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Solution-focused Therapy Groups for Borderline Personality Disorder: A Preliminary Study

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Doctorate in Clinical Psychology

The University of Edinburgh

August 2013

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CONTENT AND FORMAT

The Systematic Review (Chapter 1) and the Journal Article (Chapter 6) adhere to the author guidelines issued for the British Psychological Society (BPS) journal *Psychology and Psychotherapy: Theory, Research and Practice* (Appendix 1).

The remaining body of the thesis adheres to BPS guidelines, as recommended by the Doctorate in Clinical Psychology handbook, The University of Edinburgh.

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ABSTRACT

Objective: To investigate the effectiveness of an adjunctive, community-based, Solution-focused therapy (SFT) group for Borderline Personality Disorder (BPD) in terms of change in clinical symptoms and the subjective experiences of participants.

Methods: The study employed a mixed-methods, naturalistic, service-evaluation design in which 9 outpatients with Borderline Personality Disorder (BPD) attended 16-session SFT groups, and were assessed on clinically-relevant outcomes at baseline, 8 sessions and following group completion. Participants provided qualitative information about pre-intervention hopes and were interviewed post-group about their experience of the groups. Repeated-measures ANOVA was used to assess change in clinical symptoms during treatment, and *a priori* contrasts were conducted to explore significant results. Qualitative data was analysed inductively using semantic-level, thematic analysis as described by Braun and Clarke (2006).

Results: Improvements were indicated across all clinical outcomes with the most robust evidence of significant effects for: phobic anxiety; paranoid ideation; psychoticism; interpersonal functioning; and symptom severity. Qualitative analyses indicated that the intervention successfully addressed the hopes of the participants and that they valued: normalisation; acceptance and safety; the opportunity to share and work together; mutual support; an informal and non-directive atmosphere; and assistance with the pursuit of personally meaningful

goals. They reported noticing change, progress towards their goals, and a subjective sense that they were coping better and feeling better.

Conclusions: The study provides some preliminary evidence for the effectiveness of the intervention and it may represent a more easily-accessible, resource-efficient, less intensive alternative to specialised services. More general implications in relation to approaches to treatment for BPD are discussed.

Keywords: Borderline Personality Disorder, Solution-focused Therapy, Group psychotherapy, Community Mental Health.

CHAPTER 1

Systematic Review

The Current State of the Evidence-base for Solution-Focused Group

Psychotherapy

Abstract

Purpose: Reviews examining Solution-focused therapy (SFT) have combined modes of delivery. The review was conducted to establish the current state of the evidence, in terms of efficacy and effectiveness, for SFT-based groups for adults (18+).

Method: A systematic search of electronic databases identified 238 studies, of which 9 met the review criteria. Quality was systematically assessed using a checklist developed on the basis of guidance from: the Centre for Reviews and Dissemination (CRD), the NHS R&D Health Technology Assessment Programme (HTA, 2003), the Agency for Healthcare Research and Quality (AHRQ), the Cochrane Collaboration, and the Scottish Intercollegiate Guidelines Network (SIGN). Each study was assessed on internal validity, external validity and quality of reporting, and a narrative synthesis was conducted.

Results: Limited evidence suggests that SFT groups are an efficacious treatment for carers of Bipolar Disorder patients and chronic Hepatitis B patients. There is preliminary evidence for the effectiveness of SFT group interventions for: improvements in psychological health and return-to-work rates; improvement in attitudes towards recovery and increased “degree of control over the problem” for psychiatric patients; improvements in psychological symptoms in level 1 substance

abusers; and improvements in self-esteem and parenting in women affected by CSA and substance abuse.

Conclusions: Findings are based on single studies with small/modest samples.

Results are promising but require replication. Future studies should employ designs which increase internal validity and should: specify details of interventions; assess fidelity; use validated outcome measures; reduce selection-bias; recruit larger samples; and report power calculations.

Keywords: Solution-focused Therapy, Group Psychotherapy.

Systematic Review Background

Solution-focused therapy (SFT) emerged from the practice of family-based systemic psychotherapy at the Milwaukee Brief Family Therapy Centre during the 1980s. SFT is an inductively developed, strengths-based approach which focuses on creating a detailed vision of how things would be different in the absence of a problem, rather than on an analysis of the problem itself (Lipchik, 2002; de Shazer *et al.*, 2007; Sharry, 2007).

SFT is not a theory-based approach in the traditional sense, however, there has been open acknowledgment of the influence of other theorists and models on its development, such as Erickson's strategic therapy and brief problem-focused therapy developed at the Mental Research Institute (MRI) in Palo Alto, California. SFT may be considered as a progression of the MRI approach, which was based on a premise that problems are interactional and best solved by doing something different in relation to the problem (Metcalf, 1998). The focus of MRI brief therapy was on observable behavioural interaction in the present and on deliberate interventions to alter the ongoing system (Sharry, 2007; Walsh, 2010). The idea that problems exist within interactional systems means that small changes in a part of the system may have a significant impact on the system as a whole, and therefore changes at the individual level can alter systems in a profound way. The focus of MRI was on generating change as opposed to growth or insight (Walsh, 2010).

SFT and MRI were both strongly influenced by the strategic therapy of Milton Erickson who adopted a non-pathology model in which problems were a product of a limited repertoire of behaviours and attitudes towards the resolution of difficulties. Further characteristics of Erickson's approach included: the therapist facilitating the use of resources of which the client was unaware; facilitating the use of experiences that might contribute to resolution of the problem; an assumption that clients will continue to pursue desired changes outside therapy; an emphasis on the future, as opposed to on the past or present; and an attempt to optimise engagement by adapting to the hopes or desires of the client (O'Connell, 1998).

SFT is essentially a social constructionist approach underpinned by the epistemological position that meaning is created through social interaction and negotiation (O'Connell, 1998). In therapeutic terms constructionism emphasises the client's perceptions and experiences, rather than attempting to establish "facts". This creates opportunities within therapy for the exploration of meanings and a co-construction of reality and meaning between therapist and client (O'Connell, 1998).

SFT is a collaborative and non-pathological approach involving a reorientation from a focus on problems to a focus on solutions. There is a co-construction in the interaction between client and therapist of the client's goals and preferred future (Sharry, 2002).

Since its inception SFT has developed mainly as an individual or family-based psychotherapeutic approach with its application being reported with a variety of

populations across a range of settings. Reviews of the approach conducted to date, as well as two meta-analyses carried out by Corcoran and Pillai (2009) and Kim (2008), document its application to interventions for the following difficulties or populations: substance abuse; chronic schizophrenia; incarcerated prisoners; adult psychiatric patients; psychiatric inpatients; anger and aggression problems; behaviour problems; academic and emotional difficulties; physical abuse; bullying; somatoform disorders; children with incarcerated parents; adolescent mothers; perpetrators of domestic violence; depression; anxiety; self-harm; gambling; obesity; diabetes; truancy; obsessive-compulsive disorder; psychiatric symptoms; stress and coping; young offenders; adults on long-term sick leave; fatigue in Crohn's disease patients; older adults; children; families; and adults with a developmental delay (Corcoran & Pillai, 2009; Gingerich & Eisengart, 2000; Kim, 2008; MacDonald, 1997; Mac Donald, 2005; Miller, 1996). SFT is reported to have been adopted in the following areas or settings: prisons; social work; nursing; schools; child-protective services; foster care; private corporations; parenting groups; life coaching; public health; return-to-work programs; nursing homes; a mental health day centre; a suicide hotline; orthopaedic rehabilitation; mental health supervision; and family and marital therapy (Corcoran & Pillai, 2009; Gingerich & Eisengart, 2000; Kim, 2008; MacDonald, 1998; Miller, 1996).

Reviews of published evidence for SFT have acknowledged the challenge of synthesising a particularly heterogenous body of research, and have also highlighted that despite a continuing interest in the model, along with a growing

body of anecdotal reports of success and client satisfaction, empirical evidence for SFT effectiveness remains limited (Corcoran & Pillai, 2009; Gingerich & Eisengart, 2000; Kim, 2008;). Overall the reviews suggest preliminary support for the effectiveness of SFT across a wide range of populations and settings. The clinical efficacy of the approach remains to be established, and well-designed, controlled studies using validated quantitative outcome measures are sparse. The author of a recent meta-analysis suggests caution in terms of interpretation due to the limited number of studies available for inclusion, however, small but positive treatment effects favouring SFT are reported (Kim, 2008). Similarly a further meta-analytic review, also with a small set of included studies, reports improvement over an alternative condition in approximately 50 per cent of the reviewed research and suggests that the state of the current evidence is equivocal (Corcoran & Pillai, 2009). A recent review of the evidence-base for psychological interventions commissioned by the Australian Psychological Society concludes that there is level II evidence, characterised by the existence of at least one properly designed randomised controlled trial, for SFT in the treatment of depression and of substance abuse (Australian Psychological Society, 2010).

Proponents of SFT highlight the appeal of the collaborative, respectful elements and the emphasis on the non-expert role taken by the therapist (Kim, 2008; Sharry, 2007; Shilts & Thomas, 2005). For these reasons the SFT model may be particularly compatible with the ongoing drive towards person-centred health care in the UK (Sharry, 2007). The focus on maximising cost efficiency in health care, along with

policies such as increasing access to psychological therapies, may also have increased interest in SFT in light of evidence of similar outcomes with SFT as with more established models of therapy, and some evidence that clients may require to be seen for fewer sessions with SFT (DoH, 2005; DoH, 2012; Gingerich & Eisengart, 2000; Knekt *et al.*, 2008; Rothwell, 2005).

In the first published review of SFT research Gingerich & Eisengart (2000) suggested that SFT was "...moving from an "open trial" phase of investigation to an "efficacy" phase" (p. 495). There appears to have been some progression, with an increasing number of studies examining effectiveness and a small number that may be sufficiently rigorous as to assess efficacy. The need for further efficacy research is acknowledged, alongside a recognition that effectiveness research may be more clinically relevant in real-world settings. The need for further empirical research on the SFT model is highlighted frequently in the literature and the evidence-base appears to be continuing to expand.

Past reviews have tended to combine studies of SFT delivered in a range of modes including: individual-therapy; family therapy; couples therapy; and group therapy. There appear to be increasing numbers of published studies relating to SFT delivered in a group format and these frequently cite a number of publications guiding the application of solution-focused principles and techniques to group settings (LaFountain & Garner, 1996; Metcalf, 1998; Sharry, 2007). There is currently no review of the evidence base for group-based SFT specifically.

Systematic Review Methodology

Aims of the Review

The main aim of the review was to establish the current state of the evidence for both the efficacy and the effectiveness of group-based SFT delivered to adults (aged 18 and over). The distinction between efficacy and effectiveness is commonly made within the psychotherapy research literature. Efficacy studies are those that seek to maximise internal validity in order to isolate and evaluate the impact of an intervention whilst exercising strict controls over other conditions. Effectiveness studies are more concerned with whether or not an intervention works in a naturalistic clinical setting under the conditions in which it is likely to be administered. Effectiveness studies therefore maximise external validity affording generalisation to real clients in everyday clinical practice (Howard et al., 1996; Kazdin, 2003; Nathan et al., 2000).

There was an expectation at the outset of the review that relevant empirical studies would be limited, and therefore the purpose of the review was to synthesize the available literature to both assess the state of the existing evidence and to facilitate the effective planning of future research in this area.

Methodology

A systematic search strategy was employed to identify published studies relevant to the aims of the review. These were then evaluated using a set of quality criteria

developed to address the specific purpose of the review. The methods adopted and the reporting of the review were guided by the quality criteria for the assessment of systematic reviews produced by the Agency for Healthcare Research and Quality (AHRQ, 2002).

Search strategy

Initially the Cochrane Database of Reviews of Effects (DARE) was searched to ensure that a recent review had not been conducted in the same area. The search terms used were: 'solution-focus*', and 'solution-focus* group*'. These searches revealed no results. Checks on all the databases searched in this review confirmed that the hyphenation of 'solution-focus*' did not yield any different results from the non-hyphenated term 'solution focus*'.

Identical systematic searches were conducted of the following databases of published articles: CINAHL Plus (1937-2012); EMBASE (1974-2012); Medline (1865-2012); PsycINFO (1887-2012); and the Psychology and Behavioural Sciences Collection (1965-2012).

The search strategy for these databases was based on the PICOS method, as suggested by the Centre for Reviews and Dissemination (CRD, 2008). As the review question was not specific to any particular outcome(s), comparison(s), study design, or population, the sole focus of the search strategy was on the intervention. Due to the specificity of the review question in terms of intervention the search strategy was intentionally focused, and related terms were not included. Searches were

conducted within the domains of title, abstract and keywords for the following search string: 'solution-focus*' AND 'group*'. The search strategy used was simplistic, but was considered as viable in identifying relevant publications, in that a study in which a specific intervention was delivered would require that the nature of the intervention be specified within at least one of the searched domains. More general terms such as group psychotherapy or brief psychotherapy were not considered specific enough to address the particular aim of the review. Searches were limited to adult populations, aged 18 and over, however, it was found that this did not preclude a number of studies involving children being included in search results.

Initial searches resulted in a total of 238 articles which, following the removal of duplicates, left 126 potentially relevant studies. The titles and abstracts of these papers were screened for relevance and 106 studies were rejected at this stage due to clearly not meeting inclusion criteria. Inclusion and exclusion criteria for the review were predetermined and are detailed in Table 1. For the remaining 20 research papers they either appeared to meet criteria for inclusion or further clarification was necessary and full text was sought.

On obtaining the full texts their reference lists were hand searched and two further potentially relevant studies were identified. The full text for these two documents was also obtained. The full texts of the 22 papers were assessed according to the inclusion and exclusion criteria resulting in a total of 9 studies being included in the

review. The process of study selection is illustrated in Figure 1 and the reasons for exclusion of those studies that did not meet criteria are listed in Table 2.

Table 1 – Inclusion and Exclusion Criteria

Inclusion

- Paper evaluates the effect/effects of a therapeutic intervention
- The therapeutic intervention evaluated is clearly based on the principles of Solution-focused therapy
- Group therapy is the mode of delivery of the evaluated intervention
- Participants are adults, aged 18+
- Paper is published in English
- Papers is published in a peer-reviewed journal

Exclusion

- The paper evaluates a treatment programme, of which a Solution-focused group intervention is a component.
 - The evaluated intervention is based upon the principles and/or techniques of more than one model of therapy
 - The evaluated effects of the intervention are not based on any systematic strategy for data-gathering and analysis
 - The paper cites anecdotal evidence as the only form of outcome measurement
 - The paper evaluates a family-based intervention
 - The paper is a review (Critical Review, Systematic Review)
 - The paper is a thesis or dissertation
-

Figure 1 – Search and Study Selection Process

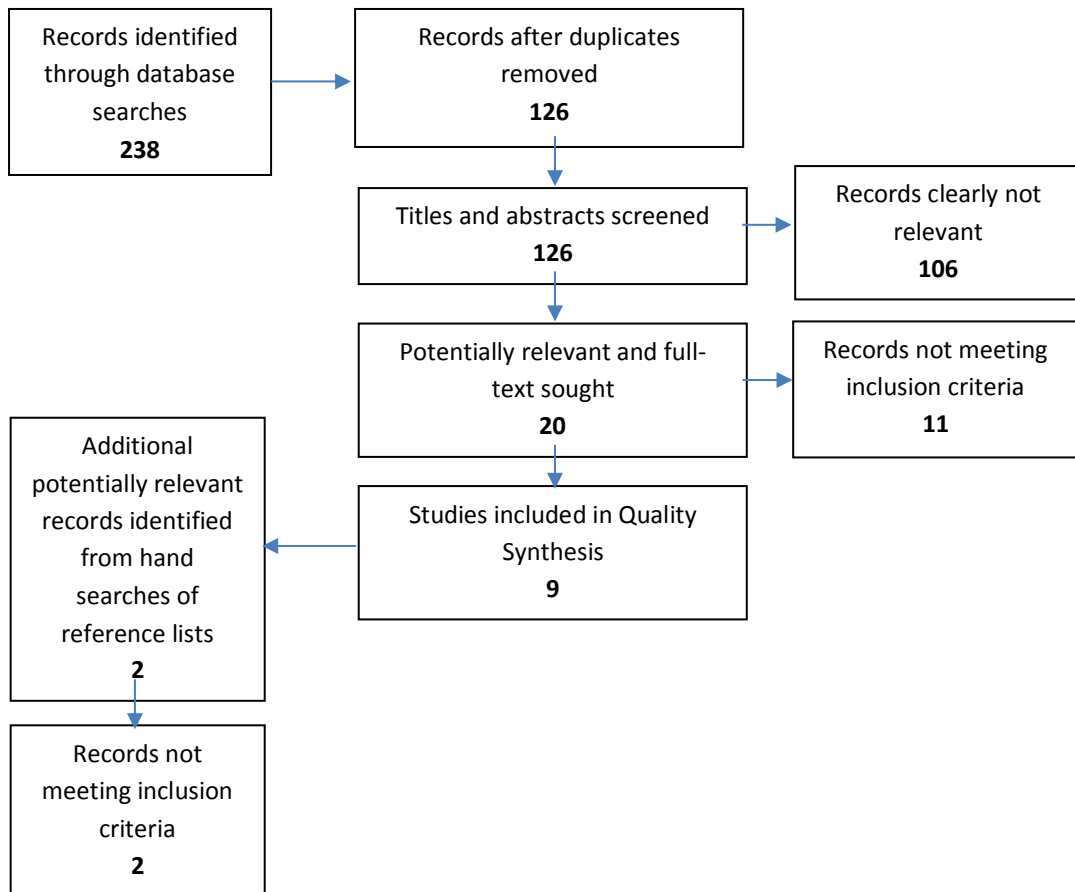


Table 2 – Reasons for exclusion for those papers procured, but not included in the review

Study author(s)	Reason for exclusion from review
Applewhite <i>et al.</i>, 2012	Not an intervention study
de Shazer & Isebaert, 2003	Interventions other than SFT were also administered
Froerer & Smock, 2009	Not an intervention study
Gray <i>et al.</i>, 2000	Not an intervention study
Johnson & Conyers, 2001	Outcomes assessed anecdotally
LaFountain & Garner, 1996	Non-adult participants only
Lange, 2001	Some cognitive behavioural therapy techniques delivered as part of the administered intervention
Linton <i>et al.</i>, 2005	Not an intervention study
McAllister <i>et al.</i>, 2009	Intervention administered included a specific educational component over and above the solution-focused group work
McCollum <i>et al.</i>, 2003	Not an intervention study
West, 2010	Not an intervention study

Development of Quality Rating System

Due to the stage of research in the area to be reviewed it was anticipated that the level of available evidence would be variable and likely to be predominantly from non-randomised studies. Guidelines and established quality checklists are less well developed for reviews which include uncontrolled, non-randomised study designs than for those which synthesise the results of RCTs. Even for those checklists used to assess the quality of RCTs there is no accepted 'gold standard' checklist and a high level of variation has been demonstrated in the quality criteria used in existing reviews (Deeks *et al.*, 2003). Many review studies identified have developed quality criteria, or modified existing quality assessment tools specifically to address their review question without clearly specifying their procedure or rationale (Deeks *et al.*, 2003). The intention in the current review was to develop an appropriate tool for the assessment of both controlled, randomised studies and uncontrolled, non-randomised studies, and to make this process and the resulting checklist as transparent as possible. Documentation from a number of organisations specialising in systematic review methods were consulted including: the Centre for Reviews and Dissemination (CRD), the NHS R&D Health Technology Assessment Programme (HTA), the Agency for Healthcare Research and Quality (AHRQ), the Cochrane Collaboration, and the Scottish Intercollegiate Guidelines Network (SIGN). The HTA's evaluation of existing quality assessment tools for non-randomised studies, which also identified a subset of the 'best' available tools, highlighted two existing checklists suitable for the assessment of both randomised and non-

randomised designs (Deeks *et al.*, 2003). These checklists, developed by Downs and Black (1998) and by Thomas and colleagues (2004) were also acquired for consultation. The strengths and weaknesses of these tools, as highlighted by the HTA, were considered in the development of the checklist for the present review (Deeks *et al.*, 2003).

As advocated by Cooper (1984) and later by Deeks *et al.* (2003) an attempt was made to incorporate labelling of the degree of presence of various objective aspects of research design with the consideration of the level of threat to validity. Cochrane Collaboration guidance advises that there is no empirical basis on which to allocate weights to different validity criteria. They also highlight, along with the AHRQ, the SIGN, and the CRD, that scoring individual criteria in order to generate an overall quality rating has been discouraged due to the unknown relationships between specific sources of bias and study outcomes (CRD, 2008; Higgins & Green, 2006; SIGN, 2011; West *et al.*, 2002). In addition many quality assessment measures include aspects related to the reporting of studies, which assess a qualitatively different aspect of research than those criteria assessing validity. An overall rating combining scores across these components may be misleading (SIGN, 2011).

An attempt has been made within the current review to make a distinction between the quality of the reporting and the quality of research conduct and concurrent effects on validity. Due to the distinction in the types of bias related to controlled, randomised versus uncontrolled, non-randomised studies, and the superiority of

RCTs in terms of preserving internal validity the aim was to generate separate evaluations of external and internal validity for each included study.

In generating the current checklist those aspects of studies reported in guidance documents as being relevant to study quality were assembled, along with those used in the checklists developed by Downs & Black (1998) and by Thomas *et al.* (2004). Duplicate items were removed, and the resulting list was divided into three categories: internal validity, external validity, and reporting. Research funding was not included as it was not relevant to any of the three categories. On the basis of available guidelines and checklists a detailed rating system was developed for each of the individually assessed criteria. This is detailed in Table 3.

