words. Although this is not part of the process outlined by Smith, *et al* (2009) it felt important as there were several key communications by participants which were explained in non-verbal ways, i.e. Makaton. Following each stage of analysis, I referred back to my reflective journal and continued to add notes.

The first stage of analysis outlined by Smith *et al* (2009) involves immersing oneself in the data, through reading and re-reading the transcript and listening to the audio recordings of the interviews. Initial thoughts can be recorded in a journal to allow the researcher to bracket off

initial ideas. I have chosen to describe, in more detail, the process which I followed during this stage. This stage has been subdivided into steps 3-7, that can be seen in Table 4. I made audio recorded reflections of my initial thoughts and wrote in a reflective journal, noting important aspects of the interview and its context which appeared relevant, immediately following interviews. This information was then put to one side for later reflections. Before transcribing the data, I listened to all audio recordings, paying particular attention to intonation, again noting any thoughts, feelings or reflections within a reflective journal. The data was then transcribed.

Stage 2, initial noting described by Smith *et al* (2009) recommends that the researcher begins to note anything on interest on the transcript, within the margins. In practice this involved, reading the transcripts of the data alongside listening to the audio recordings and recording on the transcript my initial thoughts. I did not concern myself with separating these thoughts into types of data, such as, descriptive, linguistic or conceptual. I paid particular attention to the words and metaphors used at this stage. I read the data several times adding to my initial notes. During step 9, I reflected on these initial notes, highlighting the type of data I had noted. Some notes were descriptive ("ghost, soul, demon, deities, consciousness, intangible, Latin: breath"), others were linguistic ("speeds up to where language is incomprehensible"), whilst others were conceptual ("Is distancing from the topic a defence against humiliation?"). Particular attention was paid to metaphors and similes as this can often link descriptive notes to conceptual notes. I re-read the transcript paying attention to the type of data that was under-represented. During analysis, I also noted process issues which felt important and incorporated reflections from my journal.

In stage 3, emergent themes are developed. The researcher begins to reduce the volume of detail whilst maintaining complexity. A shift happens where the researcher begins to work with the notes as opposed to transcript itself. The narrative flow of the interview is broken up into parts, representing part of the hermeneutic circle. The whole interview becomes fragmented before coming together again as a reconstituted whole. In practice, I drew a table, selecting parts of the transcript which appeared to fit together in meaning units. I labelled, or defined, these meaning units in how I understood their relation with one another, for example hostility. This was repeated for each individual participant.

Within stage 4 and 5, there is a search for connections across themes within individual cases. Themes can be listed in chronological order and moved around to form clusters of themes or one can print out themes, cut them up, placing them on the floor to move into clusters. Abstraction is a form of identifying themes which involves putting like with like. Contextualisation is a way of bringing themes together that relate to narrative moments. Numeration is another way in which themes can be grouped, reflecting the frequency in which a theme is spoken about. Function is a process whereby themes represent the specific function of

language, for example, how a participant presents themselves in the interview. Polarization, reflects the process of bringing themes together which have oppositional relationships. In order to do this I cut up the table of preliminary themes and moved them around on the floor. I was mindful of all of the ways in which themes could be grouped together. For each individual analysis, I drew out a mind map of the preliminary themes which were placed side by side on one page ready for the next stage of analysis.

Stage 6, involves looking for patterns across cases. Themes from individual cases and connections across cases are explored together. Idiosyncratic experiences are drawn together under higher order concepts and relabelled. This can show how themes are nested together under super-ordinate themes. To gain depth of analysis and by using the process of the hermeneutic circle, the researcher can move between levels again exploring the relationship between the whole data and its parts. In order to do this I gathered the transcripts from all participants, returning to the whole. I re-arranged the data again into potential themes. I now had the individual analysis laid side by side and a new arrangement of the whole data. Due consideration was given to the bigger picture relating to the research aims and identification of what was of interest and why. Group themes were finalised.

Table 4: Stages of IPA analysis (Smith, Flowers & Larkin, 2009) and descriptive steps.

Stages of analysis	Steps	Description
	1	Interviewed and recorded details of non-verbal communication.
	2	Recorded my reflections following the interview: both audio and written.
1. Reading and re-reading	3	Listened to audio recordings without transcripts. Recorded written reflections in journal.
	4	Transcribed interviews
	5	Listened to audio recording of interview with electronic transcript. Errors were corrected.
	6	Listened to audio recording with paper copy of transcript.
	7	Read and re-read paper copy.
2. Initial noting	8	Carried out a free contextual analysis, noting initial thoughts on transcript.
	9	Read again, paying particular attentions to descriptive, linguistic and conceptual data, added to transcript.
3. Developing emergent themes	10	Created a table for each participant with four columns; potential theme, quote, reflections and line number.
4. Searching for connections	11	For each participant, cut the table into individual strips, placed into potential theme groups on the floor. Moved quotes around to re-fine

across emergent themes	12	themes. Searched for connections across themes. Produced a mind map for each participant, identified potential themes and quotes illustrating themes.
	13	Re-visited reflective journal and compared themes to reflections.
5. Moving to the next case	14	Moved onto the next participant's data.
6. Looking for patterns across cases	15	Drew together mind maps onto one page to look at similarities and differences across themes for individual participants.
	16	Group analysis: Collected all paper quotes together on the floor and arranged and re-arranged into clusters.
	17	As clusters developed identified themes and patterns between themes.
	18	Wrote a description of each master theme, super-ordinate theme and subtheme.
	19	Created a table for all participants with five columns; master theme, super-ordinate theme, subtheme, quote and line number.
	20	Referred back to overview of individual analysis and reflective journal.

Section 5: Quality checks in qualitative research

To legitimatise qualitative research and ensure quality control (Elliott, Fischer, & Rennie, 1999) developed guidelines for evaluating methodological rigour. To support scientific reviews of qualitative research, to enhance quality control and to offer a set of reference points which will enable researchers to define and describe variations in research. Stiles (1993) organised quality standards under two headings. Firstly, 'standards of good practice' refers to the trustworthiness of observations. Secondly 'standards of validity' refers to trustworthiness of interpretations of the data. To encourage the trustworthiness of the data:

- Prior to meeting participants I engaged in a reflective interview with my academic supervisor.
- I spent time trying to develop relationships and trust with participants through consultation.
- Attempted to place myself in a position that could be observed as neutral and objective by not attending the GBST and through the use of an advocate.
- Re-iterated my objectivity to participants and gave them the option of how the results would be shared with staff.

To encourage trustworthiness of interpretations of the data:

- Post data collection I engaged in a further reflective interview with my academic supervisors.
- The process of analysis, including extracts of interviews, codes and themes were shared with my supervisors and discussed at length throughout the analytic process.
- An audit trail was constructed which can be used by the reader to assess the quality of my analysis (See Appendix IX and X).
- A reflective statement detailing my own experiences in relation to the topic areas in this research is presented.
- Participants' quality checked the themes.

Reflexivity

Keeping a reflective journal, pre and post reflective interviews with my supervisor and reflections with my supervisors throughout helped me to "own my perspective" (Elliot *et al*, 1999). The interpretative role of the researcher is important within IPA. Through the openness of a pen picture, readers will be supported to make an informed opinion about my interpretation of the data. I hope to provide my moral and political standpoints and my emotional investment in the research (Wilkinson, 1988).

Reflective statement

Before embarking on the project my thinking was influenced by my fore-structures (Smith., et al 2009). My ideas, values and sense-making of the world, in particular in this case of women in forensic settings, self-harm and impulsivity.

To give an indication of my fore-structures I will describe my own experience in these areas.

I am a 35 year old single, British white woman. My personal experiences shaped my initial approach to developing the areas of interest. Having negative personal experiences with police and judicial services led to a wish to support forensic populations to represent their experiences. My perspective of impulsivity was positive, whereby I felt that impulsivity could also be understood as spontaneity. I had never intentionally engaged in self-harm but had experience of others close to me and clients who self-harmed. I had worked in inpatient, hospital settings where I felt that systems had evolved that did not empower people and treatments appeared to be "prescriptive". As a co-facilitator of a DBT skills training group within an inpatient setting I recognised the complexity of clients attending and wondered what clients were thinking about?

In relation to my theoretical orientation, the majority of my experience had been in Cognitive Behavioural Therapy, although I preferred the third wave approaches, such as Compassion

Focused Therapy. I was in the second year of my Doctorate in Clinical Psychology and learning new approaches. The main approaches I was interested in were Cognitive Analytic Therapy and Psychodynamic Therapy although I was not rooted to one single approach as I was still learning.

My experiences may have led to a pre-conceived categorisation of the "researched" (Luttrell, 2010, p4). During my initial reflective interview, I considered my over positive view of impulsivity and held this in mind during the research process. Also my pre-conceived idea of offending behaviour, the judicial system and inpatient settings. I thought about whose story was being told, why, to whom and with what interpretation. This meant being aware of what was and what was not happening between us. I held in mind how I may be seen and reacted to, how my experiences may influence my responses and the dynamic between us, in turn influencing the participant's responses. During the analysis, I was informed by my reflective thinking and was cautious about how I was creating the other (Fine, 1994). As a Trainee Clinical Psychologist, I was aware of my inclination to formulate presenting difficulties. To reduce this tendency, I waited until after the analysis of the data before reading about psychological perspectives on self-harm, impulsivity and Borderline Personality Disorder. Being mindful to tell participants stories rather than my own or fitting participant narratives into pre-existing theoretical perspectives. To support me with this I reflected with my supervisors

CHAPTER THREE: RESULTS

Within the results chapter, I present pen pictures to provide contextual information about each participant. This will include a reflective summary of my experience of meeting each participant and of the interview process. In addition, a summary of participants' understanding of self-harm and impulsivity is provided. Individual analysis highlights the main theme for each participant in relation to experiences of self-harm and impulsivity. Secondly, the group analysis of self-harm and impulsivity is presented. Each theme is discussed in detail and connected to participants lived experience through the use of illustrative quotes from interviews. Thirdly, the group analysis of experiences of Group Based Skills Training (GBST) is presented, with illustrative quotes to link themes to lived experience. Fourthly, the process of experiences, across all themes, is represented in a diagram. To conclude, I present my reflections of the research process. All names, ages and places have been replaced with pseudonyms or have alternatively been removed.

Pen Portraits

All of the women are white British, with histories of abuse and neglect. They had been diagnosed with Borderline Personality Disorder. Information from the pen pictures was gathered from hospital records and from the GBST facilitators observations of participants within GBST. Participants were asked if they would like to contribute to their pen portraits and some wished to do so. Reflections on my own experiences of meeting participants is also presented. Some participants chose their own pseudonyms, some asked staff to choose for them. To acknowledge unique individual understanding and experience I present each participants understanding of self-harm and impulsivity, following on to the main individual theme for each participant in relation to self-harm and then impulsivity. These themes have been brought together as group themes in later sections.

Grace

Information from hospital records

Grace was a 27 year old woman with a mild learning disability. She had a history of self-harm and threats of suicide. At the time of interview she was still self-harming. Grace had a history of interfamilial sexual abuse, physical abuse and neglect. Grace's offending history included stalking, harassment and fraud. She had periods of imprisonment. Due to increasing risk, she was transferred from prison and had been detained in the current secure setting for 2 years.

Information added by Grace

Grace was able to tell me that she had experienced gang rape and prostitution. Grace added that her understanding of why she came to the secure hospital was for help with her attachment problems. She lived with her grandparents and her mum when she was younger. She liked school, especially maths as she was good at it. She liked to cook, bake, and play video games. She also liked dogs.

Information provided by GBST facilitators

At the time of interview Grace was engaged in her third cycle of GBST. In her interactions with others, staff perceived that Grace was ridiculed and controlled. Staff also felt that she became attached to others and needed clear boundaries. Within GBST, staff reflected that she struggled to engage as she was in love with the facilitator of the group.

My experience of meeting Grace

I first met Grace on the unit and found her engaging and likeable. I also felt quite overwhelmed as Grace would often grab my hand and want to cuddle me, which meant I had to express my need for personal space. I would describe my interaction with Grace as frantic. As she spoke I wondered if she was frightened to stop, fearful that I would leave. Whilst at the same time, I felt that those around her ridiculed her. I felt that she wanted to tell me all and for it just to be us, as she would often ask, *"Are you here to see me?"*. Grace and I met alone one more time on an individual basis before we did the interview. Due to changes within the service, where important staff members had left, the Clinical Psychologist of the service was present during the interview for safety reasons. The interview lasted 55 minutes.

Grace's understanding of self-harm and main individual theme

Grace understood self-harm to be cutting herself and banging her head as a means of taking her pain away, keeping others close and to prevent punishment. She appeared to be mindful of how others understood her self-harm, telling me, *"I'm not an attention seeker"* (line 326), *"I'm not copying others"* (line 82). In relation to self-harm, Grace told me, "*sometimes I plan it, sometimes I just do it"* (line 412).

Will you be there and understand?

Grace told me about a time when she had been trying to talk to a member of staff, but was struggling to talk about, *"the bad things I have done*" (line 327). The member of staff was due to finish her shift. Grace told her that she could not *"be certain"* (line 341) that she wouldn't self-harm. When the staff member finished her shift, Grace self-harmed in the toilet. She listened out for people going past, trying to keep it a secret to avoid punishment. At the same

time, she appeared to wish to humiliate others "*They don't even know I'm doing it, fucking idiots*" (line 363). It may be that there was also a part of her that wanted to be caught but not punished.

Grace's understanding of impulsivity and main individual theme

Grace described impulsivity as threats to harm herself, such as chucking herself off bridges and *"running off"* (line 127). She was again mindful of others' interpretation of her impulsive actions, stating, *"I'm not a violent person"* (line 19). Her understanding of impulsive acts in others were, *"hitting one another"* (line 24) and described how this *"stressed"* (line 24) her out.

Let down and alone: love me

Grace gives examples where she oscillates between self-harm and impulsive acts, switching between them in her experiences. She described an experience where she asked her family to come and see her. They agreed and she was waiting for them at the train station, however, the trains were delayed. She panicked, jumped a barrier, asked to use somebodies phone to call her family and recalled saying, *"Grandad, Grandad, where are you? Grandad said 'I am back at Manchester', he said, 'your mum wouldn't go'. He said 'I'm at home with dog and that, he said, 'your mum and your nanna's gone to Mecca bingo'…… So, I said, 'Alright"* (line 261). When Grace described her experience, my heart sank. The excited but panicked tone of voice she used when she spoke about seeing her family and then what felt like a nothingness, an empty space, illustrated by her silence. Grace goes on to say, *"I didn't know what to do then"* (line 267) *"I got bored"* (line 267) she also remembered thinking that she had no means of getting back to where she was staying and then feeling stressed out. She recalled hugging people at the train station, approaching four people, two who she described as strangers, one who was nice, but a stranger and the women she called 'Lisa' who, *"got really worried and concerned, she started chasing me, I just ran away from her, hid and started banging my head. I remember her saying to me, 'come here give me a good hug and then she's putting her hand on my leg"* (line 277). Grace talked of Lisa being concerned about her, then offering her a hug, which lead onto what appeared to be a sexual interpretation of her interaction with Lisa. She recalled that the police came and threatened to, "*take me away from her* [Lisa]" (line 282). "*I was trying to chuck myself on the train track*" (line 282). She talked about how she did not want to go back to where she was staying as she was *"just sick of these groups making fun of me"* (line 285), she had *"no money"* (line 288) and had, *"had enough"* (line 296).

Joan

Information from hospital records

Joan was a 29 year old woman with a mild learning disability and traits of anti-social personality disorder. Joan had a history of self-harm and at the time of interview was still self-harming. Joan lived with her mum until she was 5 years old and was then placed into foster care as she had been sexually abused and neglected. Joan attended a special needs school. She had a history of absconding, aggressive threats to others and self-harm within previous settings. Joan had not been to prison. Due to increasing risks to herself, and others, she was detained within the current secure hospital, where she had been for 2 years.

Information added by Joan

Joan added that she liked basketball, football and hanging round with friends.

Information provided by GBST facilitators

Joan had attended a few sessions of GBST and but chose to learn about the DBT skills on a 1-1 basis. She was on her third cycle of individual GBST. Joan explained that she struggled to be part of the group. Within GBST, Joan was described by staff as being excitable and noisy. She tended to look after others in the group which at times could be disruptive.

My experience of meeting Joan

I first met Joan when she came onto the unit part way through my visit to introduce the research, she laughed and clapped when I spoke. I felt uncomfortable and intimidated. She told me that she felt uncomfortable speaking to me in the group context and we agreed to meet individually. On my next meeting with Joan, I experienced her as playful and direct. Although she could be experienced as intimidating, in the way that she walked and addressed people, but she also came across as vulnerable, often having others with her. Joan chose to have a member of staff with her both during the first meeting and during the interview. The interview itself Joan lasted 46 minutes.

Joan's understanding of self-harm and main individual theme

Joan's sense of self-harm was, *"Can be dangerous, can be normal, different ways…I become a hazard to others, I like using weapons"* (line 36). She told me that she did not use weapons anymore. She self-harmed by tying ligatures, banging her head, scratching her arms, throwing herself on the floor. She explained that she self-harmed because, *"people aren't listening"* (line 587).

You can't be responsible

Self-harm and impulsivity were experienced as cyclical, *"Kick off first, then self-harm, kick off first, then self-harm, like that"* (line 621). Following a conflict with her mum, Joan, *"kicked off"* (line 181) and is put into seclusion. She self-harms by tying ligatures around her neck and staff found her. She describes how, "*It was hard for staff as they didn't know what to do because, just, never dealt with anything like that and one of them started crying every time they saw me like that, and I were going, just leave me, just leave me. He were like, 'no Joan, we can't, I've got responsibility and I were like, just fuck off,* [I] *don't want to know"* (line 368). She explained that self-harm made her feel better and that was, "*All you need to know"* (line 398). Her descriptions reflect her awareness that her actions have an impact on others, their response is that they cannot contain their distress and she needs to separate from them.