A system was devised to categorise studies as poor, medium, or high quality in terms of internal validity, external validity, and reporting. Although weighting of criteria is not recommended the generated checklist is highly inclusive and certain aspects were considered more significant in maintaining internal validity, external validity or reporting quality than other factors. These more essential criteria were identified through careful perusal of the consulted guidelines, and particularly through the examination of the AHRQ's evaluation of instruments used to rate study quality (West *et al.*, 2002). The identification of 'essential' criteria formed an important component of the quality rating system used in this review which is included in Table 3. 'Essential' criteria are highlighted in bold in the quality assessment table (Table 4). The same rating system applies to overall quality,

internal validity quality, external validity quality, and the quality of reporting. This is a purely arbitrary system designed to assist in the review of the evidence as a whole.

Table 3 – Quality Rating System

Internal Validity	Randomisation	Random assignment to conditions	(-/●) ● - Random assignment to groups must be explicitly stated
		Method reported and appropriate	(-/●) ● - Method of randomisation must be both reported and be a method recognised by as truly random
		Concealed for duration of study	(-/●) ● - Concealment must be clearly stated
	Blinding	Blinding of researcher collecting outcome data	(-/●) ● - It must be clear from the report that a viable attempt was made for the researcher administering outcome data to be naïve to treatment allocation
	Confounding	Acknowledged/reported	<ul style="list-style-type: none"> ⊙ - some potential confounding factors are acknowledged/reported ● - a wide range of potential confounding factors are acknowledged/reported ◆ - potential confounding factors are explored, well-covered, and explicitly acknowledged as potentially confounding
		Adjusted for	<ul style="list-style-type: none"> ⊙ - some relevant confounding factors are adjusted for, but not others (not reported) ● - a range of potentially confounding factors identified are adjusted for ◆ - analyses clearly take into account a wide range of potential confounding factors. Adjustment is made statistically where possible, and alternatively as a statement of caution in interpreting the results statistical analyses
	Loss to follow-up	Reported	(-/●) ● - loss to follow-up must be explicitly stated within the text (not needing to be deducted from tables/figures)
		Adjusted for	(-/●) ● - it must be stated that adjustments were made for missing data, e.g. imputation
	Data Analysis	Reported intention-to-treat analysis	(-/●) ● - the use of an intention-to-treat analyses must be explicitly reported
		Appropriate statistical test(s)	(-/●) ● - statistical tests must be clearly described and appropriate to both the study design and characteristics of the sample
		Follow-up period(s) reported and justified	<ul style="list-style-type: none"> ⊙ - follow-up period(s) reported, but not justified ● - follow-up period(s) adequately reported with some justification, or justification is clear on the basis of study design/aims ◆ - Follow-up period(s) clearly reported and fully justified with a clear literature-based rationale
		A priori and post hoc analyses reported	<ul style="list-style-type: none"> ⊙ - some acknowledgement of a distinction between a priori and post hoc analyses ● - clear distinction between a priori and post hoc analyses within reporting of results ◆ - clear reporting of a priori analyses related to study aims in introduction/method, and distinction between a priori and post hoc analyses in results/discussion

External Validity	Representativeness /generalisability	Description of study population	<ul style="list-style-type: none"> ⊙ - reporting of some aspect(s) of study population ● - clear reporting of the relevant characteristics of the study population, but some details that would be necessary for replication are omitted ◆ - clear reporting of characteristics of the study population, such that replication would be possible
		Recruitment method specified	<ul style="list-style-type: none"> ⊙ - reporting of some aspect(s) of recruitment process ● - clear reporting of the recruitment process, but some details that would be necessary for replication are omitted ◆ - clear reporting of the recruitment process, such that replication would be possible
		Recruitment method appropriate	(- / ●) ● - recruitment method clearly limits selection bias
		Inclusion/exclusion criteria	(- / ●) ● - criteria are explicitly stated
	Power	Justification of sample size	<ul style="list-style-type: none"> ⊙ - indirect justification through reporting of numbers who declined to participate or withdrew ● - some explicit justification of sample size ◆ - explicit justification of sample size based on relevant statistics
		Power calculation	(- / ●) ● - power calculation explicitly reported
Reporting	Background and aims	Reporting of scientific background and rationale	<ul style="list-style-type: none"> ⊙ - Some scientific background is reported that fails to sufficiently place the study in context or fails to clearly describe the rationale for the study ● - the scientific background is sufficiently covered to set a clear context for the study and its rationale ◆ - the scientific background is well covered with clear and explicit links to the rationale for the research, which is also explicitly presented
		Clear statement of aims/objectives	<ul style="list-style-type: none"> ⊙ - aims alluded to prior to method section ● - at least one aim is clearly and explicitly identified prior to method section ◆ - all aims and research questions clearly specified prior to method section
		Statement of hypotheses	(- / ●) ● - hypotheses clearly specified
	Interventions	Clear specification	<ul style="list-style-type: none"> ⊙ - references to existing literature on which intervention is based without full specification of intervention applied ● - Clear specification of elements of intervention used which are related to relevant references, but some details that would be necessary for replication are omitted ◆ - Clear specification of elements of intervention used which are related to relevant references and which would allow for replication of the intervention

		Consistency/fidelity	<ul style="list-style-type: none"> ⊙ - some attempt made to ensure fidelity and consistency of intervention, but the method used is unlikely to be reliable ● - attempt made to ensure consistency and fidelity of intervention, using a viable method and/or standardised measure ◆ - substantive attempts made to ensure consistency and fidelity of intervention, using viable methods and/or standardised measures
	Outcomes	Clear specification and description	<ul style="list-style-type: none"> ⊙ - some description of the outcomes measures, but full details are not reported ● - methods of outcome measurement are specified and are either referenced, standardised measures or are clearly described ◆ - methods of outcome measurement are specified and are either referenced, standardised measures or are clearly described with a clear justification and acknowledgement of the limitations. Non-standardised measures are reported in full such that replication would be possible.
		Measures standardised/valid/reliable	(-/●) ● - measures used are standardised and their validity and reliability has been investigated.
	Interpretation	Conclusions supported by results	<ul style="list-style-type: none"> ⊙ - at least the main conclusion of the study can be related to the reported results, although the link between the conclusion(s) and relevant results may not be clearly stated. ● - at least the main conclusion of the study can be related to the reported results, and the relevant link is clearly stated. ◆ - all reported conclusions are clearly stated and explicitly linked to the relevant reported results.
		Limitations considered	<ul style="list-style-type: none"> ⊙ - limitations are alluded to, but not clearly stated or some limitations are stated, but a major limitation has not been acknowledged. ● - most limitations, including all significant limitations, have been acknowledged. ◆ - all relevant limitations, with regard to those identified within the remit of this review, have been clearly acknowledged.
		Reporting of applications/implications	<ul style="list-style-type: none"> ⊙ - Some application or implication is implied. ● - some plausible application or implication is explicitly stated. ◆ - relevant applications/implications are explicitly stated and well covered.
	Quality Rating		

Table 4 – Quality Assessments of Included Studies

			Quick & Gizzo, 2007	Madigan <i>et al.</i> , 2012	Smock <i>et al.</i> , 2008	Proudlock & Wellman, 2011	Zimmerman <i>et al.</i> , 1997
Internal Validity	Randomisation	Random assignment to conditions	-	◆	●	-	-
		Method reported and appropriate	-	◆	-	-	-
		Concealed for duration of study	-	◆	-	-	-
	Blinding	Blinding of researcher collecting outcome data	⊙	●	-	-	-
		Acknowledged/reported	⊙	⊙	⊙	-	●
	Confounding	Adjusted for	-	-	⊙	-	●
		Reported	-	-	◆	●	-
	Loss to follow-up	Adjusted for	-	-	-	-	-
		Reported	-	-	-	-	-
	Data Analysis	Reported intention-to-treat analysis	-	-	-	-	-
		Appropriate statistical test(s)	●	●	●	●	●
		Follow-up periods reported and justified	-	⊙	⊙	-	⊙
A priori and post hoc analyses reported		⊙	-	-	-	-	
External Validity	Representativeness /generalisability	Description of study population	●	●	●	●	●
		Recruitment method specified	⊙	●	●	⊙	●
		Recruitment method limits selection bias	●	-	●	-	-
		Inclusion/exclusion criteria	-	●	●	●	-
	Power	Justification of sample size	-	⊙	-	⊙	-
Power calculation		-	-	-	-	-	
Reporting	Background and aims	Reporting of scientific background and rationale	●	⊙	◆	●	●
		Clear statement of aims/objectives	●	●	●	●	●
		Statement of hypotheses	●	-	-	-	-
	Interventions	Clear specification	●	⊙	●	●	◆
		Consistency/fidelity	-	-	◆	⊙	-
	Outcomes	Clear specification and description	●	●	◆	●	●
		Measures standardised/valid/reliable	⊙	◆	◆	●	●
	Interpretation	Conclusions supported by results	●	●	◆	⊙	●
		Limitations considered	●	●	●	●	⊙
		Reporting of applications/implications	⊙	⊙	◆	●	⊙
Quality Ratings	Internal Validity		Poor	Medium	Poor	Poor	Poor
	External Validity		Medium	Medium	Medium	Poor	Poor
	Reporting		High	Medium	High	Medium	Medium
	Overall		Medium	Medium	Medium	Poor	Poor

- Not covered/not reported/unclear , ⊙ Poorly or partially addressed, ● Adequately addressed, ◆ Well covered

Table 4 – Quality Assessments of Included Studies

			Arvand <i>et al.</i> , 2012	Thorslund, 2007	Hiebert-Murphy & Richert, 2000	Aambo, 1997
Internal Validity	Randomisation	Random assignment to conditions	●	●	-	-
		Method reported and appropriate	-	-	-	-
		Concealed for duration of study	-	-	-	-
	Blinding	Blinding of researcher collecting outcome data	-	-	-	-
	Confounding	Acknowledged/reported	●	⊙	●	-
		Adjusted for	●	-	-	-
	Loss to follow-up	Reported	-	-	●	-
		Adjusted for	-	-	-	-
	Data Analysis	Reported intention-to-treat analysis	-	⊙	-	-
		Appropriate statistical test(s)	●	●	-	-
		Follow-up periods reported and justified	●	●	●	-
		A priori and post hoc analyses reported	-	-	-	-
External Validity	Representativeness /generalisability	Description of study population	◆	●	●	⊙
		Recruitment method specified	⊙	●	●	⊙
		Recruitment method limits selection bias	●	-	●	-
		Inclusion/exclusion criteria	●	●	-	-
	Power	Justification of sample size	-	-	⊙	-
		Power calculation	-	-	-	-
Reporting	Background and aims	Reporting of scientific background and rationale	●	●	●	⊙
		Clear statement of aims/objectives	●	●	●	⊙
		Statement of hypotheses	-	-	-	-
	Interventions	Clear specification	⊙	●	●	⊙
		Consistency/fidelity	-	⊙	-	-
	Outcomes	Clear specification and description	●	●	●	-
		Measures standardised/valid/reliable	●	●	●	-
	Interpretation	Conclusions supported by results	⊙	●	●	-
		Limitations considered	●	⊙	●	-
Reporting of applications/implications		●	●	●	⊙	
Quality Ratings	Internal Validity		Medium	Poor	Poor	Poor
	External Validity		Medium	Medium	Medium	Poor
	Reporting		Medium	Medium	High	Poor
	Overall		Medium	Poor	Medium	Poor

- Not covered/not reported/unclear , ⊙ Poorly or partially addressed, ● Adequately addressed, ◆ Well covered

Quality synthesis

Following the literature search, and the application of inclusion and exclusion criteria, nine studies were included in this review. They were checked against the 28 quality criteria, of which 12 related to internal validity, 6 to external validity, and 10 to reporting. As described previously each study was rated as being of 'poor', 'medium' or 'high' quality on each of these three domains, as well as being given an overall quality rating of 'poor', 'medium', or 'high'. Due to the anticipation that RCTs would be unlikely to have been carried out in the research area thus far, only those studies rated as 'poor' for internal and external validity as well as 'poor' overall were excluded from the synthesis. This was to prevent studies with particularly low ratings on the internal validity domain being excluded due to the impact of this on the overall rating. As recommended by SIGN (2011), the outcomes of quality assessments on the eight reviewed studies are summarised in Table 4.

Two studies were excluded from the synthesis on the basis of quality ratings (Aambo, 1997; Zimmerman *et al.*, 1997). One study (Zimmerman *et al.*, 1997) was assessed as having both poor external and internal validity, with the main concern in terms of external validity relating to the recruitment method and the potential for selection bias. The experimental group self-selected by responding to a newspaper advertisement for a couple's therapy group for relationship improvement, whilst the control group also self-selected through a different advertisement at two specific sites (university married housing and a child-care centre). The control group were

incentivised to participate and it is unclear whether or not they were required to have relationship concerns at baseline, with no inclusion or exclusion criteria being reported. The remaining excluded study (Aambo, 1997) was rated poorly on all domains, and did not adequately address any of the 28 checklist criteria.

The results of the seven remaining studies are presented below, in the context of their assessed quality, and conclusions are based on their findings. Subgroup analyses based on quality assessment outcomes is an approach suggested by SIGN (SIGN, 2011).

The included studies encompass results from 274 experimental participants involved in SFT groups. For the Madigan *et al.* (2012) study the number of carers who received the SFT group intervention is reported and these participants are included within the aforementioned number of experimental participants. Madigan *et al.* also report indirect improvements in quality of life for those clients with bipolar disorder associated with the carers involved in the intervention, however, the number of associated participants with bipolar disorder that were involved is not reported and therefore cannot be included in the overall number of participants calculated for the present review. The reviewed research is international with studies conducted across Europe as well as in the USA, Canada, and Iran. Three out of the eight studies were carried out in the USA which may reflect the inception of the SFT approach there. The populations included in the research are highly diverse, with

no two studies examining the same population group. The most represented general population is that in which the primary concern relates specifically to mental health, accounting for five out of the eight studies. These studies focus predominantly on groups of mental health patients who would generally be considered to have more severe problems: histories of child sexual abuse (CSA); substance abuse ; and severe and enduring mental health difficulties (Hiebert-Murphy & Richert, 2000; Proudlock & Wellman, 2011; Smock *et al.*, 2008; Quick & Gizzo, 2007). One of the studies focuses on a population defined by a specific physical health diagnosis, chronic Hepatitis B (Arvand *et al.*, 2012), one on carers of patients with Bipolar Affective Disorder (Madigan *et al.*, 2012), and the remaining study involves people absent from work on long-term sick leave (Thorslund, 2007). All but one study included some form of empirically validated outcome measure, with two also systematically collecting qualitative feedback. The outcomes measured across studies varied considerably in line with the heterogeneity of the populations studied and the related purposes of the interventions. The relevant details of the reviewed studies, including their outcome measures, are described in Table 5.

Table 5 – Characteristics of Studies Included in the Quality Synthesis

Study (country)	Target population/ Target of intervention	Participants	Recruitment Method	Mean age at baseline (yrs)	Study design	Length of intervention	Sessions attended	Quantitative Outcome measures	Qualitative Outcome measures (if applicable)	Follow-up period	Key findings
Quick & Gizzo, 2007 (USA)	Psychiatric outpatients, variety of presenting problems	n = 108 78.7% female	Clinical	48.04	Service evaluation	5 weekly sessions	1 session – 30.6% 5 sessions – 28.7% >2 sessions – 69.4%	Self-rated 'control of the problem' using Solution-focused scaling questions	Subjective comments at start and end of group sessions	Not specified	Increase in participants' sense of control Identification of participants' subjective 'ingredients for change'
Madigan <i>et al.</i> , 2012 (Ireland)	Carers of patients with Bipolar Disorder	Carers n = 19 53% female (TAU = 10)	Media/ Clinical	(carers) 52 (patients) 42	RCT	5 weekly sessions	Not specified	WHO QOL Bref GAF KOIQ IEQ GHQ12		Post-group, 1 year and 2 years	Similar to a MFGP intervention, carers showed significantly improved knowledge and reduced overall burden and psychological distress at both follow ups, and quality of life was improved for patients. Such gains were not evident for the TAU comparison group
Smock <i>et al.</i> , 2008 (USA)	Clients referred for substance abuse treatment	n = 38 21% female	Clinical	31	RCT Or naturalistic controlled and random assignment	6 weekly sessions	6	BDI SASSI OQ-45.2 Questions evaluating social cost measures		Post-six group sessions attended	Both clients in TAU and SFGT improved overall. Clients in SFGT improved significantly on BDI and OQ whilst TAU clients did not
Proudlock & Wellman, 2011 (UK)	Adults with severe and enduring mental health difficulties/variety of presenting problems	n = 8 50% female	Clinical	Not specified	Service evaluation	6 weekly sessions	Not specified	MHRM	Facilitators records from group evaluation forms and field notes relating to client experiences of groups	Post-group	Significant increase in mean total MHRM score All participants reported the groups as having been helpful

Study (country)	Target population/ Target of intervention	Participants	Recruitment Method	Mean age at baseline (yrs)	Study design	Length of intervention	Sessions attended	Quantitative Outcome measures	Qualitative Outcome measures (if applicable)	Follow-up period	Key findings
Arvand <i>et al.</i> , 2012 (Iran)	Patients with chronic hepatitis B/ Depression and treatment completion	n = 22 27% female (experimental group n = 11)	Clinical	Experimental group = 38.1 27% Female Control group = 37.6 27% female	RCT	7 weekly sessions	Not specified	BDI Completion or non-completion of treatment		Post-group	SFGT reduced depression and increased completion of treatment in patients with chronic hepatitis B.
Thorslund, 2007 (Sweden)	People on long-term sick leave/ Psychological health and return-to-work rates	n = 30 (experimental group n = 15) 80% female	Media/ Clinical	45.4	RCT	8 sessions (3 over 3 consecutive days, followed by weekly)	Not specified	OQ-45.2 SCL-90 PBPI VAS Return-to-work rate		Post-group, 3 month follow-up	Treatment had a positive effect on return-to-work. Treatment group participants returned to work at a significantly higher rate than the control participants. Treatment group participants showed improvements in psychological health.
Hiebert-Murphy & Richert, 2000 (Canada)	Women dealing with child sexual abuse and substance abuse	n = 29 100% female	Clinical	32.2	Service Evaluation	12 weekly sessions (2 hours)	7.7	RSE PSOC KPS IPA	Post-group 'consumer satisfaction questionnaire' collecting clients' views of the group	Post-group	Increases in self-reported self-esteem, parenting satisfaction, parenting efficacy. Women reported learning to see themselves and their parenting in a more positive light. Also reported benefits of normalisation, learning communication skills, sharing, support and not feeling alone.

Studies Meeting Criteria for Adequate Internal Validity

No studies were assessed as having high internal validity, with two showing medium internal validity according to the adopted quality checklist (Arvand *et al.*, 2012; Madigan *et al.*, 2012). These two studies were also the most recently published. The strength of the Madigan *et al.* (2012) study, which evaluates a SFT group for carers of patients with bipolar affective disorder, lies in the rigor of its randomisation procedure as well as the blinding of the researchers collecting outcome data. Pre-intervention differences between groups in relation to the outcomes of interest were addressed in the design, however, other potential confounding factors such as demographic details were not reported or considered in the paper. There was a lack of specification of the actual intervention delivered such that replication would not be possible, and this limits the interpretation of the results.

The study also assessed the longer term outcomes of the evaluated interventions including follow-up at one year and two years post treatment. Unusually no outcomes are reported for participants immediately after treatment completion despite the duration of treatment being five weeks with the first outcome assessment at one year. This does not allow assessment of the maintenance of treatment gains during the first year. A further concern is the low uptake of the intervention, with only 26 per cent of those carers referred choosing to participate.

It is unclear if there are systematic differences between those carers who chose to participate and those who did not, or whether or not the intervention would be beneficial for all carers of patients with Bipolar Affective disorder. Reasons for refusal are documented.

SFT groups were included in the study as an additional control condition, with the main focus being on the assessment of multi-family group psychoeducation (MFGP). Following attrition the overall sample of carers included in the analyses at one year was 35, and at two years 31, with 14 and 13 respectively in the SFT intervention arm. The sample size is comparatively small in terms of RCT designs which is likely to limit the interpretation of results. The results suggest comparable improvement for both SFT groups and MFGP at years one and two, compared with TAU, for: carer knowledge of illness, as measured by the Knowledge of Illness Questionnaire (KOIQ); carer burden, as measured by the Involvement Evaluation Questionnaire (IEQ); carer quality of life, as measured by the WHO Qol Bref (WHOQOL); and carer psychological distress, as measured by the General Health Questionnaire 12 (GHQ12). No significant differences were found between groups in Global functioning, assessed by the Global Assessment of Functioning (GAF), at either follow-up point. No effect sizes are reported. No significant differences between groups on any outcome measures were found at baseline.

A further RCT study with a medium internal validity rating compared a waiting-list control group with an SFT group intervention targeting depressive symptoms and treatment adherence in patients with chronic Hepatitis B (Arvand *et al.*, 2012).

Random assignment to groups is reported, however, the method of randomisation and level of concealment and blinding of researchers is unclear. Loss to follow-up is not explicitly covered, although the reported data suggest no attrition.

Comparability of groups is explicitly addressed and pre-intervention group differences in depression are acknowledged and controlled for in analyses. Effects of age and gender are also explored statistically and ruled out. There is a lack of specification of the method of recruitment which raises concerns with regard to external validity. Hypotheses are also not clearly specified, but implied by the reported background and objectives. There is some specification of group content and procedures, however, it is unlikely that sufficient detail is provided to allow replication of seven two-hour sessions. The sample size is small for an RCT design, with 11 participants in each group, and no power calculation is reported. Findings suggest a pre- to post-group improvement in depressive symptoms, evaluated by the mean Beck Depression Inventory (BDI) score, and also the SFT group were significantly more likely to complete treatment for their Hepatitis B than the control group, with 100 per cent adhering well to and finishing treatment, compared with 36.4 per cent of controls. No effect sizes are reported.