Joan's understanding of impulsivity and main individual theme

Joan made sense of impulsivity as, "*Jumping in without thinking*" (line 26). For her, being aggressive towards others and subsequently experiencing regret was how she understood impulsiveness, "*I might do things like without thinking, I mean, like smacking staff or punching staff and things, and then after a while I think about it and think that was the wrong thing to do"* (line 23). She explained the difference between when she was being playful and when it became impulsive, *"Like, cos when I'm thinking, I don't tend to kick off as much, I'll mess about first and then* [I] *kick off other than just kick straight off, or I'll just press the alarm for* [the] *fun of it, cos it gets staff wound up, or patients wound up. And then, when I'm being serious, I just end up flooring* [the] *staff on* [the] *floor"* (line 113).

I can't deal with this

Joan's sense of being aggressively impulsive was that she was trying to protect whilst, at the same time, becoming overwhelmed and not feeling as though she can deal with the intensity of the moment. Adding some context to this sense making process, Joan gave me an example. She was living in a residential home with people who had learning disabilities. She recalled one of the residents *"screaming out"* (line 127). Joan believed that the resident had been sexually abused and wanted the resident to inform the police. It appeared that she felt the staff were blocking this from happening and nothing would happen, "*I goes to her, you do know you're going to have to report this to police, then staff were going no, she won't, no, she won't, she'll end up doing nothing"* (line 126). In Joan's experience, the resident continues to scream all night, Joan tried to calm her down but she continued, Joan then remarked, "*Right I can't deal with this 'cos if I don't, I'm going to lose it big and proper"* (line 130). Joan reflected on her experience and recognised that the resident's experience of sexual abuse related to her own experience of sexual abuse, *"I kicked off even more, 'cos of the stuff I've been through"* (line

138). The situation escalated, and Joan recounted her conversation with the staff. *"I can't leave her in a state and she* [staff member] *went like, 'Joan we're dealing with it', I went, 'You're not fucking dealing with it!"* (line 143). Joan talked about how she felt responsible for the residents, as she was older.

Emily

Information from hospital records

Emily was a 32 year old women who had additional diagnoses of Autism and Schizoaffective Disorder. She told me that she had self-harmed on one occasion and had acted in ways that put her at risk. Less was known about Emily's history. There were indicators of sexual abuse in the hospital notes. Emily first presented to mental health services when she was 13 years old and diagnosed with adjustment disorder. Later, she experienced periods of homelessness. Her offending behaviour included anti-social behaviour and assault on police, which was compounded by her belief that they were aliens. She had not been to prison, but had been arrested several times. She had a history of substance abuse and would use drugs when she was given leave from inpatient mental health settings. Emily had been in the current secure hospital setting for 3 years.

Information added by Emily

Emily was not available to add information to her pen picture as she had been moved to a different hospital setting when I returned to share the themes and discuss her pen picture. She did tell me at the time of the interviews that she enjoyed producing music.

Information provided by GBST facilitators

Emily attended three cycles of GBST, but following what staff described as destructive hurtful comments, a need to be in charge and arguing about her beliefs, i.e. that she was Rhianna, staff decided that she would not be able to continue attending GBST. Staff felt that she received mocking and dismissive reactions from others in the group.

My experience of meeting Emily

Emily was not on the unit when I visited to introduce the research. I first met her in the consultation group; she was the only one who attended off the unit. My experience of this initial meeting was that Emily was eager, but suspicious of the research. During our discussion, I got the sense that she wanted to ensure that she was not seen as vulnerable or weak. We agreed to meet again, however, she was not available at my next visit. We re-arranged and Emily was interviewed alone on the unit in a private room. At this interview, I experienced an atmosphere of excitement between Emily and myself. She was enthusiastic about the interview, for example

she wanted to make a CD-ROM all the notes from the group for me. At times during the interview, I did feel lost, partly because her narratives didn't always flow, but also just a felt-sense experience which I can't explain. Emily was interviewed for 55 minutes and took up the offer of a follow up interview which lasted 40 minutes.

Emily's understanding of self-harm and main individual theme

Emily understood self-harm as cutting oneself and *"putting yourself in situations"* (line 36). She explained what she meant by explaining how others could put themselves into these situations, "*could be putting them at risk or people taking the piss"* (line 39). Emily stressed that she had only self-harmed once. She talked about others who self-harmed and had received humiliating responses, such as being "*laughed at*" (line 45).

Have you got the guts?

Emily appeared to make sense of self-harm as a means of demonstrating strength. She spoke about the time when she self-harmed. Emily had been discharged from hospital and placed in a hostel. She spoke about others within the hostel, experiencing annoyance at their demands, "*I had a lot of trouble with some of the people who were living in the hostel, who wouldn't go away, asking for cigs and that and it really did my head in"* (line 200). In response, Emily cut her wrist and went into a resident's room, "*so I thought I'd bleed all over the bloody bedroom and do that to them"* (line 200). She talked of her struggle to communicate her anger towards others in words as "*it is unbelievable"* (line 247). She indicated that this had happened at other times in her life. Rather than express in words, she felt by expressing anger towards herself she can make others feel it. She talked about this being her only option, "*taking it out on myself* " (line 244). Her self-harm appeared to challenge others, where she asked, *"if they genuinely had the guts?"* (line 203). She talked about how others could not get away with what they had done. She referred to how open the cut was and how the blood was all over the bedroom, almost as if everything had come out. She explained that she had not intended to bleed as much. Experiences immediately prior to and following this incident appeared cut off. She spoke of spirits making the cut, who were strong because of her past and how she *"blacked out"* (line 29) after this incident, until she was put into the ambulance.

Emily's understanding of impulsivity and main individual theme

Emily described impulsivity as, *"Acting in a way that would shock someone"* (line 10) and gave examples of drug use, suicide attempts and murder.

"It must have been destiny"

Emily made sense of impulsivity as being something that was other worldly and due to a power that was outside of herself. Emily talked about murdering someone, although this event did not happen according to records. She began by talking about how she had done a "*lot of silly things*" (line 153: T2), including stabbing another woman, appearing to minimise, dismiss or invalidate the intensity of the experience. She appeared confused about her narrative at some points, giving inconsistences in her story. Sharing similarities with her narrative of self-harm, her experience began with others *"harassing"* (Line 171: T2) her by following her. She explained that she wanted to be left alone because she wasn't feeling well. Again, she talked about how the woman was annoying her. She told me that she stabbed the woman in the eye and reflected on this, *"I mean, the point is, if someone's coming up to your eye or something, you automatically close your eye don't you? Her eyes stayed open so that must have been her fate"* (line 208: T2). After stabbing the women Emily lost her home and was, *"put into cells"* (line 178: T2). She talked about being put into a particular cell where "*you can just die in it*" (line 192: T2). As well as talking about the loss of her home, she talked of the loss of her life. However, Emily stated that she, *"got out the other side"* (line 192: T2). She appeared to do this by rationalising the experience and focused on the demands the woman had placed on others. She appeared conflicted about showing pity, initially stating that she didn't but when she reflected on what that meant about her as a person commented, *"I'm not a horrible person, I aren't a horrible person, but I did feel really sorry for her after I did it"* (line 212: T2). It may be that by placing blame elsewhere, Emily can preserve her self-esteem.

Jessica

Information from hospital records

Jessica was a 36 year old woman who had an additional diagnosis of schizoaffective disorder. Hospital notes recorded no history of self-harm, but she had acted in ways that put her at risk. She was not self-harming at the time of interview. Jessica was physically abused, witnessed domestic violence and was neglected as a child. Aged 9 she began to use drugs. She was groomed by organised paedophile rings and sexually abused. She did art at College and had a child. Following a psychotic episode, she became involved in prostitution and drugs. Her offense history included trespassing and burglary. Jessica spent a period of time in prison for her offences. She was sectioned but would abscond and use drugs. Due to this and an increasing risk to herself, and others, she was detained within the current secure hospital setting for 2 years.

Information added by Jessica

Jessica told me that she liked socialising, cooking and art and design. She liked spending time with her daughter, mum and family and that was what she wanted to do. She thought that she had come to the hospital due to drugs and that others wanted to get her into hospital. She went to school, where everything was normal, and then went to college. "*The past so many years have not been very nice*".

Information provided by GBST facilitators

Jessica was on her second cycle of GBST. Staff noticed that Jessica was quiet in the group.

My experience of meeting Jessica

The first time I met Jessica was on the unit when I went to introduce the research to prospective participants. I experienced the atmosphere as threatening and cold. The layout of the room meant that Jessica was some distance away and we were divided by furniture. One of the women in the group was hostile and this appeared to have an impact on others, whereby they were reluctant to engage in discussion of the research. Jessica was offered an individual meeting. When I returned for the agreed interview she was not in. The interview was re-scheduled. She seemed lethargic and guarded during the interview. I felt that at times she was telling me what she thought I wanted to hear and impressed upon me the fact that she had "*learnt her lesson*". Jessica's interview lasted 45 minutes.

Jessica's understanding of self-harm

Jessica had stopped self-harming, but had self-harmed in the past by attempted suicide which she felt put her under the "*category*" (line 185) of self-harm. She also understood self-harm to be *"cutting your arms and legs"* (line 182), which she had not done. She did not want to talk about, *"what I did to myself"* (line 185), as this brought back bad memories. She did allude to self-harming when she was on drugs and that she had stopped as she had no access to means in the current hospital setting. As Jessica chose not to talk about her experiences of self-harm I did not identify a main individual theme for Jessica.

Jessica's understanding of impulsivity and main individual theme

Jessica's understanding of impulsivity was, "*where you do things without thinking, you don't think of the consequences or anything, you just do it*" (line 333). She elaborated, "*Not necessarily the way you don't think about things…but you don't really weigh up the pros and cons of things*" (line 392). She had gained this understanding about impulsivity through her work in therapy. She thought that impulsive actions included, taking drugs and talked of absconding. She appeared to recognise that absconding had a negative impact, but felt that the

circumstances surrounding it were important, *"I blew it again, I just blew it...but it's all the circumstances that go with it"* (line 131).

What's the point, I've failed anyway

Jessica made sense of impulsivity as a way of giving up hope. She provided an example which explained the circumstances around her impulsive acts, where she was in hospital and missing her family. She appeared to feel helpless to change things, *"there's nothing I can do about the situation"* (line 88). She told me that it had been seven years since she had taken drugs but she was still being punished. She described confusion about why she was still in hospital, *"I don't even know why I'm here all the time?"* (line 99). Jessica talked about restrictions placed on her which did not tolerate the use of any drink of drugs that she saw as her, "*only release"* (line 104). Before running off she described feeling *"a lot of pressure"* (line 134) an *"urge"* (line 107) and then *"running off"* (line 102). She wanted to go home but found that her home had been taken off her. She reflected on the time when she did have her flat and how she had nothing now, *"no leave, no nothing, no money"* (line 147). She also talked about how she was not part of her daughter's life and felt that she had failed. After she realised her flat had been taken off her she wanted to see her mates who used drugs, then talked about how she would have also been happy just in a pub. She got drunk and talked of feeling confused about what she wanted at the time. She wandered, going for something to eat, getting on buses, telling me that, *"I had nowhere to go"* (line 200). At one point she called the hospital to pick her up but then went for more drugs. She talked about how things escalated, with her using more drugs and drink. She was brought back to hospital and lost her leave. Ending her story where she began, being punished.

Gemma

Information from hospital records

Gemma was a 22 year old women. She had a history of self-harm and at the time of interview was still self-harming. Gemma did not know her mother, having been abandoned at birth. She had a history of alleged sexual abuse. When she was 12, she presented to Mental Health Services and from the age of 16 spent periods of time in inpatient hospitals. She had a previous conviction for actual bodily harm. Gemma had not been to prison. In inpatient settings, she secreted weapons and lighters and would abscond. Due to increased risk to herself, and others, Gemma was transferred to the current secure hospital setting, where she had been for 2 years.

Information added by Gemma

Gemma added that she went to school, but hated it. She lived with her grandparents and liked to spend her time watching films with them. She believed that she came to hospital because she kept self-harming.

Information provided by GBST facilitators

Gemma was on her second cycle of GBST at the time of interview. Staff reported that in GBST she had good interactions with others when she was well but when she was unwell tended to interfere with others care, make allegations and fall out with others.

My experience of meeting Gemma

When I first visited the unit to introduce the research Gemma was not available. Next time I visited, we saw each other on a 1-1 basis in a private room on the unit to discuss the research and consent process. I returned for the interview, but unfortunately, was 10 minutes late. She let me know that she was annoyed at me for being late as there was a birthday party she wanted to join in. We agreed to re-arrange the interview. When I saw her again, she told me she was nervous but did want to be open. She requested that I use her real name. Although this was important to her, ethical considerations overrode this choice. During the interview, Gemma became overwhelmed after 30 minutes stating, "*Ar this is head blagging this*" (line 569). I felt playful when I was with Gemma but also pressured. Due to changes in the service, I needed to complete the interviews more quickly than I had anticipated and the pressure I experienced in this interview may have reflected this, as Gemma's interview was the final one. Gemma also had an eye infection, which became sore 30 minutes into the interview. The interview lasted 35 minutes.

Gemma's understanding of self-harm and main individual theme

Gemma talked about self-harm as cutting, overdoses and tying ligatures. She made sense of her self-harm as a means to get her anger out, the only way to cope with things and to control situations.

A means of being safe

Gemma described a conflict with her boyfriend. She asked him to do something in the house while she was out. On her return, he had not done it and was *"sitting playing on the x-box"* (line 60). She remarked that, "*he thought he could take over the house*" (line 58). She turned the electrics off. He responded by becoming hostile towards her and brought a knife out of the kitchen telling her, "*If you can't kill yourself, I'll kill you*" (line 75). She recalled her decision to try and kill herself, rather than her mum coming home and finding her dead. Being on an

electric tag and not being able to leave the house, leaving in an ambulance seemed to be her only choice. She took an overdose. This followed with a period of confusion, *"You've just sat there and watched me do this and now you're telling me you're going to ring and ambulance!"* (line 135). Appearing to try and regain control, she remembered locking herself in the bathroom. He then rang the, *"tagging people"* (line 140) and dropped the knife. Gemma picked the knife up and attempted to *"slice"* (line 141) her arms. She described looking out of the window and nobody being there, then the next minute an ambulance and police car arrive. She still had the knife and the police asked her to drop it, she told them that they needed to move away from her. They *"wrestle me to the floor"* and handcuff her. She explains that, *"they weren't handcuffing me because I'd been naughty, they were handcuffing me for my own safety"* (line 145).

Gemma's understanding of impulsivity and main individual theme

For Gemma, impulsivity reflected her use of drink and drugs. She spoke of drinking and being abusive towards others. For Gemma, impulsivity and self-harm were oscillating phenomena, despite both having different meanings for her.

Blocking out the loss

Gemma spoke about being in the forensic hospital, thinking about her family, getting *"agitated and upset"* (line 260) that she was *"stuck in there* [secure hospital] *with, you know"* (line 260). She cut her legs and was taken to hospital. She decided to abscond and go to her Grandmas house. She got drunk and her grandma put her in a taxi to return to the hospital. She had the thought, "*fuck it*" (line 272) and went to get more alcohol, "*because the drink blocks things out for me*" (line 275). She struggled with knowing where to go, "*Cause you don't know where you want to go do you?"*(line 278) and talked about the death of her Great Gran, *"I was with her in her last moments, and I…when I was in the room she died and went really cold…that was just horrible"* (line 282). Thinking about this contributes to her wish to block things out with alcohol and drugs, to feel, "*nothing, that's simple"* (line 286). It appears that self-harm was a means of escape, whilst impulsivity, such as absconding, was a search for someone, who wasn't available. Drinking alcohol was then used to block out *"horrible"* feelings.

Dorothy

Information from hospital records

Dorothy was a 34 year old women from a travelling family, who had an additional diagnosis of schizoaffective disorder. She had a history of self-harm and was still self-harming at the time of interview. She witnessed the sexual abuse of siblings and from a very young age was sexually abused herself by her mum's pimp. She was removed by social services and placed into foster

care. She was removed from foster care following sexual abuse by her foster carers. She then remained in children's homes until she was an adult. She had contact with mental health services from the age of 14. She had never been imprisoned or convicted although she had a history of arson. Dorothy had been in the current secure hospital setting for 13 years. Prior to this she was in a homeless hostel and the admission followed threats to kill others and increased risk to herself due to self-harm.

Information added by Dorothy

Dorothy did not want to add any information to her pen picture.

Information provided by GBST facilitators

Dorothy was on her second cycle of GBST. Staff commented that within the GBST she was well liked and engaged well.

My experience of meeting Dorothy

I first met Dorothy on the unit as part of the discussion group with others. The unit was smaller than the others and had a more homely feel. I liked Dorothy and found her engaging. She came across as resilient and strong. She was open, able to express her needs and was keen to engage in the research. We met again on a 1-1 basis and she appeared more cautious and vulnerable this time. The room we used was for the interview was cold, with little furniture, white walls and reminded me of a police interview room. The interviews were re-scheduled twice. When I did interview Dorothy, we stopped the tape after 5 minutes, as she did not *"feel up to it that day"*. I returned again and interviewed her for 10 minutes, again she struggled to engage and wanted to end early. This was in the context of Dorothy's request for me to not to come on a Friday, which due to pressure to get the interviews completed had happened. In one of the interviews I had also closed the door, not realising it would lock and she became scared of me, saying, *"you could be anyone"*. On one occasion, I chatted to her in her flat and she appeared more comfortable. I thought about how important it was for Dorothy to have some control of the situation so that she felt safer. Following the two interviews and attempts to schedule interviews, I wrote her a letter to invite her to get in touch should she wish to be interviewed again. I received no response and as agreed in the letter I did not follow this up. Dorothy's data has not been included in the final analysis as the first tape did not cover the topic area and the second tape was deleted due to researcher error. However, Dorothy has been part of this research process and her contribution has supported my decision making process.

Dorothy's understanding of self-harm

Dorothy talked about how self-harm could be done in *"lots of different ways"* (line 10) including, *"burning, cutting, inserting, sawing, scratching"* (line 12). She said that she was self-harming *"really badly"* (line 16) before coming to the forensic hospital.