Studies Meeting Criteria for Adequate External Validity, but Rated as Poor for Internal Validity

The two RCT studies described previously were also assessed as having medium external validity. A further five studies that were evaluated as poor for internal validity were rated as medium on the external validity domain. No studies achieved the high rating for external validity, with none of the included studies adequately justifying the included sample size and none reporting power calculations. Of the seven studies included in the synthesis two did not clarify inclusion and exclusion criteria, three lacked specificity in the reporting of the recruitment method, and two used methods of recruitment that were judged as likely to increase selection bias (Table 4).

Thorslund *et al.* (2007) sought to examine the effects on return-to-work rates and psychological health of an SFT group intervention. Internal validity is threatened by the lack of specification of the randomisation procedure and lack of reporting of any subsequent concealment or blinding procedures. The resulting uneven group sizes are controlled for in analyses, but other confounding factors such as demographic differences are not addressed. There is no specific reporting of levels of attendance at group meetings, and intention-to-treat analyses are not reported, although all participants appear to be included in analyses. A comparative waiting-list control condition allows greater confidence that the effects are due to the

intervention delivered, however, it is unclear whether it is specifically the SFT approach that produces improvement due to the absence of an alternative group treatment arm.

Referrals to the study were made from a social security office in Sweden, where it is reported that staff selected participants whom they believed would benefit from the intervention. It is unclear how these decisions were made, and whether or not a systematic approach was employed. This presents a significant threat to the external validity of this research due to a lack of specification of the population of study. In contrast the group intervention is clearly specified with reference to a manual and the required modifications. Attempts were made to measure fidelity, although they were based on therapists' subjective reports which may undermine their reliability.

A further issue is the 58 per cent of referred participants who declined to take part and it is unclear how they may differ from those who entered the study. This is acknowledged by the authors as a potential limitation. The resulting sample size of 30 is modest, but adequate for the purposes of the research.

The SFT group are reported to return to work at a significantly higher rate than the control group within the three months post-intervention, and this is described as a medium effect. An improvement in psychological health is reported post-group with maintenance at three-month follow-up. Upon examination of the reported

results it is noted that significant between-group differences are present only on the Visual Analogue Scales (VAS) totally sad-totally happy subscale at post-group and follow-up, and on the Outcome Questionnaire-45.2 (OQ-45.2) at follow-up. This is in the context of reported within-group effect sizes demonstrating various areas of deterioration in the control group and improvement across all outcomes within the treatment group. A reported sign test suggests that there was a small probability that these findings were based on chance.

Smock *et al.* (2008) used a problem-centred group therapy as a comparison condition for an SFT group intervention for level 1 substance abusers and examined the effects on psychological outcomes. Participants were randomised to treatment conditions, although the method of randomisation was not reported, and intention-to-treat analyses were also not addressed despite 33 per cent of participants not completing treatment. The internal validity of the study is consequently questioned. A relative strength was the statistical control of potentially confounding between-group differences in outcomes at the baseline assessment. Further strengths were the clinical basis of the referral to the study and lack of significant exclusion criteria that may lead to less generalizable results. Both treatment groups were based on available manuals, and therapists were systematically rated both on skill and adherence. The sample size is moderate, but adequate for the purposes of the research, although as with all the included studies, no power calculation is reported. Results suggest no significant between group differences at post-test when

controlling for pre-test differences on either the BDI or the OQ-45.2. Examination of within-group differences between pre- and post-test scores showed significant improvement in the SFT group participants, but not the control group members.

The application of SFT groups to those with severe and enduring mental health difficulties and mixed diagnoses was explored using a pre-post intervention design (Proudlock & Wellman, 2011). The lack of a control group had a significant impact upon the assessment of internal validity, and the study was rated as having medium external validity. Participants are clearly defined as clinical referrals from within a National Health Service (NHS) Crisis Resolution and Home Treatment Team (CRHTT). Potential weaknesses involve an unspecified assessment of appropriateness for SFT which reduces the possibilities for generalisation, the small sample size of eight participants with an attrition of two leaving only six in the final analysis, and the lack of systematic assessment of treatment fidelity in the context of a clear specification of group content and structure. The group participants had a range of difficulties including Bipolar II, Major Depression, Generalised Anxiety Disorder, Social Phobia, and Borderline Personality Disorder. Results showed a significant increase in mean scores on the Mental Health Recovery Measure (MHRM) pre- to post-group suggesting an improvement in attitudes regarding recovery and the recovery process.

A further study with poor internal validity, but medium external validity also investigated the effects of SFT groups for psychiatric patients with mixed presentations by comparing measures pre- and post- intervention (Quick & Gizzo, 2007). The sample size for the study is larger (n = 108), however, it is reported that 30.6 per cent attended only one out of a possible five group sessions. No hypotheses were reported prior to the results section and an intention-to-treat analysis was not conducted, with those who attended only one session separated from those who attended more sessions in the analyses. Exploratory analyses for those who attended just one group session suggest that self-rated 'degree of control over the problem' increased significantly between the beginning and end of the meeting they attended, however, it is unclear why they chose not to engage further with the intervention. For the remaining participants there was a significant increase in control between the beginning of the first session attended and the end of the last session attended. A relationship was found between the extent of increase in control and number of sessions attended, such that improvement was significantly greater for those who attended five sessions than those who attended one session, or those who attended three sessions. The validity of the findings is threatened by the lack of established validity and reliability of the outcome measure. As with the majority of included studies there is no attempt to control treatment fidelity, however, the intended intervention is clearly described.

Hiebert-Murphy & Richert (2000) evaluated a SFT group for women with dealing with a history of CSA and Substance Abuse. External validity of the study was rated as medium, and internal validity was rated as poor predominantly on the basis of a lack of control condition. The initial sample size of 29 was modest and, with an attrition of 6 participants, became relatively small. The population is, however, clearly specified as all referrals to a specialist clinic, with no apparent exclusion criteria. The intended intervention is clearly described, but no systematic assessment of fidelity was employed and it is unclear who facilitated the groups or collected the data. The mean number of sessions attended was 7.7, with a range of 2-12, and an implicit intention-to-treat analysis appears to have been conducted, bar the 6 participants lost to follow-up. Results demonstrate significant improvements in: self-esteem, as assessed by the Rosenberg Self-Esteem Scale (RSE); parenting satisfaction, efficacy, and overall self-esteem, as measured by the Parenting Sense of Competence Scale (PSOC); and attitudes towards their children, as measured by the Index of Parental Attitudes (IPA). Also measured was parenting satisfaction on the Kansas Parental Satisfaction Scale (KPS) and this was found to improve, but not significantly.

Reporting

The quality of reporting was variable in the included studies, but all were rated as at least of medium quality (Table 4). It should be noted that quality ratings may be

underestimated for some studies as a lack of explicit reporting of an aspects rated in the same way as that aspect not being covered or addressed.

Supplementary qualitative findings

Three of the synthesised studies included some gathering of qualitative information relating to the SFT group interventions (Hiebert-Murphy & Richert, 2000; Proudlock & Wellman, 2011; Smock *et al.*, 2008). All these papers were rated as having poor internal validity and medium external validity. The most detailed and systematic approach to qualitative analysis and data collection was adopted by Smock *et al.* (2008) with questionnaires of open-ended questions administered at the beginning and end of sessions and subsequent analysis using the principles of grounded theory. Hiebert-Murphy & Richert (2000) summarised qualitative data included in a post-group questionnaire exploring clients' views of the group. In the study by Proudlock & Wellman (2011) client feedback was noted by therapists and summarised by the researchers. No purely qualitative studies on SFT groups were identified during this review and due to the supplementary nature of qualitative information in these predominantly quantitative studies the methodological quality in terms of qualitative research is not assessed. Common themes identified from supplementary qualitative findings across studies appear to relate to: normalisation;

feeling less alone; feeling more positive; learning and/or using specific skills or behaviours; self-acceptance; and sharing and mutual support.

Limitations

It is widely accepted that a degree of subjective judgement is inherent in the quality assessment process (SIGN, 2011). The current review relied on the opinion of only one rater, although the detailed guidance pertaining to the ratings sought to address this issue to an extent. Although the development of a checklist appropriate to the review is often recommended, it also introduces the limitation of a lack of established reliability. A weakness of the employed checklist was its reliance on the reporting of relevant criteria which may have led to study rigor being underestimated. The number of studies included in the review is relatively small leading to a relatively small overall number of study participants on which to base a review. In addition the populations from which participants are drawn are heterogenous and the need for replication of results is strongly indicated.

Conclusions

There is some limited evidence to suggest that SFT groups are efficacious for carers of patients with Bipolar Disorder in improving: burden; knowledge of illness;

quality of life; and psychological distress. They have also been shown to be superior to TAU and comparable to MFGP. The outcomes found are likely to be associated with the delivered intervention, however, the details of the SFT intervention used are unspecified. Generalisation of the results to all carers of patients with Bipolar Affective Disorder is limited by the modest sample size and high rates of refusal of the intervention. There is also some limited evidence that SFT groups may be efficacious in decreasing depressive symptoms and increasing treatment completion in patients with chronic Hepatitis B. As with the previous study the intervention is poorly specified which limits opportunities for replication. The sample size on which these findings is based is small limiting generalizability. While the findings are likely to be attributable to the intervention delivered, there is some doubt as to whether or not the randomisation procedure was appropriate which limits a more definitive conclusion in this respect.

There is preliminary evidence for the effectiveness of SFT group interventions for: improvements in psychological health and return-to-work rates for individuals who have been on sick leave for between one and five months; improvement in attitudes towards recovery for clients with severe and enduring mental health difficulties in a CRHTT; increased 'degree of control over the problem' for psychiatric patients with varying difficulties; improvements in depression and other psychological symptoms in level 1 substance abusers; and improvement in self-esteem, parenting competence and parenting attitudes in women affected by CSA and substance abuse.

All reported findings are based on single studies, with seven out of eight based on small to modest sample sizes. Results from all studies are promising but require replication.

Where the goal is to establish treatment efficacy future studies should seek to employ: RCT designs with appropriate procedures for concealed randomisation; a comparison group treatment alongside a TAU control group; controls for confounding variables; and intention-to-treat analyses. All future studies should make attempts to: clearly specify details of interventions; systematically assess fidelity; use empirically validated outcome measures; use methods of recruitment which reduce selection-bias; recruit larger samples of participants; and report power calculations. The more consistent reporting of effect sizes in future studies would also allow for meta-analyses at a later date.

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CHAPTER 2

Bridging Chapter

Purpose of Study

Hypotheses

Solution-Focused Therapy

Traditionally the role of therapy was to assist clients in an understanding of what went wrong with the aim of then being able to act differently in order to avoid reoccurrence. Solution-focused Therapy (SFT) represents a paradigm shift from predominantly pathology-centred, problem-oriented therapies (Metcalf, 1998; Sharry, 2007).

SFT was developed by De Shazer and Berg at the Brief Family Therapy Centre (BFTC) in Milwaukee. The approach was a pragmatic one and SFT is not a theory-based model in the traditional sense, but there has been open acknowledgment of the influence of other theorists and models of therapy such as Erickson's strategic therapy and brief problem-focused therapy developed at the Mental Research Institute (MRI) in Palo Alto, California. SFT may be considered as a progression of the MRI approach, with roots in family and systems approaches (Sharry, 2007; Walsh, 2010).

SFT and Brief Problem-focused Therapy

The MRI brief problem-focused model was developed by John Weakland, Richard Fisch and Paul Watzlawick and was based on a premise that problems are interactional and best solved by doing something different in relation to the problem (Metcalf, 1998). The focus of MRI brief therapy was on observable behavioural interaction in the present and on deliberate interventions to alter the

ongoing system. Problems were viewed as persisting due to the maintenance of some ongoing behaviour not in itself caused by an underlying dysfunction. It therefore followed that self-exploration or an intense focus on the past was irrelevant to resolution of the difficulty and there was an absence of any elaborate theory of personality or dysfunction. The therapist's role was to focus on promoting change and to intervene in ineffective patterns of functioning as efficiently as possible. The emphasis was on generating change as opposed to on generating growth or insight. The idea that problems exist within interactional systems also means that small changes in a part of the system may have a significant impact on the system as a whole, and therefore changes at the individual level can alter situations in a profound way (Walsh, 2010).

The original conceptualisation of SFT had many commonalities with the MRI approach such as the concept of "reframing" in which the conceptual or emotional viewpoint associated with a situation is changed to fit an alternative framework thereby changing the meaning of the situation. The use of "tasks" also reflected the MRI influence, however, the BFTC team took an inverse perspective in terms of their view of problems. They began investigating exceptions to problems and what actions served to identify and amplify solution sequences (Metcalf, 1998; Walsh, 2010). The focus of the therapist shifted to facilitating the identification of specific interactions, behaviours and thinking that were present during such exceptions allowing clients to attribute the solutions to themselves and foster confidence in

their own competence. The therapist adopted a less directive role in which the client was the expert on their own life (Metcalf, 1998).

De Shazer and Berg observed hundreds of hours of therapy and carefully noted the questions, behaviours and emotions associated with clients' conceptualisations of solutions (de Shazer et al., 2007). They identified types of therapist behaviour that appeared to make clients four times more likely to speak about solutions, change and resources: eliciting questions ("What is better?"); detail questions ("What exactly did you do differently?"); and verbal rewards ("How did you manage to do that?") (Bannink, 2007).

SFT and Ericksonian Strategic Therapy

SFT and MRI were both strongly influenced by the strategic therapy of Milton Erickson who adopted a non-pathology model in which conceptualising problems as products of a limited repertoire of behaviours and attitudes towards the resolution of difficulties. The strategic element involved the design of interventions specific to each individual client. Erickson's approach was contrary to the prevailing psychodynamic therapy of the time, and also involved a communication systems approach with an emphasis on language (Walsh, 2010).

The influence of Erickson's theories and techniques are evident in the SFT model. Erickson encouraged resistance where in SFT resistance was viewed as the client's unique way of cooperating. Erickson highlighted communication in metaphor,

emphasis of the positive, amplification of deviations, and avoidance of self-exploration, whilst de Shazer and colleagues suggested constructing metaphors using client's language, the use of compliments and exceptions to the problem, and a focus on concrete goals and the future. SFT departed from MRI in some of these respects, such as the use of compliments and the elicitation of exceptions and strengths. There was also a shift from task to process and greater emphasis on developing cooperative relationships with clients (Bannink, 2007; Walsh, 2010).

Further characteristics of Erickson's approach that are mirrored in SFT include: the therapist facilitating the use of resources of which the client was previously unaware; facilitating the use of experiences that might contribute to resolution of the problem; an assumption that clients will continue to pursue desired changes outwith therapy; an emphasis on the future; and an attempt to optimise engagement by adapting to the hopes or desires of the client (O'Connell, 1998).

SFT and Social Constructionism

SFT is essentially a social constructionist approach underpinned by the epistemological position that meaning is created through social interaction and negotiation (O'Connell, 1998). As such it follows that theories are not objective explanations of truth, but are socially constructed according to context. In therapeutic terms constructionism emphasises the client's perceptions and experiences, rather than attempting to establish "facts". This creates opportunities

within therapy for the exploration of meanings and a co-construction of reality and meaning between therapist and client. The therapist is not the expert whose role it is to impart truth to the client, but therapy becomes a dialogue in which problems and solutions are co-constructed (O'Connell, 1998).

Understandings of reality and the concept of the "self" are constructed socially in conversation and therefore the therapist is not perceived as an objective figure with a diagnostic role. This creates a therapeutic conversation different from one where the focus is on the problem, allowing the client to perceive alternative understandings of their situation and novel ways of approaching difficulties (Walsh, 2010). Due to the pivotal role of communication in SFT language plays a key role in the construction of meaning. The solution-focused questions are aimed at reframing situations in such a way as to allow clear definition of goals and solutions, the resources for which are assumed to already be present within the client (Bannink, 2007).

SFT questions relate to the formulation of goals and preferred futures, exceptions and competences, and to what is already going well and is enabling the client to manage despite the presence of the problem. Such questioning accesses information that is not routinely explored in problem-focused approaches. The expertise of the therapist is utilised subtly in choosing questions and structuring the conversation, and in applying principles of operant conditioning (Bannink, 2007).

Bannink (2007) suggests parallels between SFT and Cognitive Behavioural Therapy (CBT) in the use of the principles of classical and operant conditioning. He argues that behavioural analyses are made in SFT with regard to establishing exceptions to the problem, and that on some level desired behaviour is positively reinforced by the therapist while undesired behaviour is extinguished through non-reward in the form of lack of attention.

The therapist does not tell the client what to do differently or teach new techniques and as such SFT interventions are minimally intrusive. De Shazer has described the role of the therapist as one of “leading from behind” and of “not knowing” (Bannink, 2007). SFT has also come to be viewed as one of a number of postmodern therapies that attempt to foster a collaborative approach. SFT therapists have generally come to accept that there is an unavoidable hierarchical arrangement within therapy, however, attempts are made for this to be egalitarian and democratic in nature as opposed to authoritarian (Walsh, 2010).

Core principles of Solution-focused Therapy

The essence of SFT was described by de Shazer as “Utilising what clients bring with them to help them meet their needs in such a way that they can make satisfactory lives for themselves” (de Shazer et al., 1986, p 208). The original clinical model of SFT proposed by de Shazer et al. (1986) involves a number of stages based on minimal intervention and which could be delivered in a single session.

The main tasks/stages have endured, although the model is dynamic and has been modified for various purposes whilst maintaining a specific belief system, a set of underlying principles, and an array of techniques. A significant underlying principle of the approach remains the conception of problems being developed and maintained in the context of human interactions and that solutions therefore lie in changing these interactions whilst accepting the unique constraints of the situation.

Further assumptions include:

- Change is constant and inevitable;
- Small changes result in bigger changes;
- You cannot change the past so concentrate on the future;
- Everyone has the strengths and resources necessary to help themselves, and they are the experts;
- Every person, situation and relationship is unique;
- Everything is interconnected;
- Every problem has at least one exception;
- If it's working keep doing it, and if it's not working stop doing it.

(Dejong & Berg, 1998; de Shazer *et al.*, 2007; O'Connell, 1998).

The current modest evidence-base for the use of individual SFT in severe and enduring mental health is promising. Its conception as a 'brief therapy' has contributed to a misunderstanding that it is synonymous with short-term therapy and therefore inappropriate for use with individuals suffering from more severe and enduring mental health difficulties. A small number of published studies acknowledge and evaluate its application to more complex mental health populations (Kok & Leskela, 1996; MacDonald, 1997; Sharry *et al.*, 2002;).

Solution-focused Therapy Groups for Borderline Personality Disorder (BPD)

Interest in the treatment of Borderline Personality Disorder (BPD) has grown in recent years within a context of the past classification of the disorder as 'untreatable' and a recognition that the lack of specialist services for the treatment of BPD had led to their treatment predominantly in emergency or inpatient services during crisis presentations (DoH, 2008; NIMHE, 2003).

The British Psychological Society (Alwin et al., 2006) conceive personality disorder as an extreme expression of certain personality characteristics and describe it as follows:

People differ in the ways that they view themselves and others, engage in relationships, and cope with adversity. It is quite common for these characteristics to occasionally interfere with a person's ability to cope with life, and may also lead to difficulties in social interactions. When these difficulties are extreme and persistent, and when they lead to significant personal and/or social problems, they are described as personality disorders.

(Alwin et al., p3).

Borderline personality disorder (BPD) is described by The Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV-TR; APA, 2000) as "a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of

contexts" (p726). To receive the diagnosis an individual must meet at least five out of the following nine criteria:

- Frantic attempts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships characterised by alternation between extremes of idealisation/devaluation
- Identity disturbance; unstable self-image
- Impulsivity in at least two areas that are potentially self-damaging, e.g. sex, binge-eating, alcohol or drug abuse, chronic over-spending, gambling etc.
- Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour
- Affective instability due to marked reactivity of mood
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger
- Transient paranoia or dissociation.

Reviews of the current evidence-base for psychotherapeutic interventions for BPD suggest that no specific intervention has a particularly robust evidence-base thus far and the British Psychological Society suggest that there is no existing evidence to clearly recommend one psychotherapeutic approach over another, although

psychotherapy in general is supported for the treatment of BPD (Alwin *et al.*, 2006; Stoffers *et al.*, 2012).

A recent literature review identified four randomised-controlled trials (RCTs) of group interventions for BPD (Boudreau *et al.*, 2009). All interventions were based on different psychotherapies: schema-focused therapy; DBT skills training; Systems Training for Emotional Predictability and Problem Solving (STEPPS); and acceptance-based emotion regulation. The report concludes that there is some tentative evidence to suggest the effectiveness of groups based on these treatment modalities for up to one year following treatment completion.

SFT, adapted to group delivery, may be an appropriate approach for individuals with BPD, and an alternative to pathology-focused models of therapy. Due to the manner in which BPD is currently diagnosed it is recognised as a heterogeneous diagnostic category. The focus within SFT on individual strengths and solutions as opposed to on symptoms and problems may make SFT groupwork particularly accommodating of heterogeneity in problem presentation (Leichsenring *et al.*, 2011).

The SFT stance of positivity, respect and hope also corresponds with the BPS recommendation of fostering an attitude of respect and an approach that acknowledges BPD clients as fellow human beings (Alwin *et al.*, 2006). This is in the context of the prevalent pessimistic attitude found amongst professionals in relation to the likelihood of positive treatment outcomes for those with a diagnosis of BPD

(Koekkoek et al., 2009). A qualitative study of BPD service users' and carers' opinions, carried out to contribute to policy guidance indicated that personality disorder diagnoses carry greater stigma than any other mental disorder, and that those with BPD often feel judged by professionals and by society (Haigh, 2002).

Many individuals with BPD are likely to have had experiences with staff in health services which have been affected by a socially constructed, pejorative, and highly pathologised conception of those with BPD (Fallon, 2003; Horn et al., 2007; McGrath & Dowling, 2012). Such attitudes to the diagnosis have the potential to create negative service contacts and make individuals with BPD distrustful of services. As a strengths-based approach focused on respect and the co-construction of an alternative solution-focused dialogue, SFT may represent an intervention particularly suited to engaging BPD clients who have previously experienced services as negative.

Negative experiences of services may also contribute to difficulties in engaging those with BPD in treatment. The BPS recognise this as a challenge and also that drop-out rates tend to be high both in clinical and research settings (Alwin et al., 2006). Also thought to contribute to poor engagement are emotional instability, insecure attachment styles, and self-destructive impulsivity. Attendance may be dependent upon current emotional state or the activation of attachment systems (Alwin et al., 2006; Swift, 2009).

Despite a lack of clear theoretical understanding of the causes of BPD it is widely accepted that the aetiology of BPD involves some disruption in early attachment processes with an affect on the development of social cognition (Alwin et al., 2006; Fonagy et al., 2003; Keokkoek et al., 2009; Leichsenring et al., 2011; Linehan, 1993). Research has failed to identify a specific common attachment category amongst those with BPD, although questionnaire studies have suggested an association with insecure attachment styles, disorganisation, fearful avoidance and preoccupied styles (NICE, 2009). Some studies have highlighted the influence of inadequate mirroring in early life and Linehan (1993) emphasised invalidating family environments in the development of BPD, in which individuals must tolerate a systematic undermining of their experience of their own mind (NICE, 2009).

Thus, BPD has been suggested as being characterised by severe social impairment, and as such interpersonal therapeutic approaches with an emphasis on the interpersonal context of therapy have been suggested as potentially useful (Alwin et al., 2006; Lieb et al., 2004). A common emphasis in interpersonal approaches with BPD is the use of the interpersonal context of therapy as the means of change (Alwin et al., 2006). This conceptualisation is highly consistent with the centrality of the interactional component in SFT, and opportunities for interpersonal learning are likely to be amplified within a group situation.

The group process may also serve to avoid the development of potentially hazardous therapeutic relationships, as well as affording opportunities to address relationship difficulties as they occur within group sessions (Linehan, 1993).

Groups are suggested as less likely to allow the development of dependency and as providing more opportunities for fostering personal responsibility.

In order to better understand the interactions between those with BPD diagnoses and mental health services various studies have sought to qualitatively assess the perspectives of those with BPD with regard to their experiences of diagnosis and treatment (Katsakou et al., 2012; Miller, 1994; Webb & McCurran, 2008). Miller (1994) obtained life history narratives from individuals with BPD and examined similarities between the reports in order to gain further insight into the experiences of those with the disorder. The similarities identified were found to diverge from the clinical diagnostic criteria and were described as “a sense of estrangement”, “a coherent sense of the self as inadequate”, and “feelings of despair”. The therapeutic relationship as the first context in which those with BPD may have experienced themselves in an alternative way is highlighted, and thus the importance of avoiding reinforcement of feelings of inadequacy and powerlessness due to a power imbalance between the therapist and the client. The emphasis within SFT on clients’ strengths and resources and on the client as the expert may serve to address this issue, as well as creating an opportunity for clients to co-construct a positive alternative view of the self.

The potential benefits of group-based interventions in addressing the issues of estrangement, social validation and social support are also identified based on the narratives collected by Miller (1994), and the BPS highlights group processes as crucial with regard to addressing difficulties in interpersonal and social functioning in personality disorder (Alwin et al., 2006).

The conception of group therapy for BPD is not new and groups based on psychoanalytic and social learning theory have been reported since the late 1970s. Horowitz (1977) suggested the utility of the dilution of transference reactions in group settings, as well as opportunities for in vivo reality orientation, strengthening of ego identity, and mediation of social responses (Nehls, 1991). More recent examination of the process and outcome of group therapy for BPD within a community mental health centre has suggested experiences of Yalom's (1975) common factors in group therapy, or "curative factors", of *Universality* and *Existentialism* as helpful. *Universality* refers to the sense of shared experience and of not being alone, and *Existentialism* involves recognition of the unfairness of life, the lack of escape from pain associated with life, being ultimately alone in the world, and having ultimate responsibility for the way we choose to live.

Few studies have assessed the specific mechanisms of change associated with experimental interventions for personality disorder (Alwin et al., 2006; Levy & Scott, 2007). Bateman and Fonagy (1999) have speculated that important mechanisms

may include theoretical coherence, a focus on relationships, and an emphasis on reducing attrition, all of which are congruous with a solution-focused approach. The formation of an effective therapeutic alliance, as advocated by the SFT approach, is indicated as a factor in enhancing treatment adherence (Alwin et al., 2006).

Individuals with BPD have identified the following changes as being associated with recovery: development of self-acceptance and self-confidence; gaining control over emotions; improving relationships; employment; and making progress with symptoms such as self-harming. They were realistic in their hopes for treatment in terms of suggesting that post-treatment they would be dealing with problems more effectively and making meaningful progress as opposed to expecting full recovery quickly. Some psychotherapeutic approaches were criticised by those interviewed for neglecting personal goals and placing an extreme emphasis on areas such as self-harm (Katsakou, 2012). The expectations of treatment identified by these individuals are synonymous with the SFT model in terms of aiming for gradual and persistent change and a focus on personally meaningful goals. Recognition and acknowledgement of strengths and resources might reasonably be expected to contribute to the development of self-acceptance and self-confidence.

Receiving a diagnosis in itself may affect clients' views of themselves. Horn et al. (2007) suggest social constructionist formulations as a potentially useful alternative

to a focus on the BPD diagnosis. Through qualitative analysis of interviews the BPD diagnosis was found to be viewed by service users as a negative, static label involving unhelpful views relating to being judged, rejected, and bad. Helpful views of the self that were identified incorporated possibilities of change, involved being valued and accepted, and could develop within relationships. The combination of these perspectives is suggested as consistent with a social constructionist understanding, as one that exists between people rather than within them. The useful ways of viewing the self identified in the study were clearly associated with defining and redefining the self through social interaction. An essentialist diagnosis was viewed as rejecting and associated with hopelessness which also appeared linked with a subsequent withdrawal from or rejection of services. Due to the social constructionist background of SFT it may be expected to facilitate and enhance the construction of the more helpful self-views indicated by the clients interviewed for this study.

Psychotherapies for BPD tend to be provided within specialist services to which there remains limited access through real-life clinical settings. On the basis of BPD clients' high usage of community mental health services it has been suggested that innovation and improvement in the interventions provided in such non-specialised services is warranted (Crawford *et al.*, 2007; Koekkoek *et al.*, 2009).

Based on the existing theoretical and research evidence regarding the presentation of and treatment for individuals with BPD, as well as the current mental health service context, solution-focused groups for BPD within community settings represent a viable treatment option which may prove particularly effective in satisfying the requirements and hopes identified by service-users.

There is currently no published research which has addressed either the efficacy or the effectiveness of an SFT group for people with BPD either empirically or qualitatively.

Purpose of study

The purpose of the study was to investigate the effectiveness of an SFT-based group treatment for BPD when delivered adjunctively as a part of routine clinical practice within National Health Service (NHS) Community Mental Health Teams (CMHTs). Effectiveness is assessed both in terms of change in clinical symptoms associated with BPD, measured by way of empirically validated outcome measures, and by qualitative exploration of the subjective experiences of participants with regard to the intervention.

Hypotheses

1. Group participants' clinically relevant symptoms, as measured by empirically validated outcome measures, will significantly reduce during the course of the intervention.
2. Group participants' self-rated quality of life, as measured by The EuroQol (EQ-5D, the EuroQol Group, 1990), will significantly increase during the course of the intervention.

Secondary Research Questions

What are the dose effects for the intervention? How many group sessions are likely to be sufficient to produce significant improvement?

CHAPTER 3

Extended Methods

Design

In line with the purpose of the study a naturalistic service-evaluation design was adopted. This approach was also favoured due to the potential ethical issues surrounding withholding the proposed intervention to create a control condition, and the lack of available resources to provide a comparison treatment.

The study involved the evaluation of two SFT-based groups each affiliated with a separate National Health Service (NHS) community mental health service. Clients who were interested in participating in the group intervention attended for an initial assessment, and those who went on to join one of the groups were subsequently assessed on clinical outcomes following session 8 and again after the groups ended at a maximum of 16 sessions. All assessments using validated self-report measures were conducted by the chief investigator. Qualitative data was collected post-group only, and qualitative interviews were conducted by two psychologists who had no prior involvement with the intervention.

There were basic inclusion and exclusion criteria stipulating that participants must meet criteria for BPD, as assessed by the SCID-II, and that they must not be involved in a concurrent psychotherapeutic intervention at the outset. Participants were not obliged to forgo opportunities to engage in additional psychotherapeutic input during the course of the groups. Participants were also excluded if they were non-English speaking.

Ethics

The study protocol was reviewed by a local NHS Research Ethics Committee who agreed that the project was best categorised as a service evaluation (Appendix B).

The committee's recommendation pertaining to providing participants with written information and obtaining consent were adhered to, and the relevant documentation agreed upon (Appendix C).

Group Intervention

Groups were developed based on the SFT approach. Some consideration was given to the number of group sessions that would be offered in light of the brief nature of SFT and the concept that clients are offered only as many sessions as are required.

The presentation of the group as open-ended was rejected on the basis that this could convey a message contradictory to the brief nature of the therapeutic approach, however, it was expected that the number of sessions required would be likely to vary between group participants. Based on past and recent research pertaining to dose-related effects of psychotherapy a 16-session format was selected (Barkham *et al.*, 2006; Hansen *et al.*, 2002; Harnett *et al.*, 2010; Kopta, 2003). This was presented as the maximum number of available sessions with the potential for sooner group completion if this was the established preference of group members.

Groups were delivered on a fortnightly basis and each lasted 90 minutes. This arrangement yielded an approximate treatment duration of seven months which

was also considered appropriate in the context of the NICE guidelines for the treatment of BPD (NICE, 2009) which recommends interventions for BPD of longer than three months in duration.

For the duration of the group the role of the facilitator was to maintain a solution-focused stance of positivity, hope and respectful curiosity (de Shazer et al, 2007). Sustaining and instilling an awareness of the basic assumptions of SFT was also integral to the intervention:

- Change is constant and inevitable;
- Small changes result in bigger changes;
- You cannot change the past so concentrate on the future;
- Everyone has the strengths and resources necessary to help themselves, and they are the experts;
- Every person, situation and relationship is unique;
- Everything is interconnected;
- Every problem has at least one exception;
- If it's working keep doing it, and if it's not working stop doing it.

(Dejong & Berg, 1998; de Shazer *et al.*, 2007; O'Connell, 1998).

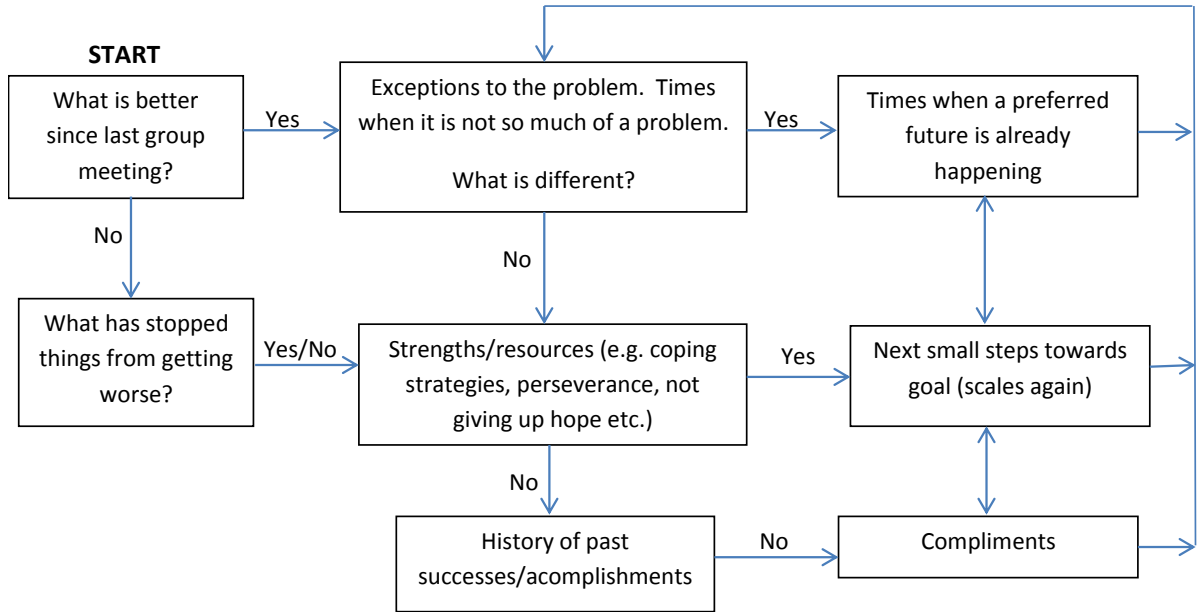
The therapeutic process was guided by the facilitator's encouragement of "change discourse", "solution discourse", and "strategy discourse" within the group (O'Connell, 1998, pp 35-40).

The SFT acronym 'EARS' was employed frequently in sessions (DeJong & Berg, 1998): E – elicit exception(s) to the problem; A – amplify the exception(s); R – reinforce the successes and strengths which the exception represents; S – Start again (i.e. What else is better?).

Discussion of problems was not actively encouraged or discouraged by the facilitator. Problems were listened to and empathised with, but no further detail was elicited, rather the facilitator's role was to guide the group discussion back to change, solution or strategy discourse (de Shazer *et al.*, 2007; O'Connell, 1998).

The initial two sessions of the group involved: basic introductions; an introduction to SFT; discussion of and agreement on ground rules and structure for the group; sharing of best hopes and expectations for attending the group; and establishing specific individual goals for each group member. The solution-focused 'miracle question' was used as a way to specify these goals in detail. Solution-focused scaling was used to assess and monitor progress towards group members' identified goals where this was helpful. The remaining sessions followed the structure illustrated in Figure 1.

Figure 1 - Process map for group sessions 3 – 16 (based on Iveson, 2002)



The Group Facilitator

The group was facilitated by the chief investigator, a Trainee Clinical Psychologist/Specialist Psychological Practitioner who had undergone a year-long specialist training placement in SFT, and with prior experience of designing and delivering group interventions. The facilitator received regular supervision throughout the duration of the group from experienced qualified psychologists with training and/or experience of the SFT approach.

Participants

Participants were recruited from two NHS CMHTs and their affiliated Day Hospitals within the same NHS board area. Two groups were then formed each

being affiliated with one of the community services where recruitment took place. Overall a total of 25 potential participants were referred of whom 12 (48%) did not attend when invited for individual pre-group assessment. A further 4 (16%) who did attend for initial assessments did not attend for group meetings. Of the remaining 9 (36%) participants who went on to attend for group meetings 8 (88.9%) were women and one (11.1%) was a man. The mean age of the participants was 32.3 years (standard deviation [SD] 10.7 years, range 20-49 years). 3 (33.3%) were employed, and 3 (33.3%) were married. The two groups will be referred to as "Group A" and "Group B". Thirteen referrals were made to Group A and twelve to Group B. In Group A eight (62%) attended for initial screening and five (38%) went on to attend group meetings. For Group B five (42%) attended for screening and four (33%) went on to attend group meetings.

Outcome Measurement

A mixture of quantitative and qualitative outcome measures was chosen for a number of reasons.

Research on SFT outcomes has typically evaluated clients' subjective perceptions of their progress, or adopted non-validated forms of outcome measurement, such as the scaling measure inherent to SFT. This is likely to be due to the consistency of this approach with the principles of the therapy itself, as well as the use of pre-defined validated measures being somewhat inconsistent with the general ethos and

therapeutic stance employed in the SFT model. On balance, although not the focus of the intervention, clinically recognised outcomes are highly relevant within the context of service delivery in the NHS and are currently emphasised in the development of clinical guidelines.

Whilst the use of validated quantitative measures is less favoured in SFT research, their application in existing studies examining the efficacy/effectiveness of psychological interventions for BPD is conventional.

To allow the results of the current study to sit within the context of existing BPD research five outcome measures were selected on the basis of those used most consistently across prominent RCT studies examining the efficacy of treatments for BPD (Bateman & Fonagy, 1999; Blum *et al.*, 2008; Clarkin *et al.*, 2007; Davidson *et al.*, 2006; Linehan *et al.*, 1991; Giesen-Bloo *et al.*, 2006). This decision was informed by NICE Guidelines for BPD which comment on the difficulties of synthesising data across existing studies due to variation in outcome measures (NICE, 2009). This report also highlights that outcomes in BPD research thus far have not adequately addressed patient experience. Therefore on the basis of their consistency with the SFT approach, and the recognised need to evaluate client experience, qualitative measures were also included in the current study.

Quantitative Outcome Measures

The diagnostic status of potential group participants was assessed using the relevant section of the Structured Clinical Interview for DSM-IV Axis I (SCID-I) at baseline and following completion of the group. The SCID was originally designed specifically for the purpose of diagnostic screening for research, and utilises a semi-structured interview. The BPD section of the SCID-I covers the nine criteria for a DSM-IV diagnosis of BPD. The reliability of the interview in determining BPD diagnosis has been shown to be high based upon two studies in which the kappa coefficient was found to be 0.91 (Lobbestael et al., 2010; Maffei et al., 1997).

The diagnostic power of the SCID-I has been shown to vary according to specific personality disorder diagnosis from 0.45 for Narcissistic to 0.95 for Antisocial. The diagnostic power was found to be 0.85 or greater for 5 of the personality disorders (First & Gibbon, 2004).

The remaining five empirically validated outcome measures were administered at baseline, following eight sessions of the group, and post-group (following a maximum of 16 sessions). Psychiatric symptoms were assessed using the Beck Depression Inventory (BDI-II, Beck, Steer & Brown, 1996a), Spielberger State-Trait Anxiety Inventory (STAI, Spielberger, *et al.*, 1970) and Brief Symptom Inventory (BSI, Derogatis & Melisaratos, 1983).

The BDI-II consists of 21 items assessing the intensity of depression. Each item includes four statements arranged in increasing severity of which participants select one. Beck et al. (1996a) demonstrated adequate reliability and validity for clinical populations, and provided evidence of convergent and discriminant validity of the scale through comparisons of correlations between the BDI-II and the revised Hamilton Rating Scale for Depression ($r = .71$) and the revised Hamilton Rating Scale for Anxiety ($r = .47$). The BDI-II has also been shown to have high internal consistency ($\alpha = .91$) (Beck et al., 1996b).

The STAI is a commonly used measure of trait and state anxiety and includes 20 items for assessing trait anxiety and 20 for state anxiety (Spielberger et al., 1983). All items are rated on a 4-point scale (e.g., from "Almost Never" to "Almost Always"). Higher scores indicate greater anxiety. Internal consistency coefficients for the scale have ranged from 0.86 to 0.95 and test-retest reliability coefficients have ranged from 0.65 to 0.75 over a two-month interval (Spielberger et al., 1983). Spielberger et al. (1989) have also provided evidence for the construct and concurrent validity of the scale.

The BSI is a 53-item self-report inventory designed to assess the status of psychological symptoms. It is a brief form of the Symptom Checklist-90-revised (SCL-90-R, Derogatis, 1977) with items relating to nine primary symptom dimensions: Somatization; Obsessive-Compulsive; Interpersonal Sensitivity;

Depression; Anxiety; Hostility; Phobic Anxiety; Paranoid Ideation; and Psychoticism. There are also three global indices of distress: the General Severity Index; the Positive Symptom Distress Index; and the Positive Symptom Total. The General Severity Index is reported as being the best single indicator of current level of distress (Derogatis & Melisaratos, 1983). Each BSI item is rated on a five-point scale ranging from "not at all" to "extremely". In terms of internal consistency, reliability was established with a sample of 1002 out-patients with alpha coefficients for the 9 primary dimensions ranging from 0.71 to 0.85. Test re-test reliability based on stability coefficients for 60 non-patient subjects ranged from 0.68 to 0.91 for the 9 primary dimensions and was 0.9 for the General Severity Index. Convergent validity for the BSI dimensions has been demonstrated on the basis of comparison with the Minnesota Multiphasic Personality Inventory (MMPI) (Derogatis et al., 1976).

Social and interpersonal functioning were measured by the Inventory of Interpersonal Problems - Short form (IIP-32, Horowitz *et al.*, 1988). The IIP-32 is a short form of the Inventory of Interpersonal Problems (Horowitz et al., 1988) designed to identify interpersonal sources of distress. The IIP and IIP-32 are comprised of statements of interpersonal difficulty preceded by either a stem of "It is hard for me to..." or "These are things I do too much...". Each item is rated on a four-point scale ranging from "not at all" to "extremely". Reliability analyses for the IIP-32 were conducted with a sample of 250 consecutive clients presenting for

individual psychotherapy (Barkham et al., 1996). Alpha coefficients for subscales ranged from 0.71 to 0.89. and was 0.85 for the full IIP-32 scale. Confirmatory factor analysis for the IIP-32 with a sample of 166 consecutive psychotherapy clients suggested validity of the measure's structure, with a coefficient alpha reliability of 0.9 for the full-scale.

The EuroQol (EQ-5D, the EuroQol Group, 1990) was administered as a general measure of quality of life. The EQ-5D is a standardized health-related quality of life questionnaire developed by the EuroQol Group in order to provide a simple, generic measure of health for clinical appraisal. UK norms are available based on a sample of 5324 individuals from the general population in England, Scotland and Wales (Kind, 1998).

Qualitative Outcome Measures

At initial assessment participants completed a written self-report form covering three questions:

1. What are your best hopes from attending the group?
2. What things would you most like to be different by the end of the group?
3. What change would make the most difference to your life that you think the group could help you with?

The SFT approach encourages clients' to consider their own interpretation of meaningful change for themselves, rather than focusing on clinically pre-defined treatment goals. The purpose of this baseline qualitative assessment was to provide a context for the post-group qualitative data in terms of evaluating whether clients' initial hopes and goals were met through the intervention, irrespective of clinically relevant outcomes.

Semi-structured, audio-taped interviews following completion of the group sought to address the following questions:

1. What were group members' subjective experiences of attending the groups?
2. What aspects of the groups did individual members find helpful/unhelpful?
3. What has changed subjectively for those who attended the group?