An alternative means of communicating?

Dorothy appeared to struggle to talk to me about her experiences, she became quieter and appeared anxious when I switched on the tape recorder. In the second interview, I found some maple seeds in my pocket. We both played with these for a while. She took one of the seeds and gently scratched it along my hand, in a repeated motion. I did not feel threatened by this but felt that it was a shared moment as we both watched the motion together. At the same time, it also felt like a gentle communication that she was angry at me. It felt as if everything around us disappeared and there was a connection between us. Perhaps this was similar to her experience when she self-harmed. A way of connecting with herself, blocking out what was going on around her, whilst at the same time, communicating feelings gently to others.

Dorothy's understanding of impulsivity

In relation to impulsivity, she described how self-harm was sometimes planned, at other times she did it impulsively. We did not get to a point in the interview where I was able to ask her about her understanding of impulsivity.

Results of the Group Analysis of Self-harm and Impulsivity

Interview data relating to experiences of self-harm, impulsivity and GBST were examined as a whole. Experiences of self-harm and impulsivity shared common themes and have been presented together. Experiences of GBST and its impact on self-harm and impulsivity were analysed separately and are discussed in the following section. A procedural diagram reflects the connections between experiences of self-harm, impulsivity and GBST.

Experiences of self-harm and impulsivity reflected three levels of themes: master themes, super-ordinate themes and sub-themes. There were four master themes: I need you for safety but I fear you, I'm going round in circles and I keep making the same mistakes, Living in a hostile world, A sense of me: finding and losing myself.

Table 5: Frequency of themes across participants relating to experiences self-harm and impulsivity

			Participant				
Master theme	*Super-ordinate theme*	Sub-theme	Grace	Joan	Emily	Jessica	Gemma
I need you for safety but I fear you							
	I need someone to hold and make sense of things						
		Chaotic search for someone safe	X	X	X	X	X
		Testing: can you contain and hold me?	X	X	X	X	X
		You don't respond to my words but you do respond to my actions	X	X	X	X	X
	Mistrust: a need to withdraw						
		Re-experiencing trauma	X	X	X	X	X
		A way to manage without you	X	X	X	X	X
	Nothing is in the middle		X	X	X	X	X

			Participant				
			Grace	Joan	Emily	Jessica	Gemma
I'm going round in circles and keep making the same mistakes							
	I can't believe the abuse		X	X	X	X	X
	A need to escape from the pressure of being stuck: the only choice		X	X	X	X	X

			Participant				
			Grace	Joan	Emily	Jessica	Gemma
Living in a hostile world							
	Escaping or avoiding the dread						
		The dread	X	X	X	X	X

		I'm trying to avoid or escape punishment	X	X	X	X	X
		Punishing myself is less frightening than you doing it as I have control	X				X
	Betrayed: you're not on my side		X	X			
	It won't happen again						
		Defiance: Acting hard		X	X		
		Protection		X	X		
		Retaliation	X		X		X
			Participant				
			Grace	Joan	Emily	Jessica	Gemma
A sense of losing and finding myself							
	A move away from intolerable feelings: alive or obliterated		X	X	X	X	X
	Lost: where do I belong?		X			X	X
	Separating and being me			X	X		

I need you for safety but I fear you

The master theme reflects the interplay of relationships and feeling safe. If interactions with others were perceived to be unsafe, intolerable feelings were experienced. Another person was needed to restore a feeling of safety. In participant experiences, others were seen to be either good or bad which is reflected in two super-ordinate themes; 'I need someone to hold and make sense of things' and 'Mistrust: a need to withdraw'. Others were either seen as a source of potential security and safety or were experienced as dangerous, threatening or neglectful.

I need someone to hold and make sense of things

The super-ordinate theme, 'I need someone to hold and make sense of things' reflects participant attempts to gain safety in relation to others. Experiences reflected three sub-themes

Chaotic search for someone safe

This subtheme captured participant experiences of searching for someone to help them to feel safe. Accounts of experience within this subtheme, were often accounts of past experiences, prior to engaging in the GBST. When participants spoke, the tone and rate of speech appeared to

reflect a range of emotions, including panic. The order in which events were described were jumpy and disconnected, where parts of experience could not be recalled, as described by Gemma "*it happened in quick motion"* (line 150). Narratives reflected interpersonal experiences that were threatening to them, for example a hostile conflict or feeling abandoned. In response there was a period of confusion. Participants self-harmed or acted impulsively, as a means of ending the interpersonal threat and moving towards someone who was experienced as safe. During this process of moving from one person to another, the chaos was reflected in participants conflicting responses to others, where participants appeared unsure who to approach or avoid.

The examples provided by Grace where she is at the train station and Gemma where she is given an ultimatum by her boyfriend, are both examples of this theme. These experiences were also shared with Emily, Joan and Jessica.

Joan provided an example, which occurred within the secure setting following her engagement in GBST. She had a psychology session and towards the end of the session she wanted to rip up the notes the psychologist had written about her. Perhaps fearful of what she had disclosed. She chased him around the room to get the notes and told him to press his alarm. Although initially she did not tell me that she had told him to press the alarm. The psychologist had added this information. The psychologist spoke rarely in the interview, to ensure the data was not influenced, Joan then amends her narrative, *"I went, 'press your alarm if you want…I'm not scared"* (line 254). Other staff came and although she initially told them she didn't want to talk, she seemed conflicted and uncertain, "*Louise comes, which is my keyworker, I didn't quite answer straightaway, right. She says, 'Joan, what's going off? We'll sit and talk about it, we'll sit and talk about it, we'll sit and talk about it,' I goes, 'no, don't want to talk about it', and she were like, fine, left me to it"* (line 258). After she had walked away Joan chased after her. "*Didn't like chasing after my key worker, Louise, like I always do, right?"*(line 259). They sat and talked about things*, "*[Louise keyworker speaking] *I know you're pissed off with me, but I will talk to you", and we sat and talked. She goes, "look, I'm going to get you through it"* (line 262).

You don't respond to my words but you do respond to my actions

Participants recounted experiences of needing someone to make sense of their experiences. They attempted to explain this need verbally but recalled their sense of dismissal by others. Through self-harm and acting impulsively others were responsive and some of their needs were met.

Prior to her admission, Gemma's family had been asking for help from services, "*You know, to be locked up somewhere so they knew I was safe, because I was drinking at that point as well,*

and it was just, it was awful" (line 168), *"But they still wouldn't section me or anything"* (line 170). It appeared distress and desperation for help build up to a point where, "*I was ready to jump off that bridge. But the police pulled me back. If it wasn't for the police then I wouldn't be here today"* (line 173). The association is made between escalating behaviour and receiving help.

Joan talked about her experience of this process within the forensic secure hospital, *"Like earlier today I told Louise that I'm going to kick off, like Louise goes, 'You can kick off 'cause you planned it, so if you kick off, you kick off'. Right! I'm like 'yeah, yeah, yeah, kind of thing' and when I don't plan it she's like, 'come on Joan, come and talk to me"* (line 553). Joan appeared to understand the staff member's acceptance of her behaviour as a dismissal. By thinking about and communicating distress she was not responded to however if she did not plan and acted impulsively, staff respond by asking her to talk about it.

Testing: can you contain and hold me?

The subtheme 'Testing: can you contain and hold me?" described experiences of certainty and uncertainty about others abilities to hold them, either in mind or physically. Joan talked about services either being able to *"handle"* (line 78) her or not being able to. She had just arrived at the secure hospital where she had to meet new people. She related her experience to a war zone and destruction, she described her experience of a conversation with the new psychiatrist she had just met,*" I said 'you do know I'm gonna punch the fuck out of you', to Dr Smith. Dr Smith went, 'bring it on, you and whose army?' So then I goes, 'you bring it on, you bring it on, you and whose army?' And then he goes, right, we're putting you in seclusion"* (line 100). Joan learnt that Dr Smith could handle her. Once in seclusion staff came to see her and talk to her.

Grace provided an example which occurred within the secure hospital. Grace seemed to test others through self-harm, those who *"find out"* (line 363) what she had done were experienced as *"knowing"* her, for example, *"Peter's* [staff member] *very clever, he knows when I'm in my room or not and what I'm up to, he don't even need to check on me."* (line 356). Like a good-enough parent with a child, he knew where she was and what she was doing, he was holding her in mind. She tested to see if others knew how she was feeling. *"Last time I did it, I sat on toilet and self-harmed, about midnight I think it were and, well they just shout you if you're alright. I said yeah I'm alright. They can't even tell if you're upset or not*" (line 360). In this example, they "*just shout*" implies no effort is being made. Her experience of them *"not even"* knowing indicates an extremity of not knowing, like they don't even meet her basic need. Through testing, participants appeared to be figuring out who was capable of understanding how they felt so that they were able to know how to respond either by continuing to try to elicit care or to become self-sufficient. Participants learnt if they could trust the other person to care or not.

Mistrust: a need to withdraw

The super-ordinate theme 'Mistrust: a need to withdraw' describes experiences of mistrusting others and a need to withdraw and find means to cope without others.

Re-experiencing my trauma

Self-harm and impulsive acts were understood by participants as responses to re-traumatisation. Past experiences of disempowerment and abuse were recalled and it felt as though these past experiences were about to happen all over again. The impulsive act was reactive to a fear of violation and abuse and served as a means of escape.

Alongside the situation and context of experience which led participants to re-experience past traumatic events, others characteristics which reflected past abusers contributed to re-experiencing past traumas, for example;

"..places I've been (push of breath through pursed lips) *there it's unreal. Right, they've done all sorts, right, but mainly...only reason why I'm used to certain people grabbing hold of me is because I've had certain people grab hold of me most of my life. Right? I'm, ugh… it's like once when Louise pins me I, I can't calm down, but if Karen pins me I calm down like that. Any men grab hold of me I flip more, I just do, because of my background*" (line 217). The experience of flipping and just doing is clearly explained as a result of the past. Joan talks of her distrust of all men and also indicates that there are some women who she cannot trust. This reflects the idiosyncratic and specific details of trauma, its complex links with past abuse and which situations trigger participants to experience fear in the present.

A way to manage without you

Self-harm and impulsive acts occurred after experiences of feeling uncared for. These acts made sense to participants as a means of being separate from others and self-sufficient. The approaches taken to withdraw differed across participants but illustrate self-harm and impulsive acts as means of emotional self-regulation and self-care, independent of others, as illustrated in the following quotes:

"It don't matter to me what they do [staff]*, I'm not really bothered. I can deal with my self-harm myself and that. It's not like I'm going get it infected, I keep it clean and stuff like that"* (Grace, line 469).

"I was on drugs and I was having a real good time on my own." (Emily, line 363: T2)

"*But I've always done it to calm myself me"* (Gemma, line 380).

Nothing is in the middle

This theme related to participant attempts to reconnect with others and experiences of hoped for re-connections not coming to fruition. The example given earlier, where Grace hoped to meet her family at the train station is an example of this. The long pause that occurred in the interview when she recounted her realisation that her family are not coming to meet her indicated a sense of loss and the empty space left in the interview is indicative of this. Jessica recounted her experience of having nothing, *"No leave, no nothing, no money"* (line 147). Emily talked about adhering to the rules, *"You seem to get nowt in life for doing what you're supposed to. You just plod along don't you*?" (line, 94). The way in which she discusses this indicates that without rebellion there is boredom and lethargy.

I'm going round in circles and keep making the same mistakes

This master theme relates to participants awareness of repeated patterns of behaviour, in response to emotion and a struggle to experience alternative ways of thinking about themselves or situations, as if on automatic pilot or acting with tunnel vision, as illustrated by Jessica,

"Cos it's like, when I go home I'll be thinking to myself em… when I get a bit, like… frustrated or angry or like… upset, I went to go for a walk and if I go for a walk then I'll think, oh, I'll have some beer or something and then I'll get drunk and then I'll be abusive towards everybody, then I'll end up locked up again" (line 64).

I can't believe the abuse

Participant recall of abusive experiences reflected confusion and disbelief. It is possible that it was too unbearable and overwhelming to believe that others did not care and were actually abusive.

Grace talked about her experience where she had met a women who she liked and had an affair with the women's husband, *"cause he wanted to see me"* (line 183). Grace was introduced to more people and it appeared that this situation declined into abuse,

"….he were like getting me into threesomes and then from what I can understand we went to Nottingham, where this bloke wanted to make money out of me, like taking photos of me and like, wearing, just taking pictures of my face and body and, which I didn't really like, and just getting me to wear stockings and just, it was just like, so like" (line 184).

Her use of the word *"just"* appeared to minimise the intensity of her experience. She ends the sentence with, *"so like"* which could be interpreted a dismissal of parts of her experience and as

a difficulty in fully understanding and processing this event. Joan described a difficult experience of feeling uncared for and stuck between two aggressors, where she perhaps felt forced to pick a side. However, again like Grace she cannot believe or process what is happening. Her mother had phoned her at the secure hospital where Joan was under section,

"She [mother] *were ringing me saying staff didn't care and telling me 'get the hell out of that place,'* [forensic hospital] *and I were going, 'mum, you're not helping, mum, you're not helping'. Staff saying to me, 'your mum doesn't care and stuff' "…caused so much arguments between me and staff that, it were unbelievable"* (line 179).

In both examples participants experience a dislike of the situation and Joan reflects that what others do is not helpful for her. Participants appeared to struggle to accept parts of others abusive behaviour towards them. Similarly they appeared to struggle to accept their own behaviour as abusive towards others. Joan gave examples of times when she had become abusive towards others and understood this as impulsive behaviour. However, at the same time she appeared to struggle to accept that this may be experienced as threatening by others, as illustrated by Joan,

"Cause I'm a danger to the community, apparently" (Joan, line 330).

Her use of the word apparently appears to mean that she did not recognise her hostility as dangerous to others, being unable to accept her behaviour as abusive.

A need to escape from the pressure of being stuck: the only choice

Unable to connect with parts of their experience, participants appeared to experience a sense of being stuck, unable to identify alternative ways of viewing their experiences and alternative routes to break cyclical patterns of behaviour. Feeling stuck reflected experiences of helplessness and powerlessness and are illustrated by the following quotes,

"*There's nothing I can do about the situation*" (Jessica, line 70)

"*I daren't live around where I was on my own but I felt like I had to"* (Emily, line 220).

For some, impulsive acts, such as absconding, were in response to the experience of being stuck.

"*..when I run off, I was under a lot of pressure*" (Jessica, line 89):

"I just packed all my stuff at Wearmouth House and some of the lasses were picking on me there so I didn't like it" (Grace, line 288).

Self-harm served as a means of becoming unstuck from feelings, including anger. The fear of expressing this within the setting meant that self-harm was the only option, even though there

was awareness of this being *"wrong".* Gemma talked about her experience after she had self-harmed,

"Em, I'm just basically thinking (yawns), *I'm just thinking, yes I've got me anger out, I feel so much relief when I get my anger out. Yeah it's by doing the wrong things, but".* {What would be the alternative if you didn't do that?}. *"I'd take it out on somebody, just like I have done here* (line 682).

The description given by Jessica appeared to reflect a weighing up of pros and cons, whereby self-harm is evaluated as a better option than aggression towards others.

Living in a hostile world

This master theme reflects three super-ordinate themes; 'Avoiding or escaping a sense of dread', 'Betrayed: you're not on my side' and 'It won't happen again'. The first, is the period prior to intrusive, violating and punishing experiences, the fear of it and attempts to stop it from happening through avoidance or escape. The second super-ordinate theme reflects experiences of taking others on, being an aggressor either to prevent it or to atone for it. Both themes highlight impulsive acts and self-harm as means to prevent traumatic experiences.

Avoiding or escaping a sense of dread

This subtheme encapsulates three further subthemes, 'the dread', 'I'm trying to avoid or escape punishment' and 'punishing myself is less frightening than you doing it as I have control'.

The dread

The "dread" happened in the space which existed between the act and the consequence. It is a wait for something bad to happen. Self-harm and impulsive acts occurred within this space. Participants experienced fear. Fear of being attacked or the intolerable wait for punishment or infliction of separation. This is illustrated in Joan's experience. She has stabbed her mum and has gone to A&E with her, the police as yet have not been notified. She described her experience of waiting with her mum, *"Fucking dread. I hate that, I hate it with a vengeance"* (line 305). She described hating dread with a vengeance, almost as if she will respond prior to someone seeking vengeance on her. When the police arrive, Joan's mum told them to go away and did not disclose what Joan had done. Joan states loudly, *"It were me!"* (line 311).

Grace talked about her experience of being arrested, *"So it were my worst fear or worst experience to go down to the custody cells. It's like 'ah, Grace, you're only going to be interviewed' but like, I knew what would happen, I was dreading it, going to prison, my ordeal being in custody, going to court and then going in prison van...it's like a big ordeal for me, it's like really distressing"* (line 95).

I'm trying to avoid punishment

Self-harm and impulsive acts were both experienced as means to prevent or avoid punishment however were also experienced as punishable acts. Setting up a cycle of self-harm or impulsive acts to avoid punishment but which also lead to punishment.

Gemma self-harmed so that she would not be punished for hitting a member of staff.

"I just wanted to end it, you know, I just, er… stop like… just stop me getting into trouble for what I did" (Gemma, line 708).

Past experiences of being punished for self-harm were recalled by Grace which lead her to try and hide her self-harm from others.

"*The reason why I didn't want no one to know is probably because, because last time when it* [self-harm] *was in the bedroom they* [staff] *put all stuff in black bin liners, loads of CDs and stuff like that. I said you're junking all...you're putting all my… tying all my CDs up together in there"* (line 352).

Grace focused on the damage staff were causing to her CDs. She did not talk about how they were doing this to prevent her from harming herself to keep her safe. She perceived their actions as punishing.

Punishing myself is less frightening than you doing it as I have control

The experience of taking control of punishment is reflected in this theme. Grace illustrated this in a complex extract, she began by talking about others doing something which frightened her and how she would not do this. It appeared that if she had control she could manage the amount of damage.