Full semi-structured interview schedules are described in Appendix D, and these were developed taking account of published guidance and by the principles of SFT (Bryman, 2004; Kvale, 1996; Turner, 2010; Willig, 2001).

Procedure

Referrals were held by the chief investigator until such time as at least ten referrals had been received for each of the two groups. Referred participants were then contacted and invited to attend for initial assessment with the chief investigator, who was also the group facilitator. At the assessment meeting further information

about the group was provided and potential participants were given the opportunity to ask questions or voice any concerns. The clinically-relevant outcome measures were administered, as well as the brief qualitative self-report form. The nature and purpose of the service-evaluation was explained to participants, who opted to sign a consent form allowing their data to be used for the present study. Participants who did not consent were not excluded from attending the group. Groups commenced immediately following completion of the initial assessments.

Power Calculation

An *a priori* power calculation showed that a sample of 20 would be required to achieve a power of 0.8 in detecting an effect size of 0.3. Taking into account the potential for attrition further calculations demonstrated that to achieve 0.8 power to detect an effect size of 0.5 9 participants would be required, and 12 participants would increase the power to 0.95.

CHAPTER 4

Extended Results

Results

Group Course

Group A

Group A took place in an NHS area with no available specialist services for BPD.

The group had five members at the outset and attendance was generally good, although one participant was frequently unable to attend due to scheduled court appearances. This participant attended on only three occasions. Two of the remaining members opted to discontinue the group following session eight. One of these members reported feeling that she had achieved as much as she could in the group, that she was functioning better than the other members, and that she was concerned about taking time off work to continue attending. The other group member who chose to discontinue had changed her place of employment creating an ethical issue pertaining to her contact with another member of the group and she no longer felt comfortable attending. The latter participant completed both quantitative and qualitative feedback despite having left the group early. The remaining two members of Group A attended regularly, although one was lost to qualitative follow-up due to recovery from an operation.

Treatment as Usual

One participant in Group A commenced individual therapy during the course of the group, but remained in the group and completed all follow-up. For one member the group was their only contact with services, and another had three-monthly outpatient psychiatric appointments in addition to the group. One of the remaining two members had regular contact with a Community Psychiatric Nurse and the other with an Occupational Therapist.

Group B

Group B was run in an area where individuals with BPD are routinely referred to an available DBT service. Some clients are assessed as unsuitable by the DBT service and some do not engage. These clients tended to be referred to the SFT group.

Attendance at Group B was less consistent than that in Group A. The group consisted of four members at the outset, with the fifth potential member citing difficulties with childcare as her primary reason for not attending. One of the other group members also identified childcare issues as a reason she was unable to attend the group more consistently.

One member of Group B was admitted to an inpatient psychiatric ward following session two of the group and despite attempts to re-engage him through contact with his keyworker, he was lost to follow-up.

Two group members attended relatively consistently and completed both quantitative and qualitative follow-ups. The remaining participant attended less frequently and was lost to follow-up due to a family bereavement.

Treatment as Usual

No members of Group B commenced additional psychotherapy during the course of the group. One member had regular contact with a Community Psychiatric Nurse, and one occasional contact with an Occupational Therapist. The remaining two participants were engaged only with the group, and were also the most regular attenders, as well as being those who provided post-group qualitative feedback.

Attendance

Difficulties in terms of engagement/attendance were openly discussed within both groups with the purpose of generating mutual solutions. Both groups converged on an agreement that group meetings should continue with a minimum of two group members in attendance. In situations when only one group member attended the group did not go ahead. It was agreed that a brief clarification of progress and goals for the upcoming period before the next group meeting could take place between the facilitator and the group member in attendance if the group member wished to do this.

By session 16 there were 3 participants engaged with each group.

Quantitative Results

Baseline Data

Baseline data for all quantitative outcome measures are presented in Table 1 for all participants, Table 2 for Group A participants, and Table 3 for Group B participants.

It is notable that both overall, and in each group separately, the baseline severity of symptoms generally appears higher for those who were screened and went on to attend a group than for those who were screened and did not attend. In Group A the exceptions to this are the mean scores for STAI State Anxiety, the BSI Anxiety Subscale, and the BSI Phobic Anxiety Subscale. The mean scores on these measures of anxiety were higher for those who were screened and subsequently did not attend Group A, than for those who did attend Group A. The standard deviations are also lower for those who did not attend which suggests that the relevant means are unlikely to have been affected by one extremely anxious participant. As all these measures relate to anxiety it is possible that high levels of anxiety may have discouraged or prevented these participants from attending. This is not true for the one participant who did not attend Group B.

The anxious non-attenders in Group A may represent a sub-group of BPD clients for whom a group-based intervention may be unsuitable.

Table 1 – Baseline Measurements for All Group Participants on All Outcome Measures

	Screened Mean (SD) n = 13	Attended Mean (SD) n = 9	Did not attend Mean (SD) n = 4
SCID-II	6.77 (1.64)	7.33 (1.32)	5.5 (1.73)
EQ-5D	39.08 (17.52)	36.67 (20.31)	44.5 (8.43)
BDI	37.62 (12.81)	41.67 (12.11)	28.5 (10.25)
STAI State	60.85 (12.93)	62.78 (13.30)	56.5 (12.66)
STAI Trait	66.85 (9.79)	68.67 (9.88)	62.75 (9.5)
IIP-32	70.08 (25.68)	77.67 (21.61)	53.00 (28.83)
BSI GSI	2.38 (0.78)	2.63 (0.71)	1.83 (0.71)
BSI PST	46.08 (5.88)	48.56 (3.71)	40.50 (6.46)
BSI PSDI	2.69 (0.64)	2.84 (0.63)	2.34 (0.59)
BSI Som	1.73 (1.18)	2.03 (1.30)	1.04 (0.43)
BSI Obs	2.79 (0.91)	3.02 (0.81)	2.29 (1.02)
BSI Int	2.75 (0.88)	3.00 (0.76)	2.19 (0.99)
BSI Depr	2.55 (0.95)	2.74 (0.95)	2.13 (0.92)
BSI Anx	2.54 (0.88)	2.57 (0.87)	2.46 (1.04)
BSI Host	1.85 (1.14)	2.38 (0.92)	0.65 (0.44)
BSI Phob	2.83 (0.80)	2.87 (0.64)	2.75 (1.22)
BSI Para	2.12 (0.95)	2.51 (0.70)	1.20 (0.86)
BSI Psyc	2.54 (0.92)	2.82 (0.93)	1.90 (0.53)

Structured Clinical Interview for DSM-IV Axis I; EQ-5D, The EuroQol overall health state; BDI, Beck Depression Inventory; STAI State, Spielberger State-Trait Anxiety Inventory State Anxiety; STAI Trait, Spielberger State-Trait Anxiety Inventory Trait Anxiety; IIP-32, Inventory of Interpersonal Problems; BSI GSI, Brief Symptom Inventory Global Severity Index; BSI PST, Brief Symptom Inventory Positive Symptom Total; BSI PSDI, Brief Symptom Inventory Positive Symptom Distress Index; BSI Som, Brief Symptom Inventory Somatisation Scale; BSI Obs, Brief Symptom Inventory Obsessive-Compulsive Scale; BSI Int, Brief Symptom Inventory Interpersonal Sensitivities Scale; BSI Depr, Brief Symptom Inventory Depression Scale; BSI Anx, Brief Symptom Inventory Anxiety Scale; BSI Host, Brief Symptom Inventory Hostility Scale; BSI Phob, Brief Symptom Inventory Phobic Anxiety Scale; BSI Para, Brief Symptom Inventory Paranoid Ideation Scale; BSI Psyc, Brief Symptom Inventory Psychoticism Scale.

Table 2 – Baseline Measurements for Group A Participants on All Outcome Measures

	Screened Mean (SD) n = 8	Attended Mean (SD) n = 5	Did not attend Mean (SD) n = 3
SCID-II	6.63 (1.77)	7.20 (1.50)	5.67 (2.08)
EQ-5D	43.75 (16.64)	45.00 (21.21)	41.67 (7.64)
BDI	37.50 (13.32)	40.00 (16.76)	33.33 (4.16)
STAI State	60.88 (14.14)	60.40 (17.57)	61.67 (8.96)
STAI Trait	67.63 (10.00)	68.00 (12.69)	67.00 (5.20)
IIP-32	74.50 (23.60)	79.20 (28.95)	66.67 (11.24)
BSI GSI	2.40 (0.87)	2.60 (0.98)	2.06 (0.66)
BSI PST	45.88 (6.56)	48.60 (4.62)	41.33 (7.64)
BSI PSDI	2.71 (0.69)	2.78 (0.85)	2.59 (0.41)
BSI Som	1.77 (1.32)	2.23 (1.48)	1.00 (0.52)
BSI Obs	2.77 (1.02)	2.90 (1.09)	2.56 (1.07)
BSI Int	2.75 (0.82)	2.85 (0.95)	2.58 (0.72)
BSI Depr	2.60 (0.95)	2.63 (1.22)	2.56 (0.38)
BSI Anx	2.54 (1.00)	2.37 (1.12)	2.83 (0.88)
BSI Host	1.8 (1.39)	2.52 (1.24)	0.60 (0.53)
BSI Phob	2.90 (0.75)	2.64 (0.82)	3.33 (0.42)
BSI Para	2.08 (1.15)	2.60 (0.91)	1.20 (1.06)
BSI Psyc	2.30 (1.00)	2.60 (1.12)	1.80 (0.60)

Structured Clinical Interview for DSM-IV Axis I; EQ-5D, The EuroQol overall health state; BDI, Beck Depression Inventory; STAI State, Spielberger State-Trait Anxiety Inventory State Anxiety; STAI Trait, Spielberger State-Trait Anxiety Inventory Trait Anxiety; IIP-32, Inventory of Interpersonal Problems; BSI GSI, Brief Symptom Inventory Global Severity Index; BSI PST, Brief Symptom Inventory Positive Symptom Total; BSI PSDI, Brief Symptom Inventory Positive Symptom Distress Index; BSI Som, Brief Symptom Inventory Somatisation Scale; BSI Obs, Brief Symptom Inventory Obsessive-Compulsive Scale; BSI Int, Brief Symptom Inventory Interpersonal Sensitivities Scale; BSI Depr, Brief Symptom Inventory Depression Scale; BSI Anx, Brief Symptom Inventory Anxiety Scale; BSI Host, Brief Symptom Inventory Hostility Scale; BSI Phob, Brief Symptom Inventory Phobic Anxiety Scale; BSI Para, Brief Symptom Inventory Paranoid Ideation Scale; BSI Psyc, Brief Symptom Inventory Psychoticism Scale.

Table 3 – Baseline Measurements for Group B Participants on All Outcome Measures

	Screened Mean (SD) n = 5	Attended Mean (SD) n = 4	Did not attend Mean (SD) n = 1
SCID-II	7.00 (1.59)	7.50 (1.29)	5.00
EQ-5D	31.60 (17.97)	26.25 (15.48)	53.00
BDI	37.80 (13.48)	43.75 (2.50)	14.00
STAI State	60.80 (12.32)	65.75 (6.24)	41.00
STAI Trait	65.60 (10.45)	69.50 (6.66)	50.00
IIP-32	63.00 (30.03)	75.75 (10.91)	12.00
BSI GSI	2.36 (0.71)	2.51 (0.24)	1.15
BSI PST	46.40 (5.32)	48.50 (2.89)	38.00
BSI PSDI	2.65 (0.63)	2.90 (0.31)	1.61
BSI Som	1.66 (1.08)	1.79 (1.20)	1.14
BSI Obs	2.83 (0.81)	3.17 (0.36)	1.50
BSI Int	2.75 (1.08)	3.19 (0.52)	1.00
BSI Depr	2.47 (1.05)	2.88 (0.60)	0.83
BSI Anx	2.53 (0.77)	2.83 (0.43)	1.33
BSI Host	1.92 (0.70)	2.20 (0.37)	0.80
BSI Phob	2.72 (0.97)	3.25 (0.25)	1.00
BSI Para	2.16 (0.65)	2.40 (0.43)	1.20
BSI Psyc	2.92 (0.70)	3.10 (0.66)	2.20

Structured Clinical Interview for DSM-IV Axis II; EQ-5D, The EuroQol overall health state; BDI, Beck Depression Inventory; STAI State, Spielberger State-Trait Anxiety Inventory State Anxiety; STAI Trait, Spielberger State-Trait Anxiety Inventory Trait Anxiety; IIP-32, Inventory of Interpersonal Problems; BSI GSI, Brief Symptom Inventory Global Severity Index; BSI PST, Brief Symptom Inventory Positive Symptom Total; BSI PSDI, Brief Symptom Inventory Positive Symptom Distress Index; BSI Som, Brief Symptom Inventory Somatisation Scale; BSI Obs, Brief Symptom Inventory Obsessive-Compulsive Scale; BSI Int, Brief Symptom Inventory Interpersonal Sensitivities Scale; BSI Depr, Brief Symptom Inventory Depression Scale; BSI Anx, Brief Symptom Inventory Anxiety Scale; BSI Host, Brief Symptom Inventory Hostility Scale; BSI Phob, Brief Symptom Inventory Phobic Anxiety Scale; BSI Para, Brief Symptom Inventory Paranoid Ideation Scale; BSI Psyc, Brief Symptom Inventory Psychoticism Scale.

Quantitative Analyses

Repeated Measures ANOVA was used to assess differences in scores on outcome measures across time. Where a significant effect of Time was demonstrated contrast tests, using one-way ANOVA, were used to compare scores at the different assessment points.

An intention-to treat (ITT) analysis was conducted including the nine participants who had attended beyond the initial assessment. Two of these nine group members attended only a small number of group sessions (two/three) and were lost to follow-up both at the 8-session midpoint and post-group. This missing data, as well other missing values, were replaced in the analyses using one of two methods. Intended as a conservative approach, the last occasion carried forward (LOCF) method of missing value replacement was adopted and, as a less conservative comparison, replacement with the occasion mean (OM). It has been demonstrated that the method of replacement of missing values (RMV) can have an influence on the results of statistical analyses (Power & Freeman, 2012). More complex approaches to RMV, such as expectation maximisation (EM) and multiple imputation (MI), were not employed as the missing data was not deemed to be missing-at-random (MAR) either intuitively or when tested in the Statistical Package for the Social Sciences (SPSS).

Due to the amount of RMV necessary in the ITT analysis (29.35%), the two participants who had not fully engaged with the intervention and accounted for a high proportion of missing data (10.48%) were removed to allow a comparison with the results for those participants who had attended at least four sessions (ALFS). Further comparison analyses were conducted due to missing data values remaining high. Separate analyses were also conducted for both the subset of participants who had provided data at least at both baseline and post-group, and for those who had complete sets of data (baseline, 8 sessions, and post-group). It is acknowledged that as the RMV is reduced by removing participants who did not provide full follow-up data the sample size and statistical power is reduced, and the likelihood of type II errors increases. These two sets of analyses are summarised in table 5 for comparison, but will not be fully reported here.

Descriptive statistics for each subset of participants used for analyses, and all 13 potential participants who attended for initial assessment, are detailed in Table 4.

Table 4 – Demographic data, rates of group attendance, and levels of missing data for all participants initially assessed and for each subset of participants used in statistical analyses

Subset	n	Age (mean, range, SD)	Gender (% female)	Employment (% employed)	Marital status (% married)	Sessions attended (mean, range, SD)	Missing data (%)
All screened	13	33.15, 20-49, 9.81	92.3	23.1	23.1	-	-
Intention- to-treat	9	32.33, 20-49, 10.78	88.9	33.3	33.3	7.44, 2-14, 3.84	29.35
Attended >4 sessions	7	31.29, 20-49, 10.44	100	42.9	42.9	8.86, 6-14, 3.02	18.87
Pre- and post-data	5	28.60, 20-41, 8.44	100	40.0	40.0	9.6, 6-14, 3.29	6.42
Complete data	4	35, 24-44, 8.29	100	50.0	50.0	10.5 8-14, 3.00	0

The progression across follow-up occasions, from baseline to 8 sessions to post-group will be referred to as 'Time' in the reporting of results. Both groups opted to continue up to the maximum number of 16 sessions and the final post-group assessment occasion will be referred to as '16 sessions'. A summary of the results of all conducted analyses is presented in Table 5, with an indication of the associated effect sizes for significant results. Figures 2 and 3 illustrate the mean scores on each outcome measure at each assessment point for the ITT analysis using RMV with OM. The pattern of means is similar in other analyses, graphs for which are included in Appendix E.

Table 5 – Results of repeated measures analyses for all data and data subsets, and with each RMV method

Included Cases	Intention to treat (n=9)		Attended >4 sessions (n=7)		Pre- and post-data (n=5)		Complete data (n=4)
	OM	LOCF	OM	LOCF	OM	LOCF	no RMV
SCID-II	X (0.58)	-	X (0.51)	-	-	-	-
EQ-5D	-	-	-	-	-	-	-
BDI	X (0.37)	X (0.33)	-	X (0.42)	(x)	(x)	(x)
STAI State	-*	-	-	X (0.33)	-	-	-
STAI Trait	X (0.35)	-	-	-	-	-	-
IIP-32	X (0.59)	(x)*	X (0.63)	(x)*	X (0.60)	X (0.61)	X (0.68)
BSI GSI	X (0.55)	-	X (0.52)	X (0.42)	X (0.59)	X (0.58)	X (0.70)
BSI PST	X (0.47)	-	X (0.42)	-	(x)	(x)	-
BSI PSDI	X (0.41)	(x)*	X (0.41)	(x)	(x)	(x)	(x)
BSI Som	-	X (0.37)	(x)	X (0.48)	X (0.57)	X (0.54)	X (0.66)
BSI Obs	X (0.45)	-	X (0.50)	(x)	(x)	(x)	(x)
BSI Int	X (0.60)	(x)*	X (0.57)	X (0.43)	X (0.55)	(x)*	(x)
BSI Depr	(x)	-*	-	-	-	-	-
BSI Anx	X (0.35)	-*	(x)	-*	(x)	(x)*	(x)
BSI Host	X (0.42)	-	(x)	-	-	-	(x)
BSI Phob	X (0.65)	X (0.37)	X (0.63)	X (0.48)	X (0.61)	X (0.62)	X (0.72)
BSI Para	X (0.59)	(x)*	X (0.57)	X (0.43)	X (0.60)	X (0.61)	X (0.72)
BSI Psyc	X (0.50)	X (0.38)	X (0.53)	X (0.49)	X (0.59)	X (0.60)	X (0.69)

*Huynh-Feldt or Greenhouse-Geisser used for overall within-subjects ANOVA due to violation of the sphericity assumption. Huynh-Feldt used when $\epsilon > 0.75$ and Greenhouse-Geisser when $\epsilon < 0.75$ (Girden, 1992).

(x) – significance found for at least one *a priori* contrast test, but not for overall repeated measures ANOVA

X – significance found for overall repeated measures ANOVA and at least one *a priori* contrast test.

η^2 - indicated in brackets for significant overall ANOVAs.

RMV, Replacement of Missing Values; OM, Occasion Mean; LOCF, Last Occasion Carried Forward; SCID-II, Structured Clinical Interview for DSM-IV Axis I; EQ-5D, The EuroQol overall health state; BDI, Beck Depression Inventory; STAI State, Spielberger State-Trait Anxiety Inventory State Anxiety; STAI Trait, Spielberger State-Trait Anxiety Inventory Trait Anxiety; IIP-32, Inventory of Interpersonal Problems; BSI GSI, Brief Symptom Inventory Global Severity Index; BSI PST, Brief Symptom Inventory Positive Symptom Total; BSI PSDI, Brief Symptom Inventory Positive Symptom Distress Index; BSI

Figure 2 - Means across the three assessment points for ITT data using RMV with OM for those measures with larger score ranges

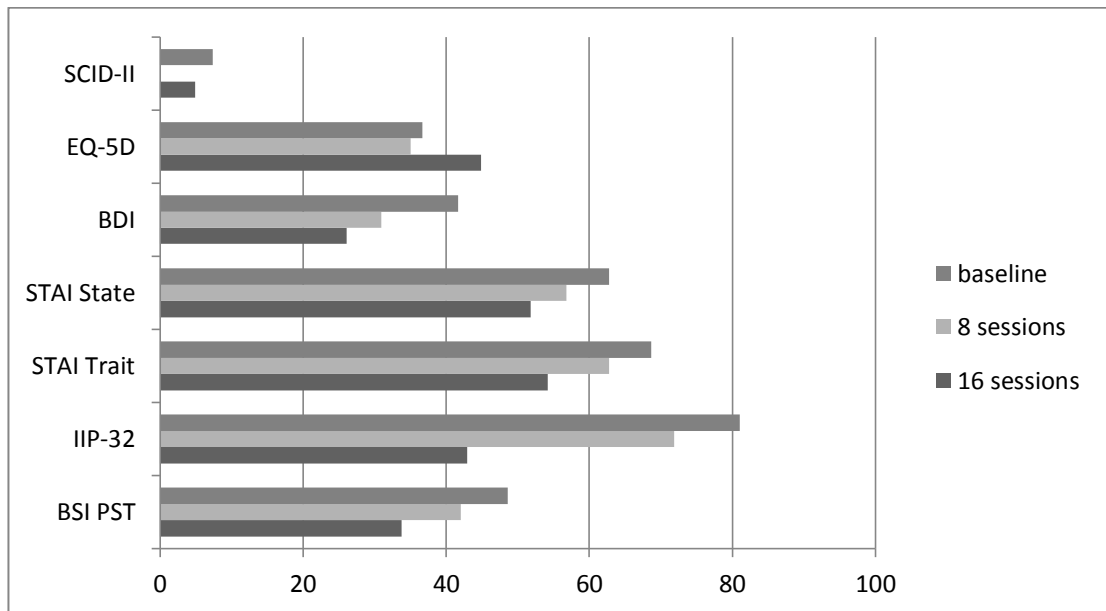
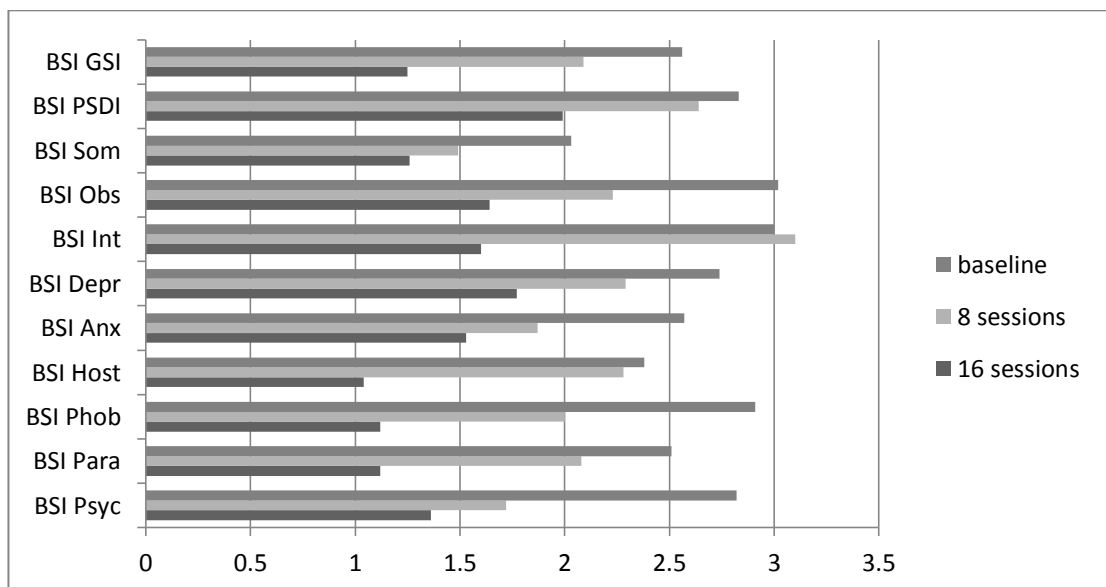


Figure 3 - Means across the three assessment points for ITT data using RMV with OM for those measures with smaller score ranges



SCID-II

RMV with OM

Both the ITT ($F(1,8) = 11.00, p < 0.05$) and ALFS ($F(1,6) = 6.26, p < 0.05$) analyses demonstrated significant effects of Time. The number of criteria met reduced significantly between baseline and 16 sessions.