"*the feeling of someone dropping a plate or just maybe just smashing it, it frightens me so like… I would just like to smash it just a little bit... When you're just like doing it* [self-harm] *in the kitchen like when everyone else is watching, I wouldn't do it* [self-harm] *in front of anyone else" (line 377).* She then describes her reason for harming herself, *"Cause I'm a bad person"* (line 389).

Betrayed: you're not on my side

Grace and Joan spoke about the difference between when self-harm was done impulsively and when they planned self-harm. For Grace she self-harmed secretly in response to a staff member leaving her and going home. She then talked about how all staff are unhelpful. An example provided by Joan also illustrates this theme. Following a psychology session Joan had, the psychologist had pressed the alarm as she was chasing him around the room,

"I wanted to rip my file up but he wouldn't let me rip my file up so I had to pick my paperwork up, what he were writing about me, right, so I goes, well, 'I don't want talk about it" (line 245).

She stated that she was *"pretty pissed off"* (line 244) and appeared to regret disclosing as much as she had. After the psychologist had pressed his alarm other staff members came. The following day I interviewed Joan, with the psychologist from this example. At one point in the interview we had been talking about self-harm and I asked her a question,

"No comment! No comment!... Cos I've got something planned for later, but I'm not going to say what in front of him, cos you'll go and tell Maria [staff member], *cos that's a big grass you are"* (line 534).

The use of the word grass, indicated that he could not be trusted as he would side of staff. Joan's tone of voice indicated that she was angry at him.

It won't happen again!

The previous theme reflects self-harm as a means to escape or avoid the fear or dread of intrusion, violation and punishment. This theme reflects self-harm and impulsive acts as physical movements towards others, as means of preventing these experiences from occurring. Getting in there first is important before anyone gets a chance to attack them.

Defiance: Acting hard

Self-harm and impulsive acts were experienced as ways in which to defy others, showing strength so that they would, *'go away'* (line, 238).
The previous example given by Emily, where she was in a hostel, self-harms and *"bleed all over the bloody bedroom"* (line 200). Could also be understood as a means of defiance. Asking them if they, *"have the guts"* (line 203), indicated that it takes strength to cut yourself. This perception is shared by Joan who talked about her experience of being admitted to an inpatient mental health ward,

"So then I goes to Dundee. I walks into Dundee police, walks into Dundee hospital. Big queue, em, acting hard, like I do, like I'm 10 men, right" (line 324). This quote reflects Joan's attempt to appear strong and invulnerable she also defies the rules which disempower her, *"I goes, 'whos been fucking sectioned, I'm not fucking sectioned, I goes I'll do what I want. I goes walking out of the building"* (line 317). Both Emily and Joan's experiences reflect bold actions of defiance which are easily observed by others, so others can see they are *"hard"* or have *"guts".*
However, these are *"acts"* which cover feelings of vulnerability and to protect themselves by pushing others away.

Protection

This theme captured a need to protect themselves from intrusive others and to protect others either from the participants or from angry or intrusive others. Emily and Joan talked about impulsive acts as attempts to protect their privacy from intruding others.

Joan, Emily, Gemma and Grace all talked about experiences where either self-harm or impulsive acts were used to protect other people. Joan's experience, that was discussed previously, regarding her need to help a resident talk of their abuse, is an example of a need to protect others. For Gemma self-harm was used as a way to channel anger as the alternative would be to *"attack a member of staff*" (line 691). If this happened she predicted that she would be punished.

Emily talked about impulsivity as a means of protecting herself. She described her experiences with other people coming to her house when she lived in the community, "*They, really do intrude in your life and, they just walk in your house and plonk themselves down, and give me this, give me this, give me this*" (line 160: T2) In response to this Emily told me that she had murdered people, although there is no record of this. *"I've always done it… like whatever I've had to do to you know, look after myself"* (line 155: T2), "*I was trying to defend my house and my privacy*" (line 157: T2).

Retaliation

Experiences of others re-enacting past experiences of abandonment and punishment led to retaliation.

Grace was talking to a member of staff but was struggling to express herself as she was, *"struggling with what's in my head"* (line 324). The staff member was due to finish her shift, Grace told her that she cannot guarantee that she won't self-harm. The staff member still finishes her shift, although it appears that Grace may have wanted her to stay. Grace then self-harmed in the toilet, *"so they didn't find out I'd self-harmed. Fucking idiots"* (line 363). As if she was making a fool of staff and humiliating them by getting one over on them.

In Emily's experiences she predicted attacks from others and impulsive aggression meant that she acted first before they could, *"I'm going to get it, so he's going to get it first"* (line 161: T2). She retaliated for imagined attacks from others which hadn't happened, yet, although she may have been physically or sexually attacked in the past.

A sense of me: finding or losing myself

Participants spoke about experiences of self-harm and impulsive acts as bringing connection with themselves or disconnecting from themselves. Being alive, existing and connected with the self was paradoxical to feeling lost and disconnected with the self. Distressing feelings, which lead up to these positions, are reflected in the themes discussed so far.

Lost: where do I belong?

This theme captured a sense of loss. Impulsive acts and self-harm were related to an attempt to find what had been lost and a response to not finding what had been lost. Participants talked about trying to find home and other people who they had lost in the past. Participants talked about what it was like when they were trying to find home or somewhere they *"should be"* (Jessica, line 82) and the experience of feeling lost.

Jessica talked about a time when she absconded. She tried to find *"home"* but realised she has lost her home, *"For some reason I just thought that I wanted to go home, I think I should be at home…so I just went home…but my flat's been took off me now, cos I've been in hospital over a year… That were no good anyway, having that flat on my own"* (line 83). She appeared to no longer know where home should be. *"I had nowhere to go… I were at a loose end where to go"* (line 130). She appeared to experience confusion in relation to going back to the secure hospital or staying out, *"I hadn't come back, I'd gone to Rotherham. I phoned them, and let know that I'd had a drink, they said we'll come and pick you up, I didn't know where I were and then I just got something* [alcohol/drugs] *and before I knew it, it were 12 o'clock."* (line 134). Although Jessica does not explicitly state that she thinks of substance use as self-harm, she does comment, *"I got myself in such a state"* (line 164). Indicating that she recognises the harm she does to herself through alcohol use.

Gemma talked about suicide as a means of belonging with others but was uncertain, *"Cause you don't know where you want to go do you?... Cause some people say they just want to be with their family members who have died in the past but it was like,…… I've got a Great Gran that's died. You know what I mean? She died a few years back"* (line 220).

Emily talks about the home she doesn't want to be at as a reason for her suicide attempt but then states but that's not *"it"* and goes on to talk about the loss of her mother's love. She appears to experience a dichotomous dilemma between always, never with the in between word being *"where?", "like when I jumped off the 10th floor flat but I did it when I was 16...and…well 15 and then the first time I got my first flat because I was suicidal, I daren't live around where I*

was on my own but I felt like I had too, but that's… it not… I always thought that my mum didn't love me as much as I wanted her to but… it's never been that… where, it's always… I'm worried about like losing her when I've just got her back the way I wanted her… but now she's got grandkids" (line 221).

A move away from intolerable feelings: Alive or obliterated

Participants appeared to experience a dichotomy between either existing or obliteration and had related beliefs about actions that would end or bring on these experiences. Impulsive acts or self-harm were believed to be a way of moving towards life or death and to stop intolerable feelings.

For Gemma, she believed that bringing on death was a way to stop intolerable feelings, *"But say if I did jump off the bridge yeah…, then I wouldn't feel nothing"* (line 225).

To stop doing, would be distressing to the point of death, as illustrated by Emily, *"Yeah, I find it hard to shut off, to go to sleep, or I end up lying on my side rocking…..There's also the fear of dying"* (line 270: T2). Through drug use, Emily appears to experience elation and hope, *"Yes because you know when you're going to be famous and you're on drugs, all you want to do is party, cause you know it's going to be your day soon"* (line 253). Impulsively shocking appears to be a between both life and death *"impulsively shocking cause there's heartbeat and life and stuff which is always when I've been really, when I've really had enough of stuff that I've acted impulsively, like when I jumped off the 10th floor flat"* (line 217).

Separating and being me

This theme relates to a need to be *"me"*. Impulsivity reflected a sense of not caring about others, attempts to become separate from others or being different from others and true to themselves.

In previous examples of conflicts with others Joan responded aggressively. She went on to explain that others know what she is like and she doesn't care. "*Joan, you're gonna have to calm down now, I'm phoning police cos of my neighbours'. I goes, 'I don't give a fuck about your neighbours, they know me, they know what I'm like*" (line 297). Following the experience where her mum tells her that staff don't care about her she appeared to want to separate from her mum and do what she wanted to do, *"I kicked off cos it was my birthday, right, and I turned to her, I goes "look, end of day, I'll do what I want, you do what you want"* (line 379).

A need to be different and separate from other people is also described by Emily when she talked about her earlier experiences and relationship with her mum, *"I told my mum that she wasn't allowed to dress me like everybody else"* (line 114: T2). When she talked about her experiences as an adult and her understanding of impulsivity she told me, *"Maybe I do things to shock other people but… I am being who I am"* (line 263).

Results of the group analysis of Group Based Skills Training

Experiences of GBST reflect three master themes; Mistrust and vulnerability: denial and defences, making sense of GBST: is it worth it? Tentative changes.

Table 6: Frequency of themes across participants relating to experiences of Group Based Skills Training.

		Participant				
Master theme	*Super-ordinate theme*	Grace	Joan	Emily	Jessica	Gemma
Mistrust and vulnerability: denial and defences	*I can't trust the facilitator*	X		X		
	Destroy or be destroyed			X		
	Scared and humiliated: separating from the group		X			X
	Hiding from others	X				
Making sense of GBST: Is it worth it?	*I don't understand it*	X	X		X	X
	What's the point: it's not worth it					
	Blackmail: pretending to comply	X				
Tentative changes	*Approaching others: awareness and communicating*	X	X	X		
	Working through it before making decisions		X		X	

Mistrust and vulnerability: denial and defences

This master theme reflected feelings of mistrust and vulnerability when participants were in the group. Uncertainty and attempts to work out the role of the facilitator occurred. For some participant's feelings of vulnerability appeared to be denied. All participants found ways to defend against being vulnerable.

I can't trust the facilitator

Participants tried to make sense of the role of the facilitator. Participants appeared to lack trust in the facilitator to be capable, responsive, protecting and available.

Emily did not appear to feel the facilitator was capable, *"So you could tell she* [the facilitator] *was on drugs but her face wouldn't keep still and I'm not talking about her jaw, the facial expressions she were making. She's genuinely not doing something"* (line 278). Emily criticised the facilitator and perceived her as incompetent *"She's got a book and reading from a book, you don't read from a book, cause that's proof that you don't know what you're talking about"* (line 282). Emily's experience of being left on her own to manage threatening others in the group is illustrated in the following quote, *"They just sit there and think that it's ok to let people have such an attitude. I know it causes problems but with the right medication and the right force, and it's perfectly ok for a police officer to do such a thing, so why not, or the courts to do such a thing, so why not a hospital?"* (line 360).

Grace explicitly states her experience*, "I'm not sure if I trust DBT mentors at the moment because like, I got told that Samantha's leaving"* (line 566).

Destroy or be destroyed

Emily perceived others as needlessly self-destructive and appeared to defend against a sense of vulnerability through a process of warning others against pursuing revenge, *"They are really loud some people when all they do is slag people off and I don't know why they slag people off cause all they're doing is cutting their nose off to spite their face"* (line 272). Emily mocked and humiliated others, *"Its cause they can't be arsed and don't want to socialise with others cause their a little embarrassed about being overweight* [snort laugh]" (line 292). She appeared to try to control the facilitator and others in the group, *"It was good I really enjoyed myself. Being able to, I know it sounds stupid, but being able to tell somebody they are wrong and how they should be doing it" (line 307).* For Emily engaging in the skills led her to experience fear of death, *"I don't like doing that anyway* [Mindfulness], *it's stupid. Well I can't sit in idleness. I get annoyed with it. I find it hard to shut off, to go to sleep or I end up on my side rocking.* {*Q: Are there any other emotions, like if you shut your eyes or try to do relaxation?} "No, no. There's also a fear of dying"* (line 530: T2).

Scared and humiliated: separating from the group

Participants talked about how difficult it was to attend the group and be around other people. Emily coped with this by becoming destructive, others coped by separating in some way from the group.

Joan was able to reflect on her experience of humiliation and refused to return to GBST. *"She showed me up when we got to class, so I wouldn't go, ever again"* (line, 474). Her use of the word class indicated that she related her experiences in GBST to earlier experiences of school.

Others appeared to share this experience but found it difficult to use emotional language to describe their experiences, *"Mostly I don't go……Just, I can't do it, sometimes it's hard……it's hard going into a group…being around people"* (Gemma, line 501).

Hiding from others

Grace talked about others as quiet which she felt depended upon who was there with the facilitator. It is not clear why that matters but she went on to talk about access to the facilitator, for example *"sometimes were all quiet in session but it depends whose there and that with Samantha. She sometimes wearing a skirt"* (line 483). She denied that this mattered but talked about how the facilitator was thinking of her and what she is thinking, *"…but that doesn't bother me. I sometimes think she's thinking I'm looking between her middle part* [vagina], *she's always doing that with her jacket* (mimes moving jacket to cover her vagina)" (line 484). Grace talked about how she and others in the group are quiet.

Making sense of GBST: Is it worth it?

The process of making sense of GBST is reflected in three themes, which move from confusing and overwhelming feelings, towards deciding if GBST is worth it. Feeling that there is little choice but to attend participants find ways to appease others to get what they want.

I don't understand it

For some participants they could not make sense of GBST and its aims. It felt confusing and overwhelming, *"Well it's taught me, I, I don't know, there's a lot in it. They tell you that, like, every so often they have a mindfulness bit on it but then they kept trying to do relaxation and in between as well, may be, I don't know, that was some sort of hint.."* (Emily, line 473). Others appeared annoyed *"It's fucking shit, sorry but it is. Em, just, sometimes I don't understand it"* (Gemma, line 583).

I asked Joan, Did you know much about it? What it was? In her response she indicated a similar experience of annoyance that Gemma experienced, *"No, that's why I told them to fuck off" (*line 472). Joan described the repetitiveness of talking which did not help her to understand it, "*Cos she goes over and over and over and over and over the same things. Even though I don't get it, full stop. All I get is that, talk, talk, talk"* (line 636).

What's the point, it's not worth it

Part of the sense making process involved understanding the goal of GBST, what will be achieved through attending GBST, Grace illustrated this point, *"Is it just a case of like wanting me to keep going and that until I put the things in place?"* (line 525). Participants appeared to weigh up the costs and benefits of attending to see the worth of GBST for them.

For Emily, she diminished the worth of GBST as it would have no impact, *"But you can't, to relax and not worry but because at the end of the day you won't get out of here for a long time anyway. Not unless there's completely nothing wrong with you"* (line, 475: T2).

Grace saw no link between self-harm and GBST, *"A shower's just, a showers not going to relax me anyway...it's not going to stop me from self-harming, it's just to keep clean isn't it? It's just relaxing, it's what you do when you wake up in the morning, it's just relaxing"* (line 552). She denied that it was relaxing and contradicts this by stating that it is relaxing, perhaps she cannot find the word for the feeling that she would need to feel to replace self-harm.

Blackmail: pretending to comply

Participants spoke about the process of joining the DBT groups. Grace's understanding of going to GBST was that it would help her to get to rehab, *"Dr Smith, once I stopped going and that he said, 'If you don't go back to DBT it won't help you go'...it's not going to help me go into rehab and that so"* (line, 528). However she experienced this as blackmail, *"Sometimes they're full of blackmail and that cause like if you're on a section 17 for instance, they take you out on walking group and like, if I recover I want to go to rehab. So sometimes, I don't know if it's like a form of blackmail?"* (line 533).

Initially most of the participants spoke of the skills that were taught within GBST and how they had been helpful but appeared to struggle to describe their experiences of the ways in which the skills had impacted on them. Gemma talked about GBST, *"When I do go to DBT, it helps me. Because I sit there and listen and, you know, it helps me learn new things*" (line 874). When we explored her experience of these new things and what they meant to her, she told me, *"I don't know it's, sometimes I don't really listen to what they're saying"* (line 875).
Grace expressed her wish to stop going to the groups but this was not agreed. She then talked about how she found ways to deceive or pretend, for example, "*In all honesty, I sometimes don't write emotions what I'm feeling down at the time,… I sometimes put happy or I felt okay and that"* (line, 520).

Tentative changes

Although participants experienced the process of joining GBST as coercive, once there, they began to experience some changes. It appeared that those who experienced some change were still trying to make sense of it and were not sure if the changes would be transferred to all settings.

Approaching others: awareness and communicating

Participants spoke about their relationships with others, for example Emily was making sense of GBST and its links to relationships, *"I think they're trying to teach you's to be like, aware of when to approach people and how to approach people" (Line 372).*

Grace talked about how she struggled with groups initially and how she was learning to manage, *"I've had to learn how to manage these groups and that… and talking to people and that, which I didn't used to be any good at before I come here…"* (line 543).

Joan experienced others as more available to her, *"Cause like I don't really understand DBT but this is what I've learnt so far...like, staff take more notice when you tell them you're struggling. They give more of a fuck"* (line 608). She had found ways to communicate her needs when she felt unable explain in words*, "Because when I get mad and I can't speak to staff, I use my Makaton and stuff, certain staff understand it and they'll go, 'come on Joan, come and talk to me'"* (line 494).

Joan attended individual GBST. Makaton uses signs and symbols to help people to communicate. It is not part of the GBST but appears to have been integrated into the DBT skills for Joan's particular needs.

Working through it before making decisions

This theme reflects a change in the way participants made decisions. Some participants spoke about becoming more aware, *"I think if you're being mindful you're more aware of what you're doing"* (Jessica, line 561). Through mindfulness Jessica thought about her options first before acting, *"Being mindful about what you're doing and that, like that's not working, you know, not doing things impulsively. Just making you stop and think about being mindful about it"* (line 562). The experience of being able to problem solve is shared by Joan, *"Because sometimes I get...frustrated...and then I'll sit back and think about it and think, perhaps not this way, this way and I'm starting to understand staff more because staff will go, 'come on Joan, chill out and think about it' and I'm like 'ok' and think about it"* (line 516). Some participants felt calmer, *"I think I listen more, and stuff like that and…..I'm a calmer person. Yeah, probably some things changed, yeah"* (Grace, line 618). The changes participants experienced reflected a

combination of increased awareness of thoughts and feelings which linked to improved relationships with staff and a sense of feeling calmer and able to listen.

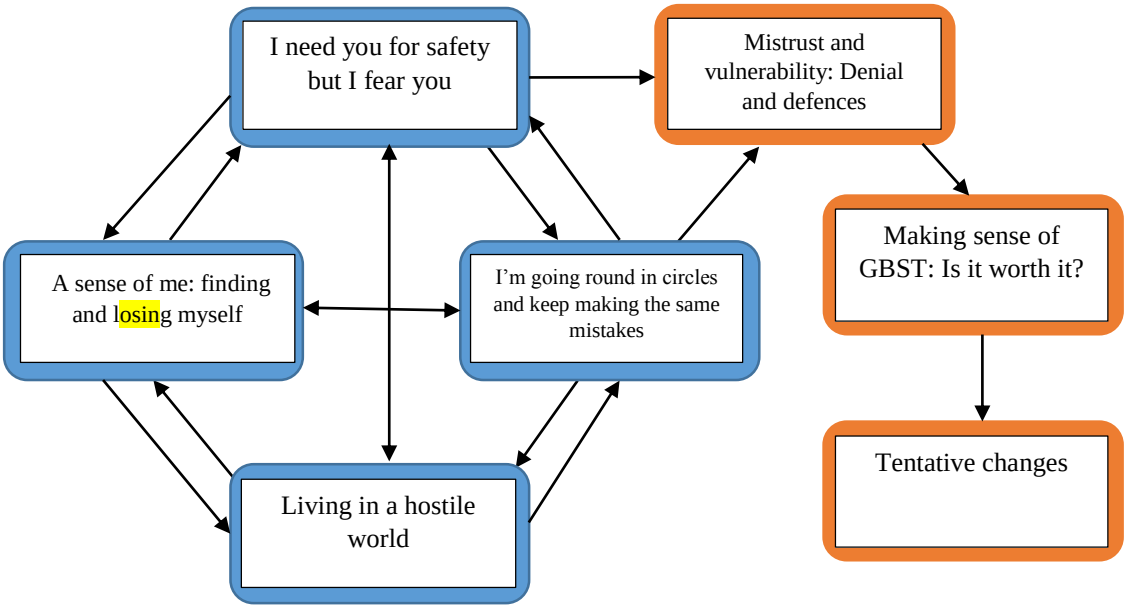

Figure 4: A Diagram of the overall process of experience of themes

The above diagram demonstrates the process participants experienced with self-harm, impulsive acts and GBST. Following on from the identification of themes, each transcript was read through again to identify patterns within participant narratives in relation to the themes identified. Quotes reflecting the themes were re-organised for each individual in the order in which they were discussed. The arrows in the diagram above reflect the direction of experiences for participants. Participant narratives reflected a move in experiences reflected in the themes, which could be in any direction and begin at any point. Self-harm and impulsive acts reflected a move from one theme towards another. Self-harm and impulsive acts were means of approaching or avoiding others, which depended upon participants' interpretation of others "trustworthiness". If others were perceived as untrustworthy, and therefore hostile, they were avoided through self-harm and impulsive acts. However, without others they could not make sense of their experience and therefore of their sense of self. This led onto a search for another or self-reliance, through self-harm and impulsive acts. This did not last and they returned again for a need for someone but also a fear of this need, experiencing the sense of 'going round in circles'. The arrows reflect the circularity of experience. For example, we can see this pattern in the narrative provided by Grace, where she is at the train station waiting for her family. She begins with a need for her family to come and meet her, as reflected in the theme *'I need you for safety but I fear you'* as she appeared to feel both excited but nervous at the same time. When

her family did not arrive she described her experience of not knowing what to do and feeling bored, which is reflected in the theme, *'A sense of me: finding and losing myself'*, where Grace appeared to feel lost. She then returned to a need for another to help her to feel safe. She experienced the police as hostile, threatening to take her away from Lisa, as reflected by the theme, *"Living in a hostile world"*. She was then returned to the place where she was being "picked on", reflected in the theme, *"I keep going round in circles and making the same mistakes"*.

The link between self-harm, impulsive acts and GBST appeared to be participants mistrust of others. Experiences of GBST and the themes identified are illustrated by the orange circles. Again participants began with a struggle in trusting others, leading to a need to withdraw. For some conflicts with others continued. However, rather being punished and go round in circles participants appeared to move forward to work through and make sense of the group. For some this led to changes, which they felt helped them in their relationships and the way they thought about things.

Reflexivity

I was interviewed about my experiences of the interviews and analysis of the data. I reflected on my previous assumptions prior to the interviews and how these had changed during the research process. Prior to the interviews I had a positive view of impulsivity as a means of having fun. It was not until I had begun analysing the data I recognised the role impulsivity had in escaping or avoiding difficult feelings. I thought about my own experiences with loss, my own defences and my own process of coming to terms with previous losses in my life. I began to have a broader perspective on experience and to analyse the data more deeply. I thought about how I positioned myself when analysing the data, for example as an advocate for participants. The interview allowed me to move away from this position to a more neutral one, recognising that the experiences shared by participants was one viewpoint amongst many. Initially I recognised that I may have over-identified with participants but through the process of the interviews I was able to recognise many differences between us, for example past experiences of severe abuse. I returned to the data and listened carefully with this new awareness.

CHAPTER FOUR: DISCUSSION

The study was designed to explore how participants made sense of self-harm and impulsivity and experiences of the group based skills training component of Dialectical Behaviour Therapy. I was also interested in their experiences of GBST and perceptions of the impact of GBST on experiences of self-harm and impulsivity.

This chapter will explore the findings in relation to the research questions and wider research literature presented in Chapter One. Further literature, which is relevant to the findings, will also be introduced. To critically appraise the research I will discuss the methodological strengths and limitations. I then explore the clinical implications of the main findings and recommend areas for further research.

Following five semi-structured interviews, the main individual idiosyncratic understandings of self-harm and impulsive acts were presented. Secondly, the group analysis is presented, reflecting four superordinate themes, twelve master themes and twelve sub-themes. The group analysis of experiences of group based skills training were analysed separately and reflected three super-ordinate themes and nine master themes. I will now bring the themes back together as a narrative of participants' experiences of self-harm, impulsive acts and GBST to answer the three research questions asked. All names, ages and places have been replaced with pseudonyms or have alternatively been removed.

1. How do women engaged in Group Based Skills Training in a forensic setting make sense of impulsivity and self-harm?

Participants made sense of their experiences of self-harm and impulsivity by describing the context they were in, where they were, if they were alone or with others, next they described the point in which their behaviour changed and they engaged in self-harm or an impulsive act. Narratives often jumped forward and backwards in time. Participants reflected on their thoughts, beliefs, intentions and feelings. Sometimes participants showed their scars to me and described what had happened, one participant appeared to re-enact her self-harm on me, without using words. When talking about the relationship between self-harm and impulsivity, participants described self-harm as either impulsive or planned. Impulsive acts such as absconding, violence and using substances were not understood as self-harm.

Participants were asked about how they understood self-harm. All participants described what is defined by self-injury, such as cutting and tying ligatures. Participants understanding of self-harm was socially constructed (Burr, 1995). Participants reflected on both their own and staff understandings of self-harm. It was thought about in a narrow sense, for example,

as a category and also in a wider sense, in relation to intentions and the connection of self-harm with relationships.

Impulsivity was understood as an act, such as absconding, substance abuse and violence, which occurred with limited thinking, feeling an *"urge"* and later reflections that it was, *"the wrong thing to do".* These understandings varied across individuals, for example, not all participants reflected that it was the wrong thing to do. Participants spoke of their intentions when they were acting impulsively. Grace did not intend to be aggressive, Joan initially intended to be playful and Emily intended to shock people. Jessica, stressed the importance of considering the circumstances in relation to self-harm.

When self-harm was experienced as impulsive, it shared the cognitive and emotional processes that occurred with other impulsive acts. When self-harm was planned participants provided warnings to staff that it may occur, they thought about access to means and locations where they would not be caught. The positive consequences of self-harm outweighed the perceived negative consequences of self-harm. This links to the literature discussed in Chapter One, that the positive consequences of self-harm contribute to the maintenance and reinforcement of these coping strategies, preventing learning of more adaptive strategies (Chapman et al., 2006; Lindenboim, Comtois, & Linehan, 2007)

The sense that participants made of self-harm and impulsivity will now be discussed in relation to the themes and literature. Headings reflect the main research findings.

The link between past and present relationships

Participants made sense of self-harm and impulsive acts in relation to relationships with others across time. Patterns across these relationships emerged which are reflected in the themes. The master theme, ***I need you for safety but I fear you*** reflected participant experiences of threatening situations and the need for another person to offer care. This finding can be understood in relation to attachment theory (Bowlby, 1969). However, in participants' recall of earlier experiences parents were also the people who neglected or abused them. Confusion, with regard to relationships, was reflected in how participants recalled their experiences, with unclear and chaotic narratives. For all participants, self-harm and impulsive acts were both understood as means of approaching or avoiding others, indicating a disorganised attachment style (Schore, 2003) and reflecting the 'approach-avoidance' dilemma (Holmes, 2002).

Fear of repetition of past experiences

Situations in the present which were perceived to share features of past traumatic experiences were feared, which reflects the theme ***'Escaping or avoiding the dread'***.

Feelings of dread or loss were experienced, memories of past traumas were recalled and there was panic and fear of past traumatic events happening again. Findings regarding the importance of relationships can be understood in relation to the attachment theory of self-harm discussed in Chapter One, whereby events within the current environment that reflect loss, rejection or disappointment are transformed into a crisis. Findings within the current research, add to this model. In addition to these feelings, dread and fear contribute to self-harm. Aligning with cognitive models of PTSD. Past events are processed in a way that produces a sense of serious current threat. The perception of current threat is accompanied by intrusions and emotional responses (Ehlers & Clark, 2000). However, the diagnosis PTSD does not capture the complex nature of repeated interpersonal traumas and a diagnosis of BPD can be demeaning and discounts personal history (Gerhardt, 2004). Pelcovitz et al (1997) proposed DESNOS (Disorders of Extreme Distress), also named "Complex PTSD" by Herman (1992). Although not accepted for inclusion within the DSM-5, it is important to locate individuals in relation to their histories, particularly when these histories can help to explain current presentations.

The struggle to process traumatic experience in words

Gerhardt (2004) has described 'the black hole' which refers to dehumanisation and lack of emotional value which is central in the borderline relationship. The 'black hole' appeared to mirror participants' experiences of having nothing and not knowing what to do, reflecting the theme, ***'nothing is in the middle'***. As described by Gerhardt (2004) "a non-verbal state of blankness; timeless, spaceless horror" (p164). Experiences reflected a struggle to articulate past experiences in words as a means of gaining support. Firstly, participants did not feel heard. Secondly, they were fearful of the response they would receive. Thirdly, experiences were too difficult to put into words. This links to literature discussed in Chapter One, where traumatic experiences can be dissociated from all semantic-linguistic-verbal representation (van Der Kolk, 1998).

Traumatic experiences are too painful to acknowledge

Participants described experiences that were *"unbelievable"* to them, reflecting the theme ***'I can't believe the abuse'***. Recall of experiences of sexual abuse, neglect or aggression, were responded to with confusion. Within the interviews participants moved away from painful memories in their narratives. The struggle to stay with painful memories or experiences and reflect on them, meant that participants experienced stuckness and could see no other way of responding, as reflected in the theme, ***'A need to escape from the pressure of being stuck: the only choice'***. Allen & Fonagy (2006) suggest that the borderline person grows up avoiding thinking and mentalizing because it would involve recognising the hatred or lack of

love in her parents' attitude to her. Emily was able to reflect on her thoughts that she felt her mother never really loved her as much as she wanted her to. The struggle to let go of self-harm and impulsive acts, can be understood as fear of separation (Allen & Fonagy, 2006). For participants', thoughts of not being with family members was distressing, hope of reunion with family members were spoken about and impulsive acts and self-harm were means of achieving this. However, reunions were often short lived or did not occur, leading on again to painful experiences and further self-harm and impulsive acts. The biosocial model of BPD highlights the role of inhibited grieving. Psychic trauma is experienced with loss and results in a state of helplessness (Varvin & Rosenbaum, 2003). This links with the attachment model of self-harm were the experience of loss, rejection or disappointment in the present is transformed into a crisis. Participant accounts can be seen to reflect a sense of helplessness and defeat without resolution, as hypothesised by the cry of pain model. Self-harm and impulsive acts served as means to find resolution, if only for a short while. This may have been better than experiencing intolerable feelings associated with having *'nothing'*.

When participants felt that they had nothing, they spoke about death, either the fear of it or a wish to move towards death to feel nothing. Reminders of past abuse or neglect, were responded to with impulsive aggression and drug use as means of feeling alive and moving away from a fear of dying. For others, suicide attempts and alcohol consumption were means of moving them towards feeling nothing, as reflected in the theme ***'a move away from intolerable feelings: alive or obliterated'***. Individuals within forensic settings, not only have to process the abuse that has been done unto them but in addition, have to process abuses they have done onto others and onto themselves, as reflected in the theme ***'I can't believe the abuse'***. Individuals with histories of abuse and neglect have often learnt to survive trauma by not allowing themselves to feel pain and negative emotions (Bordsky & Stanley, 2013). These findings link to the EAM of self-harm, whereby self-harm is a negatively re-enforced strategy for reducing or avoiding negative emotions.

Assessing trust and potential responses

Findings indicated that fear of repeated experiences of abandonment or powerlessness were mediated by participant interpretations of others behaviour. Participants assessment of others 'trustworthiness' appeared limited and dichotomous, whereby others could either be trusted or not, linking to the literature on cognitive rigidity and polarised thinking (Linehan et al., 2015) and reflected in the theme ***'Re-experiencing my trauma'***. For example, restraint was experienced differently across contexts and individual accounts. Evidence exists for the traumatising effects of restraint for individuals who have been sexually assaulted (Smith,

1995), although it appears that the specific details rather than a simple relationship are relevant to the impact that restraint has. For some participants, restraint was seen as a means of demonstrating care. When others were experienced as untrustworthy or hostile, participant accounts reflected experiences of entrapment, either through restraint or arrest. Adding to the existing evidence base of the impact of past traumas on the present, in relation to self-harm (Baker et al., 2013). An inability to trust others has been identified within both a diagnosis of DESNOS and BPD and the findings indicate that the interpretation of others as trustworthy appears to mediate the likelihood of self-harm and impulsive acts from occurring.

Self-harm and impulsive acts were used to assess if others were trustworthy, reliable and available, providing a sense of certainty, reflecting the theme, ***'Testing can you contain me'.*** Different interpretations were made of others thoughts about them, indicating an attempt to mentalize (Allen & Fonagy, 2006). Perspectives from mentalization based therapy deepen our understanding of how individuals construe the intentions of others. Participants appeared to be in 'teleological stance' where there is a reliance upon physical as opposed to mental constraints. There is a dependency on physical actions of the other as indicators of intentions (Allen & Fonagy, 2006). Self-harm has been proposed to occur when individuals are in 'teleological stance' whereby individuals need to provide concrete demonstrations of how they feel (Swenson & Choi-Kain, 2015). There were times when participants did feel held in mind by some staff, they did not require them to be physically present therefore did not need to engage in self-harm. This may be reflective of different approaches by other people, highlighting the systemic nature of difficulties.

These experiences are somewhat explained by the cry of pain whereby perceived support from others impacts on the likelihood of engaging in self-harm (Williams, 2001). Models which do not include the role of cognitive interpersonal appraisals within self-harm are limited in capturing the full complexity of this behaviour.

Preventing repetition of past experience

If others were appraised as untrustworthy, self-harm and impulsivity served as a means of escaping or withdrawing and a means of managing without others, reflecting the theme, '***A way to manage without you'***. Self-reliance can also be seen within the themes, ***'separating and being me'*** and within the group experiences, ***'scared and humiliated: separating from the group'***, which are discussed later in relation to research question 2. These findings reflect the alternative to valuing relationships discussed in the previous section, instead relationships are devalued, which is reflected in the diagnostic criteria of BPD. Separation allows for self-reliance and prevents further hurt from others.

To prevent punishment from others, participants self-harmed, as reflected in the theme ***'I'm trying to avoid or escape punishment'*** and ***'punishing myself is less frightening than you doing it as I have control'***. Paradoxically by hurting themselves participants believed that they prevented others from hurting them by inflicting punishment. Additionally, self-harm took control away from others who may punish them, allowing participants to manage the degree of punishment inflicted. Within previous research self-harm has been found to be a means of gaining control both over the environment and emotional distress. James & Warner (2005) found that self-harm and control related to powerlessness, abuse and a need for self-preservation. Although I do not contest this finding, Q-Methodology uses pre-prepared statements about the issue in question. Moving closer to subjective experience requires methodology which enables that. IPA has enabled a deeper understanding of control. In addition, it has allowed for the recognition of the circularity of patterns. Self-harm was seen to prevent punishment nevertheless, the act of self-harming was still punished. Grace perceived that others punished her for self-harming, which led her to self-harm more secretly. Experiences of feeling punished for self-harm was also found within Harker-Longton & Fish (2002). The need not to be caught is also reflected in participants accounts within Smith (2015). James & Warner (2005) argued that having control exerted upon individuals within forensic settings may increase the likelihood of self-harm from occurring. It may be that being punished for self-harm was more tolerable than the *'ordeal'* and *'dread'* of the original punishment. Reducing the severity of a punishment through self-harm could make sense, if the act elicited care from others, which we have seen within other themes.