RMV with LOCF

No significant differences were found in the number of criteria met between baseline and 16 sessions for either the ITT data ($F(1,8) = 2.770, NS$), or for the ALFS sub-group ($n=7$) ($F(1,6) = 2.965, NS$).

EQ-5D Overall Health State

RMV with OM

The ITT analysis showed no significant effect of Time ($F(2,16) = 0.84, NS$), and the same was shown for the ALFS subgroup ($F(2,12) = 0.46, NS$).

RMV with LOCF

No significant effect of Time was demonstrated for either the ITT analysis ($F(2,16) = 0.615, NS$) or the ALFS ($F(2,12) = 0.606, NS$) analysis.

BDI-II

RMV with OM

A significant effect of Time was shown in the ITT analysis ($F(2,16) = 4.63, p < 0.05$), but not for the ALFS analysis ($F(2,12) = 2.56, NS$). A priori contrast tests for the ITT analyses showed scores reduced significantly between baseline and 8 sessions ($t = 2.162, df = 24, p < 0.05$) and between baseline and 16 sessions ($t = 3.120, df = 24, p < 0.01$), but not between sessions 8 and 16 ($t = 0.958, df = 24, NS$).

RMV with LOCF

Both the ITT analysis ($F(2,16) = 3.94, p < 0.05$) and the ALFS analysis ($F(2,12) = 4.42, p < 0.05$) showed a significant effect of Time. For the ITT analysis the score was seen to reduce significantly between baseline and 16 sessions ($t = 2.138, df = 24, p < 0.05$), but not between baseline and 8 sessions ($t = 1.336, df = 24, NS$) or 8 and 16 sessions ($t = 0.802, df = 24, NS$). For the ALFS group scores were shown to decrease significantly between baseline and 16 sessions ($t = 2.332, df = 18, p < 0.05$), but not between baseline and 8 sessions ($t = 1.458, df = 18, NS$) or 8 sessions and 16 sessions ($t = 0.875, df = 18, NS$).

IIP-32

RMV with OM

A significant effect of Time was demonstrated in both the ITT analysis ($F(2,16) = 11.53, p < 0.05$) and in the ALFS analysis ($F(2,12) = 10.00, p < 0.01$). For the ITT analysis *a priori* contrasts showed a significant reduction in total score on the IIP-32 between baseline and 16 sessions ($t = 6.046, df = 24, p < 0.001$) and between 8 and 16 sessions ($t = 4.600, df = 24, p < 0.001$), but not between baseline and 8 sessions ($t = 1.357, df = 12.14, NS$). Similarly in the ALFS group contrasts demonstrated significant reductions between baseline and 16 sessions ($t = 2.525, df = 18, p < 0.001$) and between 8 sessions and 16 sessions ($t = 4.532, df = 18, p < 0.001$), but not between baseline and 8 sessions ($t = 0.692, df = 18, NS$).

RMV with LOCF

ITT analysis showed no significant effects of Time for the IIP-32 total score in either the ITT analysis ($F(1,081, 8.652) = 4.104, NS$) or the ALFS analysis ($F(1,094, 6.561) = 4.637, NS$).

STAI Trait Anxiety

RMV with OM

A significant effect of time was shown in the ITT analysis ($F(1,8) = 4.26, p < 0.05$), but not in the ALFS analysis ($F(2,12) = 2.023, NS$). *A priori* contrasts for the ITT data

was seen to significantly decrease between baseline and 16 sessions ($t = 2.808$, $df = 24$, $p < 0.05$), but not between baseline and 8 sessions ($t = 1.145$, $df = 24$, *NS*) or 8 sessions and 16 sessions ($t = 1.663$, $df = 24$, *NS*).

RMV with LOCF

No significant effects of Time were found in either the ITT analysis ($F(1,175, 9.398) = 1.94$, *NS*) or in the ALFS analysis ($F(2,12) = 2.013$, *NS*).

STAI State Anxiety

RMV with OM

No significant effects of Time were shown for either the ITT analysis ($F(1,261, 10.087) = 2.20$, *NS*) or for the ALFS analysis ($F(2, 12) = 1.98$, *NS*).

RMV with LOCF

There were no significant effects found in the ITT analysis ($F(1,099,8.793) = 2.812$, *NS*) or in the ALFS analysis ($F(1,109, 6.655) = 3.014$, *NS*).

BSI GSI

RMV with OM

Significant effects of Time were shown for both the ITT analysis ($F(2,16) = 9.61$, $p < 0.01$) and for the ALFS analysis ($F(2,12) = 6.61$, $p < 0.05$). Contrast tests on the ITT data found that the BSI GSI decreased significantly between baseline and 16 sessions

($t = 4.916$, $df = 24$, $p < 0.001$) and between 8 and 16 sessions ($t = 3.155$, $df = 24$, $p < 0.01$), but not between baseline and 8 sessions ($t = 1.761$, $df = 24$, *NS*). The same pattern was shown for the ALFS data with significant decreases between baseline and 16 sessions ($t = 4.127$, $df = 18$, $p < 0.01$) and between 8 and 16 sessions ($t = 2.466$, $df = 18$, $p < 0.05$), but not between baseline and 8 sessions ($t = 1.661$, $df = 18$, *NS*).

RMV with LOCF

The ITT analysis did not demonstrate a significant effect of Time for the BSI GSI ($F(1,173, 9.384) = 3.864$, *NS*), while in the ALFS analysis this was significant BSI GSI ($F(2,12) = 4.32$, $p < 0.05$). Contrast tests for the ALFS data demonstrated that the BSI GSI scores reduced significantly between baseline and 16 sessions ($t = 3.194$, $df = 18$, $p < 0.01$), but not between baseline and 8 sessions ($t = 1.748$, $df = 18$, *NS*) or 8 and 16 sessions ($t = 1.446$, $df = 18$, *NS*).

BSI PST

RMV with OM

A significant effect of Time was shown in both the ITT analysis ($F(2,16) = 11.73$, $p < 0.05$) and in the ALFS analysis ($F(2,12) = 4.31$, $p < 0.05$). For the ITT analysis contrasts showed that the BSI PST was significantly lower following 16 sessions than at baseline ($t = 3.896$, $df = 24$, $p < 0.05$) and following 16 sessions than at 8 sessions ($t = 2.168$, $df = 24$, $p < 0.05$), with no significant difference between baseline

and 8 sessions ($t = 1.728$, $df = 24$, *NS*). Contrasts conducted on the ALFS data found BSI PST scores were significantly less following 16 sessions than at baseline ($t = 3.064$, $df = 18$, $p < 0.01$), but there were no significant differences between baseline and 8 sessions ($t = 1.388$, $df = 18$, *NS*) or between 8 and 16 sessions ($t = 1.413$, $df = 9.48$, *NS*).

RMV with LOCF

No significant effects of Time were found in either the ITT data ($F(1,398, 11.182) = 2.40$, *NS*) or in the ALFS data ($F(2,12) = 2.531$, *NS*).

BSI PSDI

RMV with OM

Both the ITT analysis ($F(2,16) = 5.65$, $p < 0.05$) and the ALFS analysis ($F(2,12) = 4.20$, $p < 0.05$) showed significant effects of Time. Follow-up contrasts tests on the ITT data demonstrated that there was a significant reduction in BSI PSDI scores between baseline and 16 sessions ($t = 3.304$, $df = 24$, $p < 0.01$) as well as between 8 sessions and 16 sessions ($t = 2.548$, $df = 24$, $p < 0.05$), but no significant change between baseline and 8 sessions ($t = 0.756$, $df = 24$, *NS*). For the ALFS data contrasts found a significant reduction in scores between baseline and 16 sessions ($t = 2.920$, $df = 18$, $p < 0.01$), but not between baseline and 8 sessions ($t = 0.904$, $df = 18$, *NS*) or between 8 and 16 sessions ($t = 2.016$, $df = 18$, *NS*).

RMV with LOCF

No significant effects of Time were found for either the ITT data ($F(1,215, 9.717) = 3.078, NS$) or for the ALFS data ($F(2,12) = 3.334, NS$).

BSI Somatisation Scale

RMV with OM

No significant effects of Time were demonstrated in either the ITT analysis ($F(2,16) = 2.20, NS$) or in the ALFS analysis ($F(2,12) = 3.27, NS$).

RMV with LOCF

Significant effects of Time were shown in both the ITT analysis ($F(2,16) = 4.71, p < 0.05$) and in the ALFS analysis ($F(2,12) = 5.46, p < 0.05$). In contrasts conducted using the ITT data scores were seen to significantly decrease between baseline and 16 sessions ($t = 2.093, df = 24, p < 0.05$), but not between baseline and 8 sessions ($t = 1.652, df = 24, NS$) or between 8 and 16 sessions ($t = 0.441, df = 24, NS$). For the ALFS contrasts scores decreased significantly overall between baseline and 16 sessions ($t = 2.565, df = 18, p < 0.05$), but also did not differ significantly between baseline and 8 sessions ($t = 2.024, df = 18, NS$) or 8 sessions and 16 sessions ($t = 0.541, df = 18, NS$).

BSI Obsessive-Compulsive Scale

RMV with OM

Significant effects of Time were shown for both the ITT analysis ($F(2,16) = 6.65, p < 0.01$) and for the ALFS analysis ($F(2,12) = 5.91, p < 0.05$). ITT data contrast tests showed significant reductions in BSI Obsessive-Compulsive Scale scores between baseline and 8 sessions ($t = 3.669, df = 24, p < 0.01$) and between baseline and 16 sessions ($t = 2.090, df = 24, p < 0.05$), but not between 8 and 16 sessions ($t = 1.579, df = 24, NS$). For the ALFS contrasts there were significant reductions in scores between baseline and 8 sessions ($t = 2.142, df = 18, p < 0.05$) and between baseline and 16 sessions ($t = 3.443, df = 18, p < 0.01$), but not between 8 and 16 sessions ($t = 1.220, df = 10.99, NS$).

RMV with LOCF

There were no significant effects of Time found in either the ITT analysis ($F(2,16) = 2.991, NS$) or in the ALFS analysis ($F(2,12) = 3.229, NS$).

BSI Interpersonal Sensitivities Scale

RMV with OM

Significant effects of Time were shown for both the ITT analysis ($F(2,16) = 12.14, p < 0.01$) and for the ALFS analysis ($F(2,12) = 7.83, p < 0.01$). Contrasts conducted with the ITT data showed that scores decreased significantly between baseline and 16

sessions ($t = 3.590$, $df = 24$, $p < 0.01$) and between 8 and 16 sessions ($t = 4.936$, $df = 24$, $p < 0.01$), but not between baseline and 8 sessions ($t = 9.119$, $df = 24$, NS). The ALFS contrasts demonstrated that scores reduced significantly between baseline and 16 sessions ($t = 2.973$, $df = 11.4$, $p < 0.05$) and between 8 and 16 sessions ($t = 3.770$, $df = 6.615$, $p < 0.01$), but no significant difference was shown between scores at baseline and at 8 sessions ($t = -0.089$, $df = 6.977$, NS).

RMV with LOCF

The ITT analysis showed no significant effect of Time ($F(1,211,9.685) = 4.038$, NS), whereas a significant effect was found in the ALFS analysis ($F(2,12) = 4.55$, $p < 0.05$). Follow-up contrasts using the ALFS data showed that the mean score significantly decreased between baseline and 16 sessions ($t = 3.194$, $df = 18$, $p < 0.01$) and between 8 and 16 sessions ($t = 3.194$, $df = 18$, $p < 0.01$), but not between baseline and 8 sessions ($t = 1.748$, $df = 18$, NS).

BSI Depression Scale

RMV with OM

Neither the ITT analysis ($F(2,16) = 2.79$, NS) nor the ALFS analysis ($F(2,12) = 1.787$, NS) showed a significant effect of Time.

RMV with LOCF

No significant effect of Time was found in either the ITT analysis ($F(1.237,9.892) = 2.119, NS$) or in the ALFS analysis ($F(2,12) = 2.211, NS$).

BSI Anxiety Scale

RMV with OM

A significant effect of Time was shown in the ITT analysis ($F(2,16) = 4.34, p < 0.05$), but not in the ALFS analysis ($F(2,12) = 3.792, NS$). Contrast tests with ITT data demonstrated that BSI Anxiety Scale scores reduced significantly between baseline and 16 sessions ($t = 2.975, df = 24, p < 0.01$), but no significant differences were found between baseline and 8 sessions ($t = 2.014, df = 24, NS$) or between 8 and 16 sessions ($t = 0.961, df = 24, NS$).

RMV with LOCF

No significant effect of Time was found for either the ITT analysis ($F(1.063, 8.506) = 3.168, NS$) or for the ALFS analysis ($F(1.066,6.395) = 3.445, NS$).

BSI Hostility Scale

RMV with OM

A significant effect of Time was found in the ITT analysis ($F(2,16) = 5.80, p < 0.05$), but not in the ALFS analysis ($F(2,12) = 3.49, NS$). Contrasts examining the ITT data

demonstrated that there was a significant reduction in scores between baseline and 16 sessions ($t = 3.034$, $df = 24$, $p < 0.01$) and between sessions 8 and 16 ($t = 2.812$, $df = 24$, $p < 0.05$), but not between baseline and session 8 ($t = 0.222$, $df = 24$, NS).

RMV with LOCF

Neither the ITT analysis ($F(2,16) = 1.172$, NS) nor the ALFS analysis ($F(2,12) = 1.180$, NS) showed a significant effect of Time.

BSI Phobic Anxiety Scale

RMV with OM

Both the ITT analysis ($F(2,16) = 14.81$, $p < 0.001$) and the ALFS analysis ($F(2,12) = 10.02$, $p < 0.01$) found a significant effect of Time. Contrasts conducted with the ITT data showed that scores lessened significantly between baseline and 8 sessions ($t = 2.369$, $df = 24$, $p < 0.05$), between 8 sessions and 16 sessions ($t = 2.288$, $df = 24$, $p < 0.05$), and between baseline and 16 sessions ($t = 2.090$, $df = 24$, $p < 0.05$). The ALFS contrasts demonstrated that scores significantly decreased between baseline and 16 sessions ($t = 3.801$, $df = 18$, $p < 0.01$), but not between baseline and 8 sessions ($t = 2.022$, $df = 18$, NS) or between 8 sessions and 16 sessions ($t = 1.779$, $df = 18$, NS).

RMV with LOCF

A significant effect of Time was found in both the ITT ($F(2,16) = 4.71$, $p < 0.05$) and in the ALF analysis ($F(2,12) = 5.46$, $p < 0.05$). Contrasts with the ITT data showed

scores significant decreases in scores between baseline and 16 sessions ($t = 2.368$, $df = 24$, $p < 0.05$), but not between baseline and 8 sessions ($t = 1.326$, $df = 24$, *NS*) or 8 sessions and 16 sessions ($t = 1.042$, $df = 24$, *NS*). ALFS data showed a significant decrease in scores between baseline and 16 sessions ($t = 2.494$, $df = 18$, $p < 0.05$), but not between baseline and 8 sessions ($t = 1.397$, $df = 18$, *NS*) or 8 sessions and 16 sessions ($t = 1.097$, $df = 18$, *NS*).

BSI Paranoid Ideation Scale

RMV with OM

Significant effects of Time were found in both the ITT analysis ($F(2,16) = 11.71$, $p < 0.01$) and in the ALFS analysis ($F(2,12) = 7.80$, $p < 0.01$). Contrasts tests with ITT data demonstrated significant decreases in scores between baseline and 16 sessions ($t = 4.719$, $df = 24$, $p < 0.001$) and between 8 and 16 sessions ($t = 3.257$, $df = 24$, $p < 0.01$), but not between baseline and 8 sessions ($t = 1.462$, $df = 24$, *NS*). In contrasts conducted with ALFS data scores were seen to significantly reduce between baseline and 16 sessions ($t = 3.886$, $df = 18$, $p < 0.01$) and between 8 and 16 sessions ($t = 2.521$, $df = 18$, $p < 0.05$), with no significant difference between scores at baseline and at 8 sessions ($t = 1.366$, $df = 18$, *NS*).

RMV with LOCF

A significant effect of Time was found in the ALFS analysis ($F(2,12) = 4.57, p < 0.05$) and not in the ITT analysis ($F(1.216,9.730) = 4.054, NS$). Contrast tests with the ALFS data showed a significant reduction in scores was found between baseline and 16 sessions ($t = 3.123, df = 18, p < 0.01$), but not between baseline and 8 sessions ($t = 1.278, df = 18, NS$) or between 8 and 16 sessions ($t = 1.846, df = 18, NS$).

BSI Psychoticism Scale

RMV with OM

Both the ITT analysis ($F(2,16) = 8.12, p < 0.01$) and the ALFS analysis ($F(2,12) = 6.87, p < 0.05$) showed a significant effect of Time. ITT data follow-up contrasts showed significant decreases in scores between baseline and 8 sessions ($t = 2.868, df = 24, p < 0.01$) and between baseline and 16 sessions ($t = 3.804, df = 24, p < 0.01$), but not between 8 and 16 sessions ($t = 0.937, df = 24, NS$). In contrasts with ALFS data scores significantly decreased between baseline and 8 sessions ($t = 2.690, df = 18, p < 0.05$) and between baseline and 16 sessions ($t = 3.464, df = 18, p < 0.01$), but not between 8 and 16 sessions ($t = 0.774, df = 18, NS$).

RMV with LOCF

A significant effect of Time was found in both the ITT analysis ($F(2,16) = 4.99, p < 0.05$) and in the ALFS analysis ($F(2,12) = 5.85, p < 0.05$). For contrasts conducted with

ITT data there was a significant reduction in scores between baseline and 16 sessions ($t = 2.313$, $df = 24$, $p < 0.05$), with no significant differences found between either baseline and 8 sessions ($t = 1.573$, $df = 24$, *NS*) or 8 sessions and 16 sessions ($t = 0.740$, $df = 24$, *NS*). Contrasts with ALFS data demonstrated a significant reduction between baseline and 16 sessions ($t = 2.648$, $df = 18$, $p < 0.05$), but not between baseline and 8 sessions ($t = 1.801$, $df = 18$, *NS*) or 8 sessions and 16 sessions ($t = 0.847$, $df = 18$, *NS*).

Non-parametric Tests

On the basis of skewness and kurtosis statistics a number of variables in each analysis were deemed likely to violate the assumption of normality for the distribution of scores on at least one measurement occasion. Whilst the parametric tests are likely to remain robust despite minor departures from one assumption, non-parametric tests were carried out for completeness. The Friedman test for related samples was conducted to test for differences across Time, and where this was significant pairwise comparisons using the Wilcoxon Signed Ranks Test were used to further investigate differences between assessment points. Full details are reported in Appendix F. Several discrepancies were found between the parametric and non-parametric results.

BDI-II

The effect of Time for the non-parametric RMV with OM ALFS analysis did not reach significance.

STAI Trait Anxiety

The effect of Time for the non-parametric RMV with OM ITT analysis did not reach significance.

BSI GSI

For the non-parametric RMV with LOCF analysis a significant effect of Time was demonstrated, and was significantly lower at 16 sessions than at 8 sessions.

BSI PST

As with the parametric analysis, a significant effect of Time was found in the non-parametric RMV with OM ITT analysis, however, the non-parametric pairwise comparisons showed a significant difference between baseline and 8 sessions, as opposed to between 8 and 16 sessions.

BSI Somatisation Scale

Significant effects of Time were not found in either the RMV with OM ITT or RMV with OM ALFS analyses.