Participants also responded to experiences of untrustworthy others by the 'fight' response (Cannon, 1929) as means of preventing further traumatic experiences from occurring. A need to protect themselves or others were reflected in the theme, ***'protection'***. Aggression was seen as a means of protecting the self from intrusive others. Participants also spoke about harming themselves to protect others from their aggression, which was found in previous research (Brown & Beail, 2009; Kenning et al, 2010). Both are seen as means of protecting themselves. Harming the self would mean that harm was not inflicted by others. This function of self-harm is not accounted for in the models of self-harm discussed. This could be viewed from an attachment perspective, as a means of preserving relationships with others. Indeed Gemma spoke about an attack she had made on a member of staff, which she later regretted as the staff member was her keyworker. The need to preserve relationships may be more predominant within secure settings, given the power staff have over decisions, an inability to escape from these relationships and a dependence upon staff for care.

A need to show strength and defy restrictions imposed upon participants by others was demonstrated through aggression and self-harm, this reflects the theme, **'Defiance: Acting**

hard'. A wish for others to *'go away'*, self-harm and aggression were means of expressing a need for personal space or freedom. These findings may link with previous research (Smith, 2015), whereby self-harm was a means of preventing victimisation. Self-harm and outward displays of aggression overlap, highlighting the interplay of these phenomena. Although self-harm as an overt display of aggression was only illustrated within the quotes from Emily, who specified that this had only happened once. These findings link with the cry of pain model which proposes that individuals experience a sense of entrapment and helplessness and that perceptions of support and future thinking mediate self-harm.

The intent to retaliate

Participants who had tried to express themselves verbally with others appeared to feel betrayed when the other person did not respond in the hoped for way, for example understanding or changing their behaviour. Instead others were experienced as betraying the trust that the participant had given by attempting to speak about difficult experiences. Self-harm was a means of expressing anger for perceived betrayals, as reflected in the themes, ***'Betrayed you're not on my side'*** and ***'Retaliation'***. Self-harm as a an expression of self-directed anger has been acknowledged (Klonsky, 2007), however, an extensive literature review revealed no known studies highlighting the role of self-harm as a safer outward expression of anger within forensic settings. Forensic settings do have a paradoxical role of care and punishment. Perceptions of switches between these roles were experienced as a betrayal. The role of betrayal in sexual abuse is recognised. Finkelhor & Browne (1985) proposed four Traumagenic dynamics to explain the impact of sexual abuse. The third dynamic recognised was betrayal, whereby children discover that someone they were vitally dependent upon has caused them harm (Finkelhor & Browne, 1985). It may be that self-harm acts as a buffer for the expression of anger, preventing staff from retaliating with further punishment and protecting relationships with staff. Indeed, from an attachment perspective, a child who is still dependent on his parents cannot retaliate fully because to risk losing parents may endanger survival (Gerhardt, 2004). The system of a forensic setting could be seen to replicate earlier experiences of high dependency, for example, emotional support, shelter, food and freedom whilst at the same time punishing the person.

Sense of self

The sense of self is dependent upon feedback from others (Gerhardt, 2004). Struggling to express experience in words, means that it is difficult to make sense of the self in relation to experience with others. Participants spoke about the experience of having nothing and then responding by absconding, this reflected attempts to re-connect with parts of their identity. Some participants tried to find home, reconnect with family members or find friends. When

they realised their homes had been *"taken off"* them or reconnections were non-existent or short lived participants described not knowing where to go or be. For women who have been detained in secure settings, there is a real loss of family and home (Lovell & Hardy, 2014). ***'Lost: where do I belong'*** reflected similar findings by Lovell & Hardy (2014) who explored the views of women, given a diagnosis of BPD, detained within a forensic secure setting. Participants questioned their identity, place in life and where they belonged. Models or understandings of impulsive behaviour which do not take into account the real losses experienced by this population, are in danger of expressing further invalidation. The attachment model of self-harm and the cry of pain model of parasuicidal behaviour both recognise the role of loss in suicidal behaviours. Previous qualitative research on impulsivity is limited and has not highlighted the role of loss in impulsive actions within this population, highlighting a need for further research on impulsive behaviours, in particular absconding from secure settings.

2. How do women experience engaging in Group Based Skills Training?

Engagement

As discussed in Chapter one, a lack of commitment by patients was reported as a challenge for therapists (Pol, 2013). James & Warner (2005) have argued that women need to be involved as much as possible in planning, reviewing and implementing their treatment to prevent the maintenance of behaviours services are actually attempting to reduce. The pre-treatment stage of DBT, as discussed in Chapter One, aims to reach a collaborative commitment to GBST. Together with experiences of feeling blackmailed, participants also felt that the benefits of the group were unclear or too far in the future. Two participants also spoke about their fears about discharge, indicating that discharge may not be a motivating factor for some, for example Gemma stated, *"I'm dreading getting out of here".* Emily told me*, "there's nobody who can look after me apart from the hospital".* Working with client goals is an integral part of therapy, however, this may be complicated within forensic settings where focus is upon reducing risk, which may not reflect participants' goals. Katsakou et al (2012) explored what service users with BPD view as recovery. Within this research participants felt that psychotherapies, such as DBT and Mentalization Based Therapy (MBT) focused upon specific areas, like self-harm or relationships and that some of their goals were neglected. Greater attention may be needed to identify shared goals within forensic settings to overcome challenges to engagement.

Bringing past experiences to the group

As with the experiences of self-harm and impulsivity, mistrust was experienced, either mistrust of the group or the intentions of the staff proposing the therapy. Participants found it difficult to be around other people, as reflected in the theme, ***'Scared and humiliated: separating from the group'***. Associations were made between GBST, school and humiliation, as illustrated in Joan's comment about her experience of the group, *"She showed me up in class"*. Yalom recognises the transference that occurs in groups, where others in the group are living personifications of parental figures and others in their past. As discussed in Chapter One, altruism is seen by Yalom as a key therapeutic factor within groups and plays an important part in the healing process. Sharing and acceptance are seen as increasing the attractiveness of the group. It does not appear that group members' perceptions of the group were attractive. Together, hostility both given and received appeared to impact upon group cohesiveness. It has been proposed that a focus on skills rather than group process will overcome difficulties (Karterud, 2015), however, it appears that this did not occur for these participants. Rather than overcome these difficulties, the focus on skills may mask them. This provides a challenge for GBST, as a tension between focusing on transference may deviate from the skills being taught. Linehan (2015) does highlight a need to address difficulties with social anxiety prior to GBST. Although, that appears to separate off what is inherently one of the core difficulties within BPD, interpersonal difficulties and why individuals are offered treatments.

Self-preservation

Difficulties with trust were reflected in participants' experiences whilst attending the group, as reflected in ***'I can't trust the facilitator'***. Linehan proposed that facilitators protect group members and maintain confidentiality to increase trust. However, confidentiality can be difficult to maintain when participants attending the group live together and have pre-existing relationships, which continue outside of the group. Experiences of mistrust and humiliation contributed to strategies aimed at preserving a sense of self-esteem. Emily appeared to use downward social comparison to maintain her sense of self-esteem (Taylor & Lobel, 1989) and may have projected her feelings about herself onto others in the group (Breuer & Freud, 2010). Emily tries to *"take over"*, controlling the facilitator and others in the group, as reflected in the theme, ***'destroy or be destroyed'***. In addition, to her negative experiences with others in the group, Emily appeared to experience negative effects from mindfulness, as she talked about a fear of death. The positive effects of mindfulness have been proposed, however recent research has begun to consider the adverse effects of mindfulness (Hanley, Abell, Osborn, Roehrig, & Canto, 2016). Manocha (2000) has asserted that "meditation is contraindicated in those [individuals] suffering from psychosis and

should only be applied with great caution in those with severe psychological problems" (pp. 1137–1138). DBT has not been designed for individuals with psychosis and previous research has excluded individuals with a co-morbid diagnosis of psychosis. As highlighted in Chapter One, pressures exist on services to increasingly accept poorly functioning patients reduces the ability of therapists to select clients for therapy on the basis of suitability. Emily was included in this research as it reflects the reality of individuals within forensic settings who attend GBST. Her experience of being excluded from the group may have led her to further imbed her beliefs to protect her self-esteem, as reflected in the following quote,

"I was helping out and then I got told that erm I wasn't allowed to go to DBT anymore cause I wasn't get a lot out of it basically cause I was arguing points with Ann [the facilitator] but unfortunately cause I'm hospital director, erm she got herself sacked".

When certain others were present Grace remained quiet and perceived others as also being quiet, as reflected in the theme, ***'hiding from others'***. She attempted to 'read' the minds of others in the group. Difficulties with mentalization have been seen within the themes relating to self-harm and impulsivity. Whereas DBT puts emotional dysregulation at the core of deficits, MBT places instability in mentalizing at the core. Although MBT and DBT are conceptually different there is convergence on some of the interventions used. It has been thought that failures to mentalize are correlated with nearly all forms of psychopathy (Swenson & Choi-Kain, 2015). Due to the co-morbid presentations within forensic settings, further integration and focus on mentalization, may target difficulties that are experienced across all psychopathologies.

The struggle to understand

Fear of the group may have led to difficulties with engaging in the skills taught, Maslow's hierarchy of needs, identifies that a sense of safety, love and belonging need to be reached before individuals can begin to achieve and problem solve (Maslow, 1954). Additionally, high levels of arousal will impact on cognitive processes, such as attention, memory and problem solving (Lupien, Maheu, Tu, Fiocco & Schramek, 2007). Participants' descriptions of what they learnt in GBST was limited. Participants explicitly stated, *"I don't understand it".* They appeared to feel confused and overwhelmed by the amount of information and how it was delivered. For four of the participants' anger was experienced, leading to rejection through non-attendance. This reflects previous research exploring the experiences of GBST within outpatient settings, whereby participants reported difficulty in understanding the material (Barnicot et al., 2015). Joan and Grace attended the adapted version of GBST. Joan indicated that the repetitiveness of the programme and hearing this in words was not helpful for her and disengaged from the group. Previous research has highlighted participants wishes

to have more information presented visually and for handouts to be simplified (Sakdalan et al., 2010). It appears that modification of the materials was not sufficient to enhance engagement for Joan, who also struggled with being in a group. Indicating that programmes need to recognise both anxiety experienced in groups and the way in which materials are presented.

3. How do women describe the impact of Group Based Skills Training on their impulsivity and self-harm?

Gemma and Emily struggled to identify how GBST impacted upon their self-harm and impulsivity. Gemma responded by saying, *"mostly I don't go, so there's not much I can say about DBT really".* Emily moved away from the question and spoke about staying in hospital, as it was the only place that could provide care. Grace could not see the connection between relaxation and self-harm. However, Grace did feel that she listened more, and felt like a calmer person. The struggle to recall particular skills, may have occurred for a number of reasons. Potentially, the anxiety experienced within the group may have prevented participants from learning, alternatively, as noted for individuals who have experienced trauma, expressing experience in words may be a challenge.

Participants did provide examples of different ways of relating to staff, reflected in the theme, ***'Approaching others: awareness and communicating'***, which can be linked to the interpersonal effectiveness module. Emily, Grace and Joan spoke about learning how to approach and communicate with others. Emily recognised that the facilitators were trying to teach this. Grace appeared to have learnt through exposure in the group and Joan had learnt how to communicate without words. This reflects unique individual differences in what is helpful, also found within Nee & Farman (2005). It appears that for participants within this study, interpersonal difficulties are primary and what participants 'took' from the GBST, appears to reflect its importance to them. Interpersonal effectiveness may take prominence within a forensic setting, due to the proximity of others, the lack of choice in who one lives with, who offers care and makes decisions.

Jessica and Joan, illustrated an ability to engage in reflective thought and problem solve. Jessica did relate the changes she experienced to mindfulness, which helped her to reduce absconding and substance abuse by being more mindful when she was out on leave, rather than *"wandering about".* Attending to her shopping list, rather than becoming distracted by thoughts. Examples provided by Joan illustrated her ability to control proximity with others. This helped her to reduce impulsive behaviours by, *"stopping and thinking about it".* She communicated her need for *'time out',* with a hand signal when she felt unable to communicate with words, to give her time to reflect before she returned to the staff member.

Jessica and Joan both spoke about how they had learnt their strategies on a 1-1 basis with another person outside of GBST. It appears that through additional 1-1 support Joan and Jessica were able to transfer and combine the skills learnt in GBST into meaningful actions for them. This reflects one of the five functions of DBT, discussed in Chapter One, of the generalisation of skills. Delivering single modules of the programme of DBT, as highlighted by Linehan (1993), may limit generalisation of skills.

The themes, reflected a process that participants went through when joining and attending, or not attending GBST. This process can be seen to reflect the stages of change (Prochaska & Norcross, 2001). Gemma and Emily could be seen to be within the pre-contemplative stage. Contemplation is the next stage, which is marked by ambivalence. This may be reflected within the theme, ***'what's the point it's not worth it'***, where there appears to be a weighing up of the costs and benefits of engaging. For Jessica and Joan, they appear to be trying out new ways of being illustrating the phase of action (Prochaska & Norcross, 2001). This process can also be seen to reflect Kolb's four stage experiential learning model. Initially, beginning with concrete experience, for example attending the group or using a concrete strategy, such as a shopping list. Indeed, retention of learning has been shown to be more effective when individuals participate in exercises or learn by doing with a 'coach' (Lalley & Miller, 2007).

Linking findings to psychological theory

As illustrated in *Figure 4*, themes within this research appeared to follow a narrative or pattern which was cyclical. The interconnected nature of the themes can be understood in relation to psychological theories. The theme; '*I need you for safety but I fear you'* aligns with attachment theory reflecting both deactivating and activating strategies. Disorganised attachment has been understood as a combination of Type A avoidant and Type C ambivalent-resistant and reflects a behavioural breakdown instead of a coherent strategy. For these findings the variation of strategies is consistent with the Dynamic-Maturational Model of Attachment (Crittenden, 2006), shown in Figure 5.

Figure 5: Diagram of the Dynamic-Maturational Model of Attachment (Crittenden, 2006).

Rather than a disorganised pattern, Crittenden instead proposed that infants were displaying an organised combination of avoidant and resistant attachment strategies. Individuals using a Type A strategy organise around expected outcomes whilst minimising awareness of feelings. Disorders of inhibition and compulsion are tied to too great a reliance on cognitive information. Individuals using Type C strategy lack confidence in what will happen next and focus on feelings as guides to behaviour. This reflects participants' accounts, as there appeared to be an awareness that certain behaviours would either bring others within closer proximity or push others away. Examples reflect a range of attachment strategies. Grace attempts to become self-reliant with self-harm being a means of emotional regulation. This could be seen to represent an A6 attachment strategy, whereby individuals do not trust others to be predictable. They protect themselves by relying on no one other than themselves (Crittenden, 2006). This links to the psychodynamic perspective that self-harm is a means of 'holding oneself together' and as a means of sticking concretely to an object (Ogden, 2004). This is reflected within Grace's account, whereby she is aware that she has something to self-harm with in her room should she need it and that she does not care what others do as she can take care of her own self-harm. Alternatively, self-harm and impulsive acts served as means to seek revenge for perceived attacks on the self. The example of self-harm given by Emily reflects this and can be seen as a C7 attachment strategy, which is a willingness to attack anyone combined with fear of everyone. At an extreme this pattern becomes delusional with delusions of revenge or paranoia of enemies. Self-harm and impulsive behaviours, such as aggression and absconding complement the attachment literature but

highlight a requirement to better understand complex attachment patterns with individuals who have had to develop various strategies given their challenging environmental histories.

When participant narratives reflected a sense of feeling unsafe and a need for another, this process was reflected in the themes, *'Chaotic search for someone safe', 'Testing: can you contain and hold me?', 'You don't respond to my words but you do respond to my actions'*. These findings complement psychoanalytic understandings regarding the antisocial tendency (Winnicott, 1964). Winnicott proposes that the antisocial tendency develops in an infant who experienced a good enough environment at the time of absolute dependence but that was subsequently lost. The antisocial tendency stems from early deprivation and reflects the hopeful search for the good enough environment that once existed (Abram, 2007). This understanding is reflected within the subtheme, *'Chaotic search for someone safe'* whereby participant narratives reflected the hopeful search for family outside of the hospital and with staff members within the hospital. This search also reflects an unconscious communication for the 'lost boundary' and an environment that will say 'no' but in a way that is not punitive. This can be seen within accounts whereby participants appear to be trying to find the balance between being contained or thought of without being punished. Winnicott proposed that if the environment consistently fails the child then the individual will lose touch with the original deprivation and the antisocial way will become a means of keeping psychic pain at bay (Abram, 2007). The master theme, *'I'm going round in circles and keep making the same mistakes'* reflects this theoretical perspective as participants were aware that they kept repeating the same behaviours but were not getting what they needed however they struggled to articulate what this was.

Participants past and present experiences appeared to be minimised or distorted, which can be understood by cognitive theory, in particular cognitive bias whereby individuals create their own 'subjective social reality'. As discussed previously research supported propositions about cognitive rigidity and polarized thinking (Linehan et al., 2015). Indeed, the findings within this research linked to theoretical understandings of cognitive distortions (Beck, 1967). Cognitive bias appeared to mediate responses from participants in this study in particular biases towards hostility, as reflected in the master theme, *'Living in a hostile world'*. For example, Gemma assumes that staff would punish her for her attack on a member of staff, reflecting her attempt to 'mind read' the potential thoughts and intentions of others. Whilst there may be some truth to this belief she does not consider alternative potential responses by staff members.