BSI Hostility Scale

As with the parametric analysis, a significant effect of Time was found in the non-parametric RMV with OM ITT analysis, however, the non-parametric pairwise comparisons showed a significant difference between baseline and 8 sessions, as opposed to between 8 and 16 sessions.

Qualitative Analysis

Four participants were interviewed two of whom had attended Group A and two from Group B. The other participant who had remained engaged with Group B declined follow-up after session 16 due to a recent bereavement. The other participant who had initially been engaged with Group B did not respond to correspondence relating to the follow-up. Of those not interviewed from Group A one declined citing an unwillingness to request leave from work, one declined to provide a reason for not attending follow-up, and one had disengaged from the community mental health service generally and did not respond to invitations to attend for follow-up.

Three of the four participants interviewed had provided quantitative data across all three time points, with the remaining interviewee completing quantitative outcome measures at baseline and at 16 sessions only. For three of those interviewed the group was their only contact with services during the course of the groups. One hundred per cent of those interviewed were female, fifty per cent were employed and fifty per cent married. The mean age of the interviewees was 29 years (SD 9.60, range 20-41 years). The mean number of sessions attended was 9 (SD 3.46, range 6-14 sessions).

The semi-structured interviews were conducted by two psychologists according to the geographical area associated with each group. One psychologist therefore interviewed those from Group A and the other interviewed those from Group B.

All interviews closely followed the pre-determined interview schedule, however, interviews varied in duration according to the extent to which the interviewees were willing or able to elaborate. The pattern of variation did not suggest a systematic difference between interviewers as one interview was significantly longer than the other three. The mean duration of interview was 19 minutes 54 seconds, with a range from 14 minutes 56 seconds to 35 minutes 50 seconds.

Analysis Procedure

Qualitative data was transcribed and analysed using an inductive, semantic-level, thematic analysis approach, following the guide described by Braun and Clarke (2006). The analysis was conducted by the chief investigator, also the group facilitator, which is likely to have an influence with regard to the interpretations drawn.

The analysis was carried out across questions, in order to identify commonalities within the data as a whole, with two exceptions. The information about participants' hopes collected pre-group were examined exclusively as a separate subtheme, as the intention was to use this data comparatively to obtain a sense of whether these hopes had been met post-intervention. The final question in the post-

group semi-structured interviews was related to what participants would remember most about their time in the group. The purpose of this question was to obtain an indication of the most salient aspect of the intervention for each group member, and so this data was examined both separately to address this question and also as part of the main dataset.

The analysis was not a linear process, but did involve a number of general stages. Noticing potential patterns or commonalities between ideas expressed by different participants was unavoidable during the transcription process, however, notes were not taken until after there had been an opportunity to read through the full dataset in its entirety. An orthographic transcript was produced and a hardcopy was then read through a number of times during which notes and ideas for potential codes were added. During this process codes were refined as much as possible before a table was produced containing all the potential codes in one column alongside the data extracts relevant to them. Following this the transcripts were approached systematically to ensure that all meaningful items of data were represented. As recommended by Braun & Clark (2006) some surrounding data for each item was kept to maintain the context. A theme column was then introduced into the data analysis table and codes were grouped according to potential themes. Themes were then reorganised such that some which appeared related were grouped together into overarching themes and some divided to include subordinate themes. The initial thematic map relating to the data was produced at this stage (Figure 4).

The data was revisited a number of times in terms of a consideration of the appropriateness of the identified themes. Attempts were made to concisely define each theme to explore internal homogeneity and external heterogeneity. Some themes that were not sufficiently supported by the data were removed, and some were subsumed by other themes. The original full dataset was then revisited in the context of the generated themes to ensure that the proposed thematic structure fit with the data as a whole. This process of theme refinement resulted in the final thematic map (Figure 5). The detail of the themes identified follows.

Consideration of the Roles of Group Facilitator/Researcher and Interviewers

While there can be reflexive awareness on the part of the group facilitator/researcher in terms of their dual role and the potential biases in the interpretation of data that this may produce, the influence on the study participants is more difficult to identify and control. Due to the interpersonal relationships developed between group members and the facilitator research participants may have been less inclined to acknowledge negatives or lack of impact related to the intervention to protect the facilitator from disappointment in their research findings. Any expectation of having to provide negative feedback at interview may therefore have discouraged some participants, particularly those who had experienced the group less favourably, from attending for follow-up.

Objectivity as it relates to bias is arguably present in all research due to the investment of time and resources by researchers, and their hope that research findings will be significant and positive. For quantitative data this can be controlled to an extent by the predetermination of measures to be used and the nature of quantitative analysis. In terms of the interpretation of qualitative interviews, where the researcher has an investment in the outcome, the subject of objectivity raises epistemological questions regarding the objectivity of knowledge generally. Kvale & Brinkman (2009) suggest that a definition of objectivity as “freedom from bias” cannot be employed, and should be replaced with reflexive objectivity, in this case relating to the role of the researcher/group facilitator. As prejudice is unavoidable an awareness of the potential conflict between the roles of researcher and group facilitator when approaching interpretation of the interview data at least affords objectivity in relation to subjectivity.

Attempts were made to maintain an awareness of this influence during qualitative analysis, and it is also accepted that the purpose of the analysis is not to uncover an ultimate truth, but rather a socially constructed description of experience in which the researcher has also played a role. This perspective is also consistent with the social constructionist theoretical basis of the evaluated intervention.

Social constructionist ideas can also be related to the issue of the impact of two interviewers in that all such interviews are unique and exist within a social context

(Seidman, 1998). Social factors such as gender, age, class, status, and ethnicity exert influence on interview interactions. Each interview is a reflection of the qualities of both the participant and interviewer and how they interact. The development of such interrelationships cannot be influenced in the course of research (Kvale, 2007). Just as different interactions will have occurred between each interviewer and each participant different interactions would also have occurred between each participant and a single interviewer due to reciprocal influences and differences between participants.

Due to the lack of influence over this interactional process Kvale (2007) recommends a focus on the skills and knowledge of the interviewers in producing high quality interviews. Interviewer qualities identified are: knowledge of subject; structure; clarity; gentle approach; sensitivity; openness; steering; critical; remembering; and interpreting. It is highlighted that many of these skills are required for therapeutic interviews and in this sense the psychologists conducting the interviews in this study will be highly experienced in these areas. The researcher provided knowledge of the subject area and clear research questions, as well as an agreed interview structure.

No research interviews can be classed as open dialogues between egalitarian partners, and a clear power imbalance exists between a user of mental health services and a psychologist. The possibility that group participants reacted to this

imbalance by responding as they believed the interviewer would wish them to cannot be ruled out. Such influences on responses were deemed as potentially less likely to occur with interviewers independent of the running of the groups, although potentially participants were conscious that the group facilitator would be listening to their responses.

Figure 4 – Qualitative Analysis: Initial Thematic Map

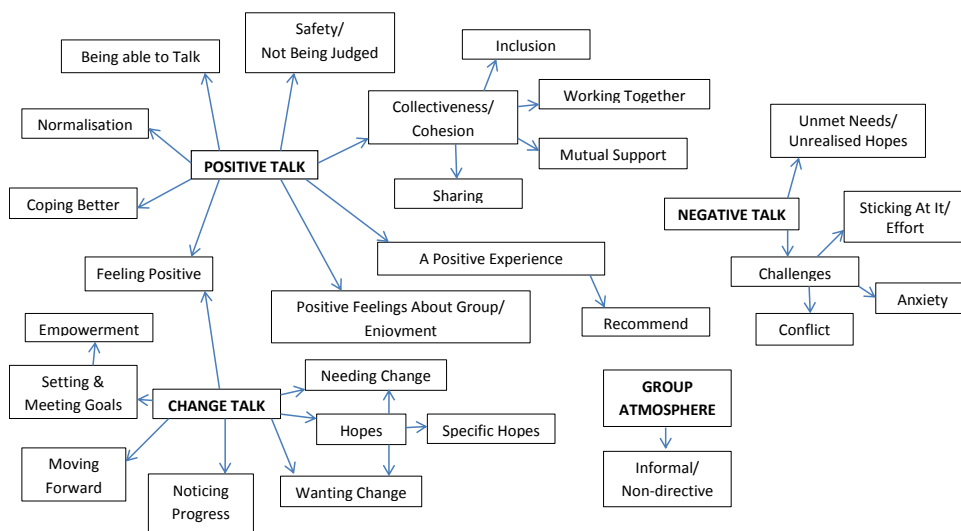
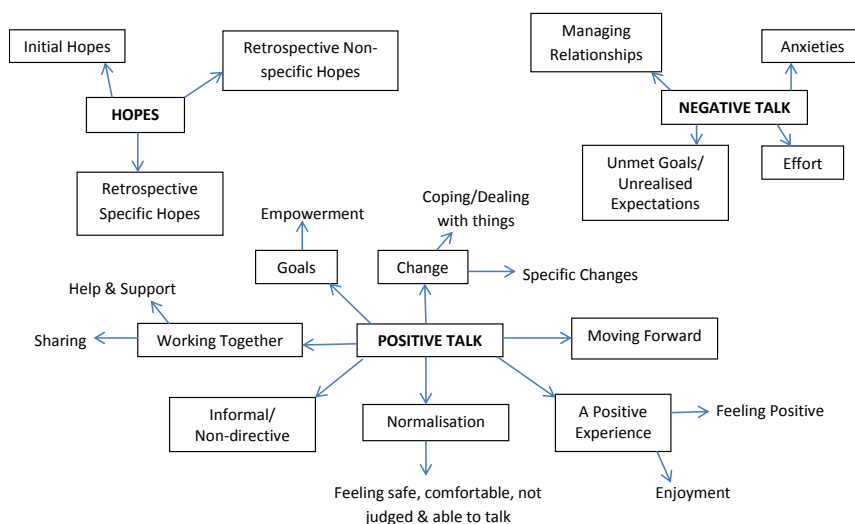


Figure 5 – Qualitative Analysis: Final Thematic Map



Hopes

- *Initial hopes*

Commonalities were identified in the initial hopes expressed by participants, as well as a range of specific hopes particular to the individuals that were not deemed common enough to form a category in their own right. The participants provided the information in written form and were relatively concise in their responses. The main subthemes identified, ordered by most to least frequently occurring, were:

Coping or dealing with things better ('...learn to cope better', 'Learning to deal with what's wrong with me'); *Feel better* ('I will feel more positive about life', '...to gradually feel better'); *More positive view of self* ('Feel a bit more likeable. Feel better about myself', 'More self-esteem and confidence'); *Improved Interpersonal Relationships* ('To help how I come across to people', 'Believing and trusting other people'); *Better relationship with BPD* ('To learn more about my diagnosis', 'To change my opinions about my diagnosis'); *Less anger/aggression* ('To help with anger outbursts', 'Control temper at home'); and *Normalisation* ('To meet other people with BPD...', 'Listening to others with problems like mine'). Some examples of *specific changes* that were hoped for are: 'Feeling able to talk about it', 'Motivation', 'To help get kids back' and '...to react calmly when people say negative things...'.

During the post-group interviews all the participants reflected upon what their hopes had been on entering the group.

- *Retrospective Non-specific Hopes*

All those interviewed mentioned hopes relating to a general sense of improvement such as being 'normal', 'happy', or 'better'. This appears to suggest a hope for a qualitatively different outlook and/or experience of life that is not directly related to any one specific change and is consistent with some of the initial hopes expressed by participants (*Feel better*).

- *Retrospective Specific Hopes*

Three of the interviewees expressed more specific hopes, with two suggesting a desire to better grasp and accept their BPD diagnosis. A reduction in anxiety and a hope to manage without the need for medication were also mentioned.

Positive Talk

Data was categorised as positive talk when it conveyed some sense of a positive aspect of the group intervention in terms of structure, process, or outcomes.

- *Working together*

All those interviewed identified some positive aspects of working collectively within the group. They conveyed a sense of active involvement, negotiation and shared agreement amongst group members, with nobody being excluded ('Everybody got a chance. If we didn't want it we could say. Everybody agreed on how it was', '...everyone was pleased with it.', '...we could talk about anything that

we wanted to...’, ‘we all kinda done it as a group and nobody really objected...we set our own rules’, ‘...that was good cos it wasn’t just the [facilitator] saying ‘we’re gonna do this, this and this’...we got to decide...’). One participant indicated that they saw the aspect of working together as vital to a successful outcome (‘...the group does work for you if you’re willing to work with them’). The presence and value of mutual support and sharing within the group was frequently acknowledged and the ease for group members in providing this for others was reported (‘...we supported each other in the group.’, ‘So it was nice to get some information and support from other people.’, ‘...they tried to help you, they gave you ideas if you needed...’, ‘...it wsa easy just to tell them and suggest what helped for me might help for them, so it was easy just to suggest that...’, ‘...they were able to help...’, ‘We shared some personal things to help each other.’, ‘...people who just wanted to help you.’, ‘It was good to be able to like get things from them as well.’, ‘People in the group had em...ehm...see when they were having down days or when they were having dips in their moods and stuff, they had ways of em trying to bring themselves out of it, like different ideas. So they would give you tips on how to do that...’, ‘Knowing there was other people there with the same problem who couldn’t go outside and their suggestions for going out...’, ‘In a way it was helpful cos you’re hearing other people, how they deal with it...’).

- *Informal and Non-directive*

Two of the interviewees talked positively about the general atmosphere and ethos of the group as informal and alluded to the facilitator allowing autonomy within the group rather than directing it extensively. This appeared to be at odds with what these participants expected based on their knowledge or experience of services ('I thought it was gonna be a big group of people that were gonna judge everything you said, when in actual fact it was a small group of people who just wanted to help you.', 'I didn't feel it was very clinical...', 'Most groups that you go to it's all the same things [sighs] that they set out, 'here's a plan', and ehm 'these are the things that you're looking for', an' it's all about y'know that you have to follow self-help an' 'these are the things that you look for', an' it's just [sighs]. I know all these things, but the group wasn't like that. The group, it was, it was totally different from what I expected... Yeah, it was really good.', 'I thought that was good cos it wasn't just [facilitator] saying 'we're gonna do this, this and this'. It was an asking 'Right. What do you want to do in the group? What do you want to focus on in the group?' and we got to decide the certain parts that we wanted to get help with. So that was good.', 'So taking control and making decisions about how to get me better myself was something new and scary. It's helped me a lot, because I can now make decisions on a day-to-day basis...', '...it was rather strange because I hadn't ever thought about it before, my own individual goals. What I needed to make myself feel better.').

- *Normalisation*

All the interviewees appeared to emphasise the importance of the experience of meeting and working with other people with BPD ('...it's unbelievable to know that there's somebody the same way that I am.', '...there is people like you and you do see that for yourself.', '[what was positive about the group?] Meeting other people with the same...', 'I know there's loads of people out there that have mental health problems, I mean I come from a family full of it [laughs], but to actually know there were some people my age with it was [pause] different.'). Participants spoke about the impact of this in terms of their realisations that they weren't 'crazy', that 'it's not all made up', that they are not 'weird' and that they are not 'all alone'. One group member gave a vivid description of the impact of meeting others with BPD on her by saying '...I don't have to suffer in silence or feel like I'm standing in the middle of a crowded room screaming and then nobody pays attention...'. Participants described the influence of this phenomenon on their experience of the group in terms of an unspoken sense of shared understanding and acceptance, allowing group members to feel safe and able to speak openly and honestly ('Aye other group members too cos they were able to help you cos they kened what you were feeling.', '...we could all relate to it...', '...nobody would judge me for how I was feeling, or the thoughts that I had, or, just nobody to judge me. Cos they were the same.', 'Nobody criticised you at all, cos we were all in the same situation. [Mm hm. So it felt quite a safe place to be?] Very safe.', 'I could talk about things in the group

[pause] and they would understand. But I can't talk to anybody else about because people in the group knew. Y'know it's all the same that they were going through.', 'I was able to open up and talk, which is something I've never really been able to do before.').

- *Goals*

The process of setting, working towards and meeting goals was commonly referred to by all interviewees. Participants spent the most time talking generally about the process of how goals were discussed within the group and relaying their own goals to the interviewer. At times this process was alluded to as having been positive. Some of the participants reports suggested a sense of achievement and empowerment inherent to the task of taking on personal responsibility for improvement ('I thought that was good cos it wasn't just [facilitator] saying 'we're gonna do this, this and this'. It was an asking 'Right. What do you want to do in the group? What do you want to focus on in the group?' and we got to decide the certain parts that we wanted to get help with. So that was good.', 'I managed to keep it going...', '[what was positive about the group?] I think the work we did ourselves.', 'It's helped me a lot, because I can now make decisions on a day-to-day basis without phoning my mum or my gran and being like 'I need help, do I do this or do I do that?' I can turn round and do it myself. I don't have to have anybody helping me now.'). One participant spoke in a positively about the novelty of

making decisions herself about how to get better ('it was rather strange because I hadn't ever thought about it before, my own individual goals. What I needed to make myself feel better.'). Three of the interviewees conveyed a sense that they perceived the process of working towards goals as ongoing ('I think it was very good cos I still use them to now.', 'Like I'd worry about getting on a bus. I dinnae as much worry about that anymore...and like I still get worry and like I got a bike and I'd love to go on it, but I just have this thing where I cannae do it, but I think to myself 'I've done it with the bus' so it'll come, ken what I mean? It's like wee bits at a time ken? Like something that seemed impossible before, or you can't do it yet, it seems like it could be possible in the future.', '[So does it feel that you've met the goals that you set for yourself them?] [pause] [intake of breath] some of them. Not all of them. I still can't go outside unless I have music blaring in my ears so I can't hear people. Otherwise if I can hear them I get paranoid that they're talking about me. I've always had to deal with that. [So that's stuck around.] Yes, and I can't get rid of that. I know I'm never gonna get rid of that em, but, what was the question again? [both laugh] [Just thinking about whether or not you think that you've met the goals that you set for yourself.] Ah, I have met some of them. I can get up in the morning now, I can go outside isay as long as I have my music on I can, [pause] I feel I can get a bit more out of life rather than hiding in here with the curtains shut and not moving off the couch.').

- *Change*

As well as talking about change indirectly through dialogue about achieving goals two of the participants spoke in general terms about noticing change that they attributed to attending the group, with one group member citing this as the reason that they continued to attend ('And I think when I started to go I could see a change, that's why I kept coming back.', 'gradually I could see wee changes.....to the point where you look at the start and the end of it and you realise 'it has done something', 'Just [pause] I'd tell them that it, I cannae really explain how it is, but, you don't feel like it's doing anything, but actually it is. When you look like, as a, [pause] at the time when you're going you're like [intake of breath] 'what is this doing?', but it's not til you've left and you feel a lot better cos you've been there.', 'Yeah and it did make a difference...it made a big difference to me...', 'Everything was better.').

Three of the participants referred to a sense of seeing themselves coping better while attending the group ('I don't have to have anybody helping me now.', 'I felt as though I was coping more with things...', 'I would have said that I was probably a stronger person, ehm, aannnd ehm, I could probably cope with more.', 'this group helped me on how ...to keep it on an even keel...'). All the interviewees described more specific changes, the majority of which were related to being able to carry out tasks or activities and some related to improvements in mood ('I can get up in the morning now, I can go outside isay as long as I have my music on I can, [pause] I feel I can get a bit more out of life rather than hiding in here with the curtains shut

and not moving off the couch.', 'I can now make decisions on a day-to-day', 'a little bit more relaxed with things. Just in myself. In myself.', 'Like I'd worry about getting on a bus. I dinnae as much worry about that anymore...', 'able to open up and talk, which is something I've never really been able to do before.', 'I can go out with my friends, I can go and see my gran, I can, and I still can't take [son's name] to the park on my own, but I can take him to see his family. I can walk down to the shop with him now and I don't have to get my neighbour to watch him so I can put my headphones in and ignore everybody. I can go there without doing that and listen to the world. It's just helped me with day-to-day things.', '...it's it's calmed my anxiety down...').

- *Moving Forward*

Some of what the participants said conveyed an idea about how they were starting to move forward after the end of the group. One interviewee who had left the group early reported feeling 'like I'm ten steps back', but also acknowledged '...that's nothing to do with the group, that's just what's going on just now.' All the participants mentioned at least one aspect of the group that they were continuing to engage with such as ongoing positive contact with another group member and the continuing use of goals and the strategy of approaching tasks a step at a time. Two group members described a sense of hope for the future ('Like something that

seemed impossible before, or you can't do it yet, it seems like it could be possible in the future.', 'Hope and faith that there is a way that it can all get sorted.').

- *Positive Experience*

All the participants reinforced their positive view of their experience of the group with frequent general comments such as: 'It was just a really really good group.'; 'It was better than what I expected... Way better.'; '...it was perfect.'; '...it was a nice place to go.'; '...it was just a, a positive experience.'; '...the group's wonderful.'.

There was also a sense that the interviewees had felt more positive as a result of attending the group ('I just feel a wee bit more alive inside.', 'I was more positive because I felt as though I was coping more with things...ehm...and I felt as though things were on the up...', '...everybody would tell you I had a spring in my step that times that I did attend that group.'). Two of the interviewees also explicitly reported enjoying the groups ('I actually enjoyed going.', '...I really wanted to go back, I really enjoyed it...', '...I had something to look forward to...').

Negative Talk

Data was categorised as negative talk when it referred to some negative or challenging aspect of engaging in the intervention.

- *Managing Relationships*

Two of the participants spoke about the challenges of managing interpersonal relationships within their groups ('It was quite hard. Cos everybody had their own each personal triggers and how to handle, you've got to watch how you say things and how you handle it, but...It was quite hard some weeks if someone was going through a bad patch you didn't know how to react, but it was ok, once you got to know them it was fine.', '...I thought, I thought we were being open and honest when we come to the group. I thought we were telling everything. You're not. You're telling me stuff, but then you're not telling them...').