The self develops from interactions and experiences with the world. Connecting with the self without another to provide safety and containment can lead to a difficulty in developing a

coherent sense of self (Abram, 2007). The findings from this research indicated that self-harm and impulsivity were means of either feeling alive and connected with the self or deadening their connection with themselves and others. This can be understood in relation to the concepts of true self and false self (Abram, 2007). Examples of the experience of being connected with the true self, as Emily describes, *"being who I am",* reflected spontaneity and an authentic experience. Joan and Emily gave examples whereby they did what they wanted despite others demands or intrusions. The alternative to this was the experience of the false self, lacking in spontaneity and feeling dead and empty inside. Jessica appeared to reflect this, complying with the rules but feeling hopeless and disconnected, *"there's nothing I can do about the situation"*. The findings from this research complement psychodynamic, social, cognitive and behavioural understandings of self-harm and impulsivity. Self-harm and impulsivity have been understood from these different perspectives but by exploring the experience of self-harm and impulsivity this research has highlighted a need to integrate dissected understandings into the process of self-harm and impulsive acts to understand the complex nature of behaviour and how this can differ between individuals and across time. A recognition of the reciprocity of relationships, the cultural and organisational structure in relation to self-harm and impulsivity, is needed within forensic settings to redress the power imbalance and support the empowerment of women to find ways out of their difficulties.

Considering the differences in a forensic setting

As discussed earlier, the social perspective agrees that self-harm is in response to earlier life events but highlights the role of the current context. Relational phenomena differ within a forensic setting compared with interactions with friends and family members within the community or within in-patient settings, where friends and family may live more closely. There are a limited number of low secure forensic hospitals compared with inpatient hospitals so patients may live further away from family and friends. For women in forensic settings, the majority of interactions occur with staff members and women with similar difficulties to themselves, limiting the range of different forms of relationship. Given that women receive often indeterminate sentences the staff or organisation hold power over many decisions, such as moving on to rehabilitation or release which depends on the interpretation of the patient's behaviour. Participants spoke of their self-harm and impulsivity in relation to being within a forensic setting, for example Jessica stated, *"My liberty has been taken away"* in relation to absconding. The following quote by Emily illustrates her attempt to make sense of inequality and human rights within the hospital with a belief that she is less likely to be *"heard"*,

"I'll give you an example, in this hospital they've got a zero tolerance group for racism. Now you can understand a lot of people being a little bit racist cause a lot of doctors are black and they can't get what they want from the doctor so you can't really, you've got to really tolerate them [patients] being racist, you can't really not tolerate them cause at the end of the day if it were you and you wanted something but the only problem is that you work you're more likely to get heard than an unemployed person is. They say that there's equal rights in the human rights but there's not cause the human rights act is not actually an act it's just something that is heard of. It's not an actual act it's the equal opportunities act that is an act".

The power imbalance experienced by participants was also reflected in the theme '*blackmail: pretending to comply'* whereby participants felt coerced into attending GBST. Some participants experienced fear and humiliation in relation to others in the group, as reflected in the theme, *'scared and humiliated separating from the group'.* From a social perspective, these experiences can also be understood in relation to social identity theory (Tajfel, 1979), which is concerned with person's sense of who they are based on their group membership. The in-group will discriminate against the out-group, thus enhancing self-image. Emily describes both patients and staff as them and you, she does not appear to experience a sense of belonging to a group. Participants rarely spoke of other patients in relation to self-harm and impulsivity, if they did this was in a derogatory or frustrated manner. From a psychodynamic perspective this could be understood as a defence against identifying with others (Baumeister, Dale & Sommer, 1998). If participants did identify with others this may have contributed to a recognition of parts of the self and behaviours that may have been too painful for participants to experience. Without a feeling of belonging within the forensic hospital, impulsive acts reflected an attempt to find a sense of belonging back with their family or friends. In participants experiences they found that their family let them down, did not welcome them or that their homes were not there anymore. Again this reflects a difference between forensic and outpatient settings. Women are detained within forensic settings due to the perceived risk they pose to themselves or others. This risk means that women in forensic settings experience greater degrees of external control than women within the community, within this study that was reflected in the control of cigarette time. The Ashworth enquiry made reference to the treatment of women as excessively restricted and infantilized (HMSO, 1992). Poiter (1993) cited the 'power game' and suppression which resulted in women attempting to regain power through self-harm. Indeed, within forensic settings feelings of anxiety, anger, guilt and powerlessness may increase rather than decrease (Milligan, Waller & Andrews, 2002). For some women this may be exasperated by lack of contact with their children (Houck & Loper, 2002). Quite often women are detained for an

indeterminate period of time, which means that their "world" outside of the forensic setting changes or opportunities for change in patients' relationships within the family are limited. When participants experienced this change or re-experienced abandonment or rejection the response was further impulsive acts and self-harm. Connecting with attachment theory, the attachment behaviour adopted may still be a functional strategy to adopt, given the environmental context around the individual. Indeed, participant quotes either reflected a dilemma between a wish to leave or stay within the forensic setting as it was a place they were cared for. As previously discussed, a forensic setting has a paradoxical role of care and containment or punishment. Participants spoke of having their liberty taken away from them and being unable to express themselves in particular ways. For Jessica, absconding occurred when she felt powerless to do anything about her situation. For Gemma and Jessica, self-harm was used to prevent anger being expressed towards others whilst simultaneously expressing anger towards others. Although the forensic setting and programmes offered attempt to expand the repertoire of behaviours, it may inadvertently restrict them therefore increasing the reliance upon behaviours such as self-harm when other means of *"release"* are not available. Joan and Grace reflected in the changes they were experiencing and appeared to relate this to consistent and trusting relationships with others. This can be understood in relation to the 'common factors' within therapy. Rosenzweig (1936) proposed that some implicit common factors, such as the therapeutic relationship, are perhaps more important than the methods used. Feedback from the women within this research appear to reflect both the struggle with and effect of relationships on self-harm and impulsivity and engagement within GBST.

Although steps were taken to reduce potential limitations, unpredictable events occurred where these limitations could not always be avoided.

Strengths and limitations

This study explored women's experiences of self-harm, impulsivity and GBST, within a forensic setting. This study has added to understandings and has further broadened the research base. This is the first study, to my knowledge, that has explored the experiences of GBST within a forensic setting. There are many strengths as well as limitations, to the current study, which are discussed below.

Sampling and recruitment

A major challenge of working with women who have experienced traumatic interpersonal experiences, is mistrust. A strength of this research was the time taken to build trust with participants and to empower them as much as possible during the recruitment stages. This was reflected in participant's ability to engage in the process.

To capture therapy within a real world setting, I chose to minimise the exclusion and inclusion criteria. This was reflected in the heterogeneous sample. I feel that this reflects the diversity and complexity of experiences within these settings. Core group themes were found across participants, demonstrating that interpersonal challenges are central for participants. Nevertheless, there was variability across participants, which may have reflected both individual differences in addition to participant's mental health and psychological orientation at the time of the interview. However, recruiting participants from the private secure hospital, may mean the experiences reflect the specific culture of private secure settings, as such generalisability may be limited.

Interviews

I did not attend the GBST to minimise my association with members of the GBST. It was hoped that by reducing my links with the system participants would feel more able to be open and honest. Four participants were interviewed without a staff member present. The interviews appeared to reflect this. Initial reservations and suspicions appeared to reduce over time.

Changes occurred in the service prior to the interviews, with many staff leaving their posts. This may have impacted upon participants' anxiety levels and reports of the GBST. For example, Grace commented on the facilitator leaving and her uncertainty regarding trust.

The length of interview varied between participants and was impacted by service 'rules', for example cigarette time was once an hour for five minutes, which meant participants often wanted to end the interview by 55 minutes. For two participants, staff joined the interview. This may have limited participants' ability to speak to me openly. However, this also enriched the data at times. For example, Joan was interviewed with the member of staff who she had a disagreement with the previous day. This brought the interpersonally challenging experiences into the room and opened up a conversation.

Although participants were given a copy of the interview schedule and were able to select which topic they wished to discuss first, information which related to my final research question had to be placed at the end of the interview. The limited reflections on the impact of GBST on self-harm and impulsivity may have been due to fatigue with the interview process. To minimise fatigue, breaks were offered. However, given that Emily was offered an additional interview, she still struggled to make links between the GBST and impulsivity.

Participants were provided with a range of interventions which may have impacted on their ability to separate out the effects of the different interventions. This was reflected in participant accounts of what they had found helpful, for example Jessica spoke about the list

she uses when she goes shopping. This was something that was recommended to her in a different intervention.

Difficulties in representing their experiences through language were considered. IPA assumes participants are able to access and interpret experiences, this ability varied amongst participants. Some participants struggled with using emotional language for their experiences, at times this required empathic statements from me in the interview, which may have affected the results. To compensate for these challenges, considerations were made of body language and gaps in experiences that were not spoken about. The use of IPA and the interpretation of language may have limited understanding of participant experiences.

Analysis

IPA supports interviewers to 'bracket off' assumptions in order to gain closer access to experience. IPA acknowledges that researchers bring their own experiences, beliefs and assumptions however being a Trainee Clinical Psychologist meant that I found it difficult not to empathise and formulate. I experienced the challenge of trying not to fit participant experiences into psychological models and theories. To minimise this I read very little about borderline personality disorder, impulsivity and self-harm prior to conducting the interviews. In addition, a number of quality checks were carried out.

Quality checks

As discussed in Chapter two, many quality checks were used throughout the study, allowing me to note when particular feelings and assumptions arose and consider whether these were affecting the interview process. Changes within the service meant that I had to complete the interviews more quickly than anticipated. The space for reflection between interviews was restricted. I recognise that my own personal experiences and perspective will have affected the analysis as per the double hermeneutic, (Smith, Jarman & Osborne, 1999). In particular, having personal involvement in judicial system in the past may have skewed my perspective, however, equally this may have helped me to be more compassionate and less judgemental. Qualitative research, in particular IPA, was a new approach for me. A researcher with different life experiences and who was more experienced in IPA, may have found different results. To strengthen the validity and reliability of the analysis, all themes were discussed with supervisors. In keeping with service user involvement, I visited participants once I had completed the group themes to check for validity of the findings. Participants were open in providing feedback and confirmed when themes did not apply to them, which was consistent with my findings. They reflected that the themes that did apply to them personally, made sense to them.

Extracts are provided in Chapter three to allow for transparency. I selected extracts provided both "good and appropriate illustrations for each theme" (Smith, Flowers & Larkin, 2009; p. 182) and attempted to reflect individual experiences, to represent the diversity in experience as well as convergence. I have also provided examples of parts of the analysis process in Appendix VIII, IX and X. In Chapter three, I have provided demographic and contextual information for each participant in order to situate the sample (Elliott et al., 1999) and ensure transparency.

Clinical implications

Current models of understanding self-harm appear dissected, addressing different elements of self-harm. An integrative model could be developed for forensic populations, which considers early traumatic experiences and fear of re-traumatisation in the present. Models which recognise the role of trauma may open up more compassionate dialogues and approaches. It is important to recognise the systemic cyclical pattern which occurs within secure settings by including both external reinforcers, such as punishment and internal reinforcers, such as avoidance of negative affect. By including external reinforcers both individuals and those who care for them can be supported to share responsibility, recognising relational maintaining factors. A model which frames these recognised patterns but also allows participants to identify their own unique triggers and maintaining factors can allow for idiosyncratic formulations.

Group based skills training

Clinical implications of these findings indicate the importance of enhancing feelings of safety within GBST for individuals within forensic settings. The paradoxical role of care and punishment within secure settings and past experiences of groups may have contributed to individuals seeing the group as authoritarian, for example like school. This combined with joining a group of individuals who have coped with challenges through aggression and hostility was shown to impact on group safety and cohesiveness. Forensic services which spend time and consider the importance of enhancing safety within the group may improve engagement and learning of skills. Participants spoke about 1-1 support which appeared to enhance the generalisation of skills. It appears this is an important adjunct to the group, perhaps by providing a safe base from which to explore (Bowlby, 1969). Only providing one mode of DBT may not be sufficient for this population.

Collaboration between individuals and secure services may be a challenge, as goals may not align, for example within this research some participants were fearful of moving back into

the community as their needs were not met there. It is possible that a longer period of time is spent to ensure shared goals are developed.

Participants spoke about feeling overwhelmed by the amount of information provided and its mode of delivery, for example through didactic talking. For this population, reducing the amount of information provided in words and increasing concrete or experiential exercises may enhance the understanding of skills.

Integrating Linehan based techniques within GBST may bring more flexibility and accurate mentalizing to foster more secure relationships within GBST. In addition, fostering mentalization may reduce self-harm behaviours as a communication of distress. Swenson & Choi-Kain (2015) discussed the overlap between MBT and DBT skills. They have highlighted the importance of recognising when mentalizing has gone 'off line' as failure to mentalize can impact interpersonal and emotional difficulties. The authors recognised that the beginners mind in DBT may be a helpful strategy to reinstate mentalizing. However, a focus on behaviourally orientated techniques may limit the exploration of mentalizing. Linehan (2015) recognises the need to adapt GBST for the population it is delivered to.

Future research

Self-harm was experienced as an impulsive act however this was not always the case. Different elements of impulsivity may be related to self-harm that is perceived as planned than when it is perceived as impulsive. From the research findings within this study, it appeared that urgency was associated with impulsive self-harm but when self-harm was planned there appeared to be an ability to persevere with the task. Self-harm that was planned appeared to be driven by retaliation for perceived abandonment or intrusion. Quantitative research could explore the differing functions of self-harm and the relationship to the different elements of impulsivity. This may inform interventions that can target different dimensions of impulsivity associated with self-harm.

Self-report measures of impulsivity categorise the constructs, however research exploring the meaning behind impulsive acts is important. Impulsive acts meant that they received care, despite some punishment. Weighing up of the pros and cons should be seen from the perspectives of participants.

Many of the participants in this study indicated that perceptions of the group and the system influenced attendance and engagement. Future qualitative research could explore participant's perceptions of the system, others in the group, group cohesiveness and sense of safety. This may contribute to programmes that are designed with consideration of the context around the individual.

Research should consider the complexity and heterogeneity of individuals within forensic settings. These differences amongst participants was reflected in the diversity of experiences reported. Mindfulness appeared to be experienced negatively for Emily, who had a co-morbid diagnosis of schizo-affective disorder. Exploration of the negative and potentially re-traumatising effects of mindfulness can be carried out to ensure that ethical interventions are offered. Participants found the skills taught were challenging to understand. Qualitative research could explore skills which are helpful or those skills which require adaption. Quantitative research may follow up these findings following adaptions to GBST within forensic settings, to assess associations and outcomes between particular skills in relation to targeted goals, such as reductions in self-harm.

Conclusion

This research explored how women detained in a low secure forensic setting made sense of self-harm and impulsivity. Experiences of the Group Based Skills component of Dialectical Behaviour Therapy was explored. Understandings of the relationship between these three phenomenon were enquired about. Qualitative methods had rarely been adopted to explore these areas. Using Interpretative Phenomenological Analysis, four master themes were identified relating to self-harm and impulsivity. Three master themes were generated relating to GBST. These themes contributed to the research questions outlined within this study. Participants made sense of self-harm and impulsivity by reflecting on experience over time, moving through their experiences in various contexts. Showing scars or demonstrating self-harm in a physical way was also used as a way of communicating experience. Central to participant experiences were relationships with others and with their own sense of self. Self-harm and impulsive acts were recognised as means to finding connection with or disconnection from others, alongside this, intolerable feelings could be managed. Participants showed awareness of being stuck in repeated patterns of behaviour, however, as past experiences could not be made sense of and appeared to unbearable to think of, that other ways of being did not or could not exist in their minds. Participants made sense of GBST, by thinking through the process of engaging. Fears arose about going into a group context and negative memories of school were recalled. Once in the group, participants experienced a process considering if the group was worth engaging in. Participants struggled to understand the materials taught, reminding some of earlier experiences of academic challenges or found skills to emotionally challenging. In response to these barriers, some participants attended sporadically, another participant chose to learn on a 1-1 basis. One participant became more comfortable in the group over time and one participant was asked to leave due to her responses towards others. The findings of this study highlights the

complexity and variety in idiosyncratic experiences and qualitative methods are essential to ensure this is recognised and attended to, to develop targeted interventions for this population. Further research needs to be conducted to expand on these findings to develop models of self-harm which consider the context and to provide information for the adaption of GBST with this population.

Final reflections

As previously highlighted, prior to interviewing participants, my view of impulsivity was that of spontaneity. I now feel that this is part of a larger picture. In the same way that participants presenting behaviours are part of a larger picture and make sense when this is taken into consideration. I hope that future research can empower women in forensic settings to help others to understand self-harm and impulsive acts from their own experiences, rather than from expert discourses.

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APPENDICIES

Appendix I: Search Strategy

Search terms

Group Based Skills Training	Self-harm	Impulsivity	Forensic
Group based skills training	Self-harm	Impulsivity	Forensic
Dialectical Behav*	Self-injury	Impul*	Offend*
Skills training	Parasuic*	Risk*	Secure
Mindful*	Self-mutilation		In-patient
Interpersonal effectiveness	Self-poison*		Prison
Emotion regulation	Cutting		Jail
Distress tolerance			

Sources of information

PsycINFO (1806-present)

Medline (1950-present)

EMBASE (1947-present)

AMED (1985-present)

CINAHL

Cochrane Library

Conference papers Index

Proquest dissertations and thesis

You tube

Exclusions: Non English Papers

Date range: 1806-Present

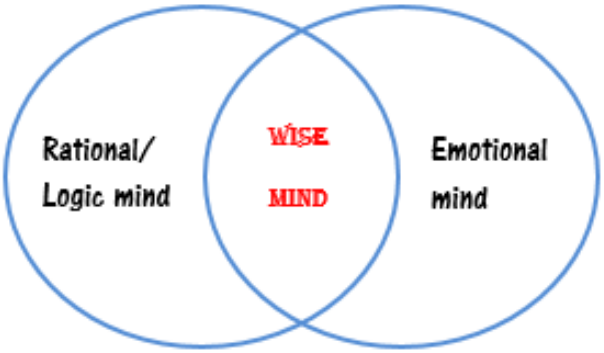
Appendix II: Poster

UNIVERSITY OF LEEDS

WHAT ARE YOUR EXPERIENCES OF Dialectical Behaviour Therapy (DBT) GROUPS?

My name is Anna Whalen and I am carrying out research on women's experiences of DBT groups as part of a Doctoral thesis

It is important for professionals designing treatments or interventions to hear what you think about them



I would like to meet you if you have attended DBT groups within the last 3 months and ask you to help me shape the research and then tell me about what your experiences have been like

If you would like to know more please speak to your advocate or I will be available to speak to on ....(Dates)Information sheets are available .....(where).....

Appendix III: Participant information sheet

Names, ages and places have either been removed or replaced

Participant information sheet

Introduction

You are being invited to take part in a study about your experiences of Dialectical Behaviour Therapy (DBT) group based skills training, with a focus on your thoughts about how this may or may not relate to self-harm and impulsivity. This project is being run by me, Anna Whalen, Trainee Clinical Psychologist, as part of my research degree at Leeds University. I will be supervised by staff at the University of Leeds Dr Amanda Harrison, Senior lecturer in Behavioral Neuroscience and Dr Carol Martin, Academic Director of the Doctorate in Clinical Psychology and Honorary Senior Lecturer in Clinical Psychology.

To carry out this research I would like to invite you to be co-researchers to ensure you feel part of the design of this study. I would like to invite you to participate if you have attended DBT group based skills training within the last 3 months.

What is the purpose of this study?

The purpose of this study is to explore your own individual experience of what it is like to attend group based skills training. Research is limited in this area and it is morally and ethically important for you to have a voice. Research so far shows that DBT can help to reduce self-harm. However, this is not the experience for everyone. By sharing your experience this may be the beginning of developing a better understanding. I will aim to publish the research so that others will have some insight into experiences of taking part. Initially this will be published as a thesis. The information you will provide may be used at a later date for an academic publication within journals.

What will happen if I decide to take part?

Before you decide to take part you will have the opportunity to ask me questions or speak to your advocate,…….. You will also have time to speak to staff at ……to ensure you feel supported if you decide to take part.

If you decide to take part I will be available in …….half a day a week on a Thursday afternoon for two weeks if you would like to speak to me. This allows you two weeks

to reflect and seek any support you feel you may need. I will then ask you to sign a consent form. You are under no obligation to take part and this will not affect your stay at…….. You can withdraw from the study up until data from our discussions have been anonymised.

Once we have signed the consent form I will invite everyone who is taking part to talk about what you feel is important when designing this study, for example what questions are important for me to ask you. All those who have chosen to take part will meet up as a group up to five times for one hour a week to shape the study and contribute your ideas. After this I would like to spend 1-2 hours with you individually to ask you about your experiences, using the questions that you have designed in the groups. Information we have spoken about in the individual meetings will be voice recorded and transcribed. All data will be anonymised. I will then read through our individual discussions and see if the topics we have discussed can be grouped together under themes. After I have done this I would like to visit you again to ask about your opinions of how I have done this. We will also talk about what information from the analysis and demographic information you are comfortable with me sharing in the research.

If at any point during our time together information is shared by you that indicates an increased risk of harm to yourself or others I will share this information with staff for your or others protection.

<u>Do I have to take part?</u>

No. It is your decision to take part in this study and this will not affect any part of your stay or decisions whilst at…….. Once I have given you this information sheet you have up to 2 weeks to decide if you wish to take part. You can withdraw from the study up until data from our discussions have been anonymised.

<u>Who will know about my taking part and what happens to the information?</u>

Others who have chosen to take part will be aware of your participation and staff at …….All those involved will be asked to keep all information discussed confidential. All voice recorded information will be recorded on an encrypted voice recorder and kept at the University and locked securely. Once transcribed and anonymised voice recordings will be erased and any transcribed data will be stored on the M drive of the University computer system, which is secure. All paper documents will be locked securely at the university. Data will be stored for up to

three years. I will use quotes from our discussions but I will ask you before I do this if I can use these. Quotes will be anonymised.

What if I feel distressed by taking part?

If you become distressed at any point staff at ……will offer support, in addition to us talking about this when I am available. You can ask to see me individually when I visit if you want to discuss this. When we design the research you may wish to identify people you can seek support from. You still have the option, up until the data is anonymised to withdraw from the study.

Possible risks and benefits of taking part

You could benefit from taking part as this will give you the opportunity to influence the design of the research. Contributing to the design of the research may support feelings of empowerment.

Being able to talk to someone who is independent of …….may have a therapeutic benefit. Providing feedback about the care you receive may help professionals understand what it is like from your perspective. As a result they may amend the Group Based Skills Training, if this is necessary. The risks for you may include increased distress when you share your experiences, although measures will be put in place to support you with this. These measures will include identifying staff members who you feel may support you if you become distressed. We can talk about this further when we meet.

Who has reviewed this study?

This study has been reviewed by the National Research Ethics Committee (NRES) and the School of Medicine Research Ethics Committee (SoMREC), who have both provided ethical approval.

How will the results of the study be provided?

We can discuss this when we meet. You may wish to receive a copy of the results verbally, in a report or receive a copy of the thesis. We will feedback a summary of the results to staff, so that they can improve or make changes to the DBT group based skills programme. Again we can discuss how you want to do this as a group, for example either as a presentation or report.

Can I get further information?

If you would like any further information before making a decision, please speak to Anna Whalen who will be available for half a day a week on a Thursday afternoon.

Alternatively, you can speak to your advocate, …….or……., Clinical Psychologist at ……

If for any reason you wish to make a complaint you can contact any of the following people:

Amanda Harrison (supervisor of researcher) and/or Carol Martin (supervisor of researcher) at Leeds University.

……..at …….

…….(your advocate) at ……..

Thank you

Appendix IV: Consent form

UNIVERSITY OF LEEDS

Participant Identification Number:

CONSENT FORM

Title of Project: Experiences of impulsivity and self-harm for women participating in DBT skills group: A qualitative enquiry in a secure setting

Name of Researcher: Anna Whalen

	Please initial box
1. I confirm that I have read the information sheet dated 30/10/2014 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw up until the data has been anonymised without giving any reason, without my medical care or legal rights being affected.	☐
3. I understand that the information collected about me will be used to support research in the future, and may be shared anonymously within publications and other researchers.	☐
4. I agree to interviews being audio recorded	☐
5. I understand that relevant sections of data collected during the study may be looked at by individuals from……..., from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐ ☐
6. I agree to take part in the above study.	

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix V: Interview schedule

Names, ages and places have either been removed or replaced

Interview schedule

Experiences of impulsivity, self-harm and DBT groups: A qualitative enquiry in a secure setting

1. How do you understand impulsivity?

Prompts:

- For example acting before thinking things through? Doing something without planning it out beforehand ? Acted on the spur of the moment?
- Have you ever acted "impulsively"? Can you tell me about it?
- Have others ever said to you that you have done things without thinking thing through the consequences first? Can you tell me about that?
- Do you know of other people who act impulsively or without thinking? Can you tell me about that?
- What word could we use for that? Would you like to use that word today to describe what you have been doing?

2. How do you understand self-harm?

Prompts

- Have you ever harmed yourself? Can you tell me about that?
- Have you ever hurt yourself physically in anyway? Can you tell me about that?
- Have other people ever talked to you about self-harm?
- Do you know of other people who self-harm, can you tell me about that?
- What word could we use for that? Would you like to use that word today to describe what you have been doing?

3. Can you tell me your story about how you came to be at **Removed** ?

Prompts:

- Before you came to **Removed** did you act "impulsively"? Example
- Before you came to **Removed** did you self-harm then? Example
- Did others think you experienced difficulties (problems/ needed extra support)?
- Did you have difficulties which led you to be here?

For examples explore:

- What happened before? Intentions? Thoughts? Images? Feelings? Physical Sensations? Others behaviour/ reactions?
- What happened during? Intentions? Thoughts? Images? Feelings? Physical sensations? Others behaviour/ reactions?
- What happened after? Intentions? Thoughts? Images? Feelings? Physical sensations? Others behaviour/ reactions?
    - Did *example* get you what you needed?
    - Did *example* help to stop something from happening?
    - If you couldn't do that what would have happened?

4. Do you think that self-harm is or was something that you did "impulsively"? Can you tell me about that?
    - Do you think impulsivity and self-harm go together for you?

5. What is it like to be in the DBT group?
    - How did you come to attend the group?
    - What impacts on your attendance? Staff, feelings, other service users?
    - What happens when you are there?
        - Staff running it, perception, relationship?
        - Others in the group?
        - Topics discussed?
        - Perceived intention or purpose of the DBT group?
        - Structure?

6. Has anything changed for you since attending the DBT groups?

    Prompts:
    - Has there been anything from the DBT groups that you think has helped? Can you tell me about that?
    - Has there been anything unhelpful from the DBT groups? Can you tell me about that?
    - Do you experience self-harm differently since attending the DBT groups?
    - Do you experience *impulsivity* differently since attending DBT groups?

- For examples explore:

What happened before? Intentions? Thoughts? Images? Feelings? Physical Sensations? Others behaviour/ reactions?

- What happened during? Intentions? Thoughts? Images? Feelings? Physical sensations? Others behaviour/ reactions?

- What happened after? Intentions? Thoughts? Images? Feelings? Physical sensations? Others behaviour/ reactions?

    - How did you get what you needed?
    - Were you able to stop "something" from happening?
    - What is different now?

<u>If answer is no to question 6</u>

You say you haven't experienced any changes in (impulsivity/self-harm), have you noticed any other changes since attending the DBT groups? Can you tell me about that?

If not, how do you feel about that? What do you think prevented DBT groups from making a difference? What do you think would have made a difference?

7. Is there anything I have missed that you feel is important for me to know?

Appendix VI: Ethical approval letter

NHS
Health Research Authority

National Research Ethics Service

NRES Committee North West - Greater Manchester East
3rd Floor
Barlow House
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7816
Fax: 0161 625 7299

09 December 2014

Miss Anna C Whalen
Trainee Clinical Psychologist
Leeds Teaching hospitals NHS trust
University of Leeds
Charles Thackrah Building
101 Clarendon Road
LS2 9LJ

Dear Miss Whalen

Study title:	**Experiences of impulsivity and self-harm for women in a forensic setting engaged in the group based skills component of Dialectical Behaviour Therapy.**
REC reference:	**14/NW/1349**
IRAS project ID:	**155447**

Thank you for your letter of 07 November 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Miss Rachel Heron, nrescommittee.northwest-gmeast@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.
Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

14/NW/1349	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Signed on behalf of Dr Francis Chan Chair

Email: nrescommittee.northwest-gmeast@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Clare Skinner, Leeds University

Appendix VII: Confidentiality agreement

Confidentiality Statement for Transcribers

Ethics Committee, School of Psychology, Leeds University

The British Psychological Society has published a set of guidelines on ethical principles for conducting research. One of these principles concerns maintaining the confidentiality of information obtained from participants during an investigation.

As a transcriber you have access to material obtained from research participants. In concordance with the BPS ethical guidelines, the Ethics Committee of the D.Clin.Psychol course requires that you sign this Confidentiality Statement for every project in which you act as transcriber.

General

1) I understand that the material I am transcribing is confidential.
2) The material transcribed will be discussed with no-one.
3) The identity of research participants will not be divulged.

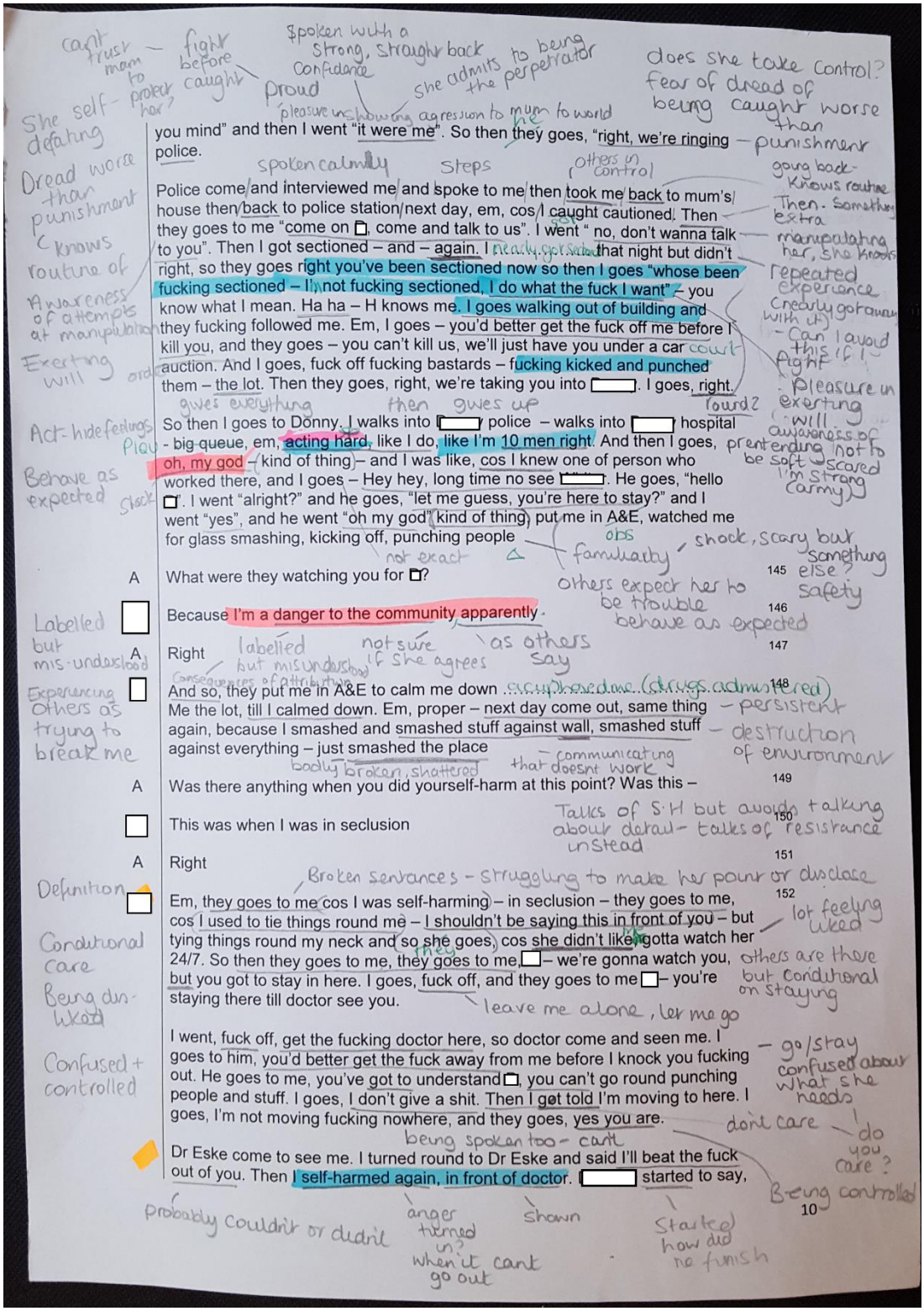
Transcription procedure

4) Transcription will be conducted in such a way that the confidentiality of the material is maintained.
5) I will ensure that audio-recordings cannot be overheard and that transcripts, or parts of transcripts, are not read by people without official right of access.
6) All materials relating to transcription will be returned to the researcher.

Signed.....**Date**.....
Print name.....
Researcher.....
Project title.....

Appendix VIII: Analysis of transcript

Names, ages and places have either been removed or replaced



you mind" and then I went "it were me". So then they goes, "right, we're ringing police.

Police come and interviewed me and spoke to me then took me back to mum's house then back to police station next day, em, cos I caught cautioned. Then they goes to me "come on [redacted], come and talk to us". I went " no, don't wanna talk to you". Then I got sectioned – and – again. I [redacted] that night but didn't right, so they goes right you've been sectioned now so then I goes "whose been fucking sectioned – I'm not fucking sectioned, I do what the fuck I want" – you know what I mean. Ha ha – H knows me. I goes walking out of building and they fucking followed me. Em, I goes – you'd better get the fuck off me before I kill you, and they goes – you can't kill us, we'll just have you under a car auction. And I goes, fuck off fucking bastards – fucking kicked and punched them – the lot. Then they goes, right, we're taking you into [redacted]. I goes, right.

So then I goes to Donny, I walks into [redacted] police – walks into [redacted] hospital - big queue, em, acting hard, like I do, like I'm 10 men right. And then I goes, oh, my god – kind of thing)– and I was like, cos I knew one of person who worked there, and I goes – Hey hey, long time no see [redacted]. He goes, "hello [redacted]". I went "alright?" and he goes, "let me guess, you're here to stay?" and I went "yes", and he went "oh my god" kind of thing, put me in A&E, watched me for glass smashing, kicking off, punching people

A What were they watching you for [redacted]?

Because I'm a danger to the community apparently.

A Right

And so, they put me in A&E to calm me down [redacted] Me the lot, till I calmed down. Em, proper – next day come out, same thing again, because I smashed and smashed stuff against wall, smashed stuff against everything – just smashed the place

A Was there anything when you did yourself-harm at this point? Was this –

This was when I was in seclusion

A Right

Em, they goes to me cos I was self-harming – in seclusion – they goes to me, cos I used to tie things round me – I shouldn't be saying this in front of you – but tying things round my neck and so she goes, cos she didn't like, gotta watch her 24/7. So then they goes to me, they goes to me, [redacted] – we're gonna watch you, but you got to stay in here. I goes, fuck off, and they goes to me [redacted] – you're staying there till doctor see you.

I went, fuck off, get the fucking doctor here, so doctor come and seen me. I goes to him, you'd better get the fuck away from me before I knock you fucking out. He goes to me, you've got to understand [redacted], you can't go round punching people and stuff. I goes, I don't give a shit. Then I got told I'm moving to here. I goes, I'm not moving fucking nowhere, and they goes, yes you are.

Dr Eske come to see me. I turned round to Dr Eske and said I'll beat the fuck out of you. Then I self-harmed again, in front of doctor. [redacted] started to say,

Appendix IX: Analysis process

Names, ages and places have either been removed or replaced

Appendix X: Analysis process

Names, ages and places have either been removed or replaced