- *Anxieties*

Three of the participants relayed their experience of having to overcome anxiety in order to attend the group, with one describing having to brace herself before each group meeting ('I was really scared, I have to say when I first walked into that room. I didn't know anyone. And I didn't know if 'How am I gonna get on with them?' 'Are we all gonna get on ok?' and 'What state is everybody's PD at?'. Cos mine was bad at the time so I didn't know what I was walking into. How were we

all going to cope as a group? Was it going to work? How many was going to be there?', 'I was petrified [laughs] I don't do well at meeting people at all. I take panic attacks really easy. [Right, so it took a lot of courage for you to go?] Yeah, it took a lot for me to go.', 'It was daunting. I mean it really was. I know there's loads of people out there that have mental health problems, I mean I come from a family full of it [laughs], but to actually know there were some people my age with it was [pause] different.', 'Every time I was coming I was just like '[exhale of breath]'.'). While anxiety was acknowledged as a challenge there were also suggestions that confronting such anxieties had been beneficial ('to actually meet other people, like cos that was the thing that you're so scared of, but to actually go in with a room full of people. That helps.').

- *Effort*

Interviewees addressed various forms of effort related to attending the group. They described working hard ('I worked hard', '...it was really hard to start off with...'), challenging themselves ('...I got really upset, but I really wanted to go back', 'Every time I was coming I was just like [exhale of breath]', having to 'stay focused', and feeling 'drained'. Some participants alluded to the amount of effort required reducing over the course of the intervention ('It was quite hard some weeks if someone was going through a bad patch you didn't know how to react, but it was ok, once you got to know them it was fine.', 'It became really easy after a while.').

- *Unmet Goals/Unrealised Hopes*

Two participants expressed the view that they would have benefited from the opportunity to attend more group meetings, either because they did not attend all available sessions or because they wanted a longer-term intervention ('I really wish I had seen the group through because I don't feel as though I got the full benefit from the group...', 'Yeah, it was only every fortnight, but it would have been nice if it was every week.', 'I'd like to go to another one if there's any more available.').

One participant was the most regular attender in a group where attendance was frequently low. She commented on the additional benefits she might have expected if more people had attended more often, 'Just eh it's hard to say because, cos it was only a small amount of people. It would have been good to come every week and the same people being there and building relationships with the people you're with...').

CHAPTER 5

Discussion

Discussion

The results demonstrate progressive improvements in symptoms over the course of the intervention across all outcome measures, although this was not consistent for the EQ-5D overall health state or for the BSI Interpersonal Sensitivities Scale. In ITT analyses quality of life was seen to have reduced by session eight with subsequent improvement such that it had improved to above baseline levels by session sixteen. For analyses where the OM method of RMV was adopted there were increases in mean scores on the BSI Interpersonal Sensitivities Scale followed by decreases to below baseline means at session sixteen. Whilst scores on all other outcome measures consistently increased, suggesting improvement, not all of these differences were found to be significant. The most robust findings across analyses were significant improvements in phobic anxiety and psychoticism. The BSI Phobic Anxiety Scale measures a construct similar to agoraphobia involving irrational and disproportionate fear responses to specific situations, and associated disruptions to activities (Derogatis, 1993). This improvement may be related to qualitative reports suggesting a process of challenging anxieties, particularly in relation to feared situations such as going out, getting the bus, and attending the group. The benefits of this change, and the associated reductions in disruption to activities, were highlighted by the participants interviewed. The BSI Psychoticism Scale refers to isolation and withdrawal associated with a schizoid lifestyle and taps into interpersonal alienation (Derogatis, 1993). The *Normalisation* theme highlighted in

the qualitative analysis, along with participant reports of feeling less alone and more supported, could be associated with improvements on this scale.

Opportunities for normalisation within the group may also have been instrumental in the significant reductions in somatisation found in some analyses. Discussing similar experiences within the group may have afforded group members opportunities to reframe inaccurate or extreme interpretations of bodily sensations, and overcoming anxieties may be linked with less extreme interpretations of the associated autonomic effects.

The results across all analysis suggest significant improvements in interpersonal functioning, predominantly between sessions 8 and 16. Qualitative themes related to this improvement may be identified as: *Normalisation*, *Managing Relationships*, and mutual support and sharing through *Working Together*. Some results also indicated a significant reduction in the number of criteria met on the SCID-II. This does not, however, necessarily reflect a change from above to below the diagnostic threshold although this was the case for some participants. Relatively consistent improvements in depressive symptoms across analyses are evident, with some reaching significance. Qualitative data suggests that this may be associated with the processes of seeing change, empowerment and a feeling of continuing to move forward, as well as with the positive experience of the group. Significant reductions in symptom severity and related distress are indicated by changes in BSI indices. The qualitative analysis included frequent references to generalised subjective

impressions of feeling better and coping better which may relate to such improvements. Less conservative analyses suggested significant improvements in both hostility and obsessive-compulsive symptoms.

Improvements in general anxiety were found to be significant in some, but not all, analyses. Non-significant results appear inconsistent with qualitative reports emphasising the beneficial effects of the group in terms of anxiety. The qualitative data also suggest increases in coping abilities and in the ability to challenge difficulties, and it is possible that group members' skills and confidence in coping with anxiety increased as opposed to anxiety symptoms being markedly reduced. A further possibility is the influence of RMV method. It was expected that a greater number of significant outcomes would be found when using the less conservative OM method of RMV. Differences across analyses highlight the potential impact of the level and pattern of missing data on all results. Significant differences between baseline and 8-session scores are only present in analyses where OM was used as the RMV method. These findings could be explained as an artefact of the pattern of missing data, such that a large amount of 8-session assessment data was replaced with baseline data in RMV with LOCF analyses. The deterioration in quality of life found in ITT analyses at 8 sessions, followed by overall improvement by 16 sessions, may also be an artefact of the level of RMV required at the 8 session assessment point.

From an alternative perspective the lack of significant differences between baseline and 8 sessions may indicate a requirement for a 16-session treatment dose. In the context of a varied pattern and level of attendance the results are difficult to interpret in relation to treatment dose, however, such attendance patterns are likely to be typical in the BPD population, due to issues relating to emotional instability, impulsivity, and attachment style, and so the number of sessions offered in practice may need to account for this (Alwin et al., 2006; Swift, 2009).

The qualitative data indicate that some group members would have liked the groups to continue for longer, and it is unclear whether or not this would have led to more significant improvements. All the participants interviewed following the group mentioned their maintenance of some aspect of the group intervention and long-term follow-up would be beneficial in assessing the level of maintenance of treatment gains.

The findings from the current study are consistent with evaluations of the effects of SFT groups for a range of presenting problems which have demonstrated the potential for impacts on: depressive symptoms; quality of life; psychological distress; self-esteem; and the degree of perceived control over problems (Arvand *et al.*, 2012; Madigan *et al.*, 2012; Thorslund *et al.*, 2007; Quick & Gizzo, 2007). One study also suggested a positive impact on adherence to concurrent health treatment which, if facilitated through SFT group attendance by CMHT outpatients with BPD,

may indirectly benefit clients through increased engagement with other available treatments (Arvand *et al.*, 2012).

Similar results in terms of improvements in BPD-related symptoms and depression have been found following individual psychotherapeutic interventions for BPD including DBT, transference-focused therapy (TFP), schema-focused therapy, CBT and supportive therapy (Clarkin *et al.*, 2007; Davidson *et al.*, 2006; Giesen-Bloo *et al.*, 2006; and Linehan *et al.*, 1991). Levels of distress and dysfunction as assessed by BSI indices following one year of individual CBT remained relatively high for both the intervention group and treatment-as-usual (TAU) which seems to be in contrast with the significant improvements found in the current study (Davidson *et al.*, 2006). BSI indices have not been reported in other studies to allow further comparison.

Group treatments for BPD based upon Systems Training for Emotional Predictability and Problem Solving (STEPPS), acceptance-based emotion regulation, DBT skills, and schema-focused therapy applied to outpatients with BPD have also been demonstrated to have positive effects on BPD-specific symptoms and mood (Blum *et al.*, 2008; Farrell *et al.*, 2009; Gratz & Gunderson, 2006; Soler *et al.*, 2009). All these group interventions provided weekly group sessions and the duration of treatment ranged from 13 to 30 weeks. Group interventions were adjunctive to TAU for all but the DBT skills group, and both the schema-focused and acceptance-based emotion regulation groups required participants to be in concurrent individual

psychotherapy. Participants with comorbid psychotic disorders were excluded from all the reported group treatments, and those with below average IQ or cognitive impairment were excluded from all but the DBT skills group. Co-morbidity with alcohol or substance dependence was also used as an exclusion criteria in all but the schema-focused treatment, and the DBT skills group also excluded those who reported at least one high risk suicide attempt in the previous 6 month period or reported greater than 'some chance' of attempting suicide within the upcoming year. There are therefore some questions pertaining to both the level of severity of the BPD participants involved in these studies as well as the effectiveness of treatments for those with particular patterns of comorbidity not included in the research thus far. The SFT group treatment delivered as part of the present study appears to have produced improvements despite being less intensive in terms of frequency, not requiring concurrent individual psychotherapy, and not excluding on the basis of either severity or co-morbidity.

A further advantage of the current study is the inclusion of systematically gathered, detailed qualitative feedback to allow the relation of empirical outcomes to the clients' experiences of the intervention.

The qualitative results indicate that the majority of the participants' initial hopes were addressed by the intervention. The themes identified inductively from the qualitative data suggest that the group contributed to positive change which was

associated with coping better, feeling better, empowerment, and working together towards specific, personally-defined goals. Aspects of the group which appear to have facilitated change are: *Normalisation, Working Together*, mutual support and sharing, the *Informal and Non-directive* nature of the intervention, the process of working towards personally meaningful goals, and the positive experience of attending the group. Fewer negative themes were induced from the data and most are likely to be inherent to the process of change through group psychotherapy. Some form of effort is required for the engagement in any psychotherapy, and group psychotherapy in particular is likely to provoke some level of anxiety. Group therapy cannot be separated from the management of interpersonal relationships, and in fact the exposure to such interactions in a relatively safe environment may be inextricably linked to the improvements in interpersonal relating. The challenging of anxiety through group attendance may have been instrumental in overcoming it, particularly in terms of confronting a feared situation. The processes of working hard and challenging oneself are likely to be associated with the sense of empowerment and with the achievement of progress. The negative of low group numbers due to variations in attendance is difficult to overcome for this population. Other studies have reported poor attendance and high rates of attrition in studies of BPD (Blum *et al.*, 2008; Clarkin *et al.*, 2007; Giesen-Bloo *et al.*, 2006). A potential advantage of a CMHT-based intervention may be established relationships between

clients and keyworkers, and existing contact with other agencies or family members, who could all be actively engaged in encouraging attendance.

Qualitative results are consistent with the feedback gathered from clients with histories of CSA and substance abuse issues who underwent a weekly, 12-session, SFT group intervention. This is relevant due to histories of CSA and substance abuse being commonly found amongst those with BPD diagnoses. Participants reported: seeing themselves more positively; benefits of normalisation; learning specific skills; the importance of sharing and support; and the experience of feeling less alone. In the absence of relevant qualitative studies it is unclear whether these components are inherent in all group interventions for clients with BPD or similar difficulties, or if some or all of them are specific to SFT group treatments.

Some of the themes identified in the qualitative analysis are consistent with Yalom's (1975) identification of common "curative factors" associated with psychotherapeutic groups. The *Working Together* theme identified in the present study has similarities with elements of Yalom's *Altruism* and *Group Cohesiveness* factors. Elements of the *Group Cohesiveness* factor are also present in the current study's *Normalisation* theme, which is strikingly similar to Yalom's *Universality* factor. Individual data extracts relating to being able to talk in the group and feeling better as a result could be construed as consistent with Yalom's *Catharsis*, and references to hope for further progress as relevant to Yalom's *Instillation of Hope*.

This is somewhat consistent with Nehls' (1991) description of a community-based group intervention for BPD in which Yalom's "curative factors" of *Universality* and *Existentialism* were identified as important to the experience of group members.

The positive experience of the informal, non-directive ethos in which the therapist "leads from behind" and adopts a non-expert stance to encourage the pursuit of goals that are meaningful to each client, may be more associated with SFT than with other approaches. Swift (2009) points out that there may be an inconsistency in simultaneously attempting to accept the patient as they are whilst encouraging them to change in specific ways. A recent qualitative study exploring BPD clients' perspectives on recovery reported a view that psychotherapies for BPD often had an extreme focus on specific areas, such as self-harm or relationships, and that some of their personal goals were neglected (Katsakou *et al.*, 2012). Participant feedback following acceptance-based emotion regulation groups for BPD suggested greater enthusiasm about sessions which focused on individually-meaningful goals and on initiating related actions (Gratz & Gunderson, 2006). Group ownership has also been highlighted as important in qualitative reports from clients in BPD-specific services (Crawford *et al.*, 2007). SFT groups represent a treatment option suited to fulfilling BPD clients' desire for the pursuit of individually meaningful goals.

Crawford and colleagues (2007) evaluation of BPD-specific services in England also reported that service-users appreciated a range of therapeutic options. For those

clients who do not meet criteria for available specialist services this may be crucial in order for them to access psychotherapy. It has been highlighted that there is a potential issue with the availability of and access to specialised treatment programmes in real world clinical settings, and that there is a need to improve 'care-as-usual' for BPD (Crawford *et al.*, 2007; Koekkoek *et al.*, 2009). The current study demonstrates the potential benefit to clients of a resource-efficient, community-based intervention operating with limited exclusion criteria. The need to improve access to psychological therapies for individuals with severe mental illness, such as personality disorder has been recently highlighted by the DoH (2011), and NICE (2009) have recommended research to assess the relative efficacy of psychological therapies delivered in community mental health settings.

Limitations

Limitations of the research include the lack of a control or comparison condition. This is recognised as important in the context of the lack of significant differences found between treatment and TAU in relevant outcomes for two studies evaluating individual DBT and individual CBT interventions (Davidson *et al.*, 2006; Linehan, 1991). The lack of a control group prevents the assertion that the observed improvements are actually associated with receiving the intervention. The sample size is also limited, and only one therapist was involved in delivering the groups, and therefore replication is required to increase generalisability. In relation to this,

the reasons that some group participants did not complete outcome measurement at all time points, or did not attend for qualitative interviews, is unclear. It is possible that those who declined to respond had found the intervention less beneficial or differed systematically in some other way from those who participated. Differences in results from analyses adopting different RMV methods further demonstrates the potential impact of the choice of method on findings, and to an extent limits interpretation. The influence on the results of the dual role of chief investigator/group facilitator is unknown, although the qualitative interviews were conducted by psychologists independent of the intervention and research activities.

Conclusions

The study provides some preliminary evidence for the effectiveness of an adjunctive, community-based, SFT group for clients with BPD delivered in a real-world setting. The outcomes were consistent with findings from studies of other individual and group psychotherapies for BPD and showed improvements in: phobic anxiety; psychoticism; interpersonal functioning; depression; anxiety; hostility; obsessive-compulsive symptoms; somatisation; symptom severity and related distress; and the number of diagnostic criteria met. The most robust findings, in terms of effect sizes and consistency of significance across analyses, were improvements in: phobic anxiety; paranoid ideation; psychoticism; interpersonal functioning; and symptom severity. Qualitative analyses indicated

the intervention successfully addressed the hopes of the participants and that they valued: normalisation; acceptance and safety; the opportunity to share and work together; mutual support; an informal and non-directive atmosphere; and assistance with the pursuit of personally meaningful goals. Those interviewed reported noticing change, progress towards their goals, and a subjective sense that they were coping better and feeling better. Group members also recognised the inherent challenge and necessity of hard work, confronting anxieties and managing relationships in the group. All those interviewed emphasised that attending the group had been a positive experience. The SFT groups for BPD may represent a more easily-accessible, resource-efficient, less intensive alternative to specialised services that may also address client feedback that has highlighted a preference for a focus on individual goals.

Implications

A solution-focused therapy approach for BPD represents a departure from traditional therapeutic approaches more aligned with conventional “scientific” understandings that emphasise the logic of cause and effect. As opposed to focusing on a detailed formulation of what went wrong in order to identify a remedy, the focus in SFT is on the formulation of solutions through interaction and creative processes. The improvements found in the present study indicate that, despite suggestions otherwise, a detailed exploration and understanding of causes

and past experiences related to BPD may not be necessary. It may be that long-term, intense interventions involving exploration of the past are not necessary for producing change in this population. Despite a concerted research effort to identify a specific aetiology or cause associated with BPD, this remains unclear (Alwin et al., 2006). It could be argued that traditional cause and effect based approaches may be difficult to deliver effectively in the context of a current lack of clarity regarding the relevant factors in the development of BPD.

The qualitative results of the present study reflect some common factors relating to group process identified by Yalom (1975). It is unclear whether it was these processes that were associated with change in this study, or something specific to SFT groupwork. It is also possible that the SFT approach served to facilitate or enhance these group processes.

Research on individual treatments and specialised treatment programmes has failed to provide evidence for the superiority of any one approach over another. Along with indications that effective group approaches may be tapping into inherent group processes, this raises questions about whether psychotherapy for BPD in general relies on common therapeutic factors to bring about change. Rather than seeking to establish the efficacy and effectiveness of specific therapeutic models of treatment for individuals with BPD, it may be that effort would be more usefully applied to investigating those aspects of interventions that facilitate and enhance

beneficial common therapeutic factors. In the present study one of the most robust improvements was found to be in the area of interpersonal functioning.

Interpersonal interactions have been highlighted as important in the treatment of BPD and it may be that the relational aspects of all therapies for individuals with BPD are instrumental to their effectiveness.

Whether or not groups offer crucial characteristics, possibly related to interactional processes, that cannot be reproduced in individual therapeutic settings should be carefully considered in the design of services. It has been suggested that group therapy should be offered within community services as part of a multidimensional model, and a case study conducted by Grobman (1980) describes a woman with BPD who benefited from group therapy following a lack of progress in individual work (Nehls, 1991). Group therapy may represent an important treatment option, but may not be appropriate for all BPD clients. Findings of the current study indicate that those with high baseline anxiety scores may have been unable to tolerate attending a group.

There has been an emphasis on the creation of specialised services for individuals with BPD outwith community mental health services. This may be both unnecessary and contributory to the stigma already associated with BPD by way of the implicit suggestion that those with BPD are “too ill” to be treated in the community. The availability of a range of treatment models and modalities may be

beneficial in allowing treatment to be offered on the basis of individual needs (Alwin et al., 2006). The potential benefit of an SFT-based group intervention delivered within community services with minimal resources has been demonstrated in the current study. Psychologists and psychotherapists based in community teams may be well-placed to offer similar treatment options and contribute to the improvement of care-as-usual for those with BPD. Community delivery would potentially also enhance treatment by maintaining coherence and consistency both in terms of therapeutic approach and relationships between clients and staff.

A further implication of the present study relates to inconsistencies found between quantitative outcomes and qualitative reports. For example qualitative data strongly indicated that group participants had been challenging and coping more effectively with anxiety, in contrast to a lack of significant change found for clinical measures of anxiety. The neglect of qualitative exploration of therapeutic process in existing research may be unhelpfully over-valuing symptomatic improvement over functional improvement. Both the current study and others emphasise the potential value of client-identified goals (Katsakou et al., 2012; Nehls, 1991). Attention to the treatment outcomes that are meaningful to clients, regardless of their relationship to clinical symptoms, may be beneficially emphasised irrespective of therapeutic model or stance.

CHAPTER 6

Journal Article

Solution-focused Therapy Groups for Borderline Personality Disorder:

A Preliminary Study

Abstract

Objective: To investigate the effectiveness of an adjunctive, community-based, Solution-focused therapy (SFT) group for BPD in terms of change in clinical symptoms and the subjective experiences of participants.

Methods: The study employed a mixed-methods, naturalistic, service-evaluation design in which 9 outpatients with Borderline Personality Disorder (BPD) attended 16-session SFT groups, and were assessed on clinically-relevant outcomes at baseline, 8 sessions and following group completion. Participants provided qualitative information about pre-intervention hopes and were interviewed post-group about their experience of the groups. Repeated-measures ANOVA was used to assess change in clinical symptoms during treatment, and *a priori* contrasts were conducted to explore significant results. Qualitative data was analysed inductively using semantic-level, thematic analysis as described by Braun and Clarke (2006).

Results: Improvements were indicated across all clinical outcomes with the most robust evidence of significant effects for: phobic anxiety; paranoid ideation; psychoticism; interpersonal functioning; and symptom severity. Qualitative analyses indicated the intervention successfully addressed the hopes of the

participants and that they valued: normalisation; acceptance and safety; the opportunity to share and work together; mutual support; an informal and non-directive atmosphere; and assistance with the pursuit of personally meaningful goals. Those interviewed reported noticing change, progress towards their goals, and a subjective sense that they were coping better and feeling better.

Conclusions: The study provides some preliminary evidence for the effectiveness of the intervention and it may represent a more easily-accessible, resource-efficient, less intensive alternative to specialised services. More general implications in relation to approaches to treatment for BPD are discussed.

Keywords: Borderline Personality Disorder, Solution-focused Therapy, Group psychotherapy, Community Mental Health

Background

Interest in the treatment of Borderline Personality Disorder (BPD) has grown in recent years within a context of the past classification of the disorder as 'untreatable' and a recognition that the lack of specialist services for the treatment of BPD had led to their treatment predominantly in emergency or inpatient services during crisis presentations (DoH, 2008; NIMHE, 2003).

Reviews of the current evidence-base for psychotherapeutic interventions for BPD suggest that no specific intervention has a particularly robust evidence-base thus far and the British Psychological Society suggest that there is no existing evidence to clearly recommend one psychotherapeutic approach over another (Alwin *et al.*, 2006; Stoffers *et al.*, 2012). A recent Cochrane Review includes studies involving interventions compared with control conditions for Dialectical Behaviour Therapy (DBT), mentalisation-based treatment, Transference-focused Psychotherapy (TFP), Cognitive-Behavioural Therapy (CBT), dynamic deconstructive therapy, Interpersonal Psychotherapy (IPT), client-centred therapy, and schema-focused therapy (Stoffers *et al.*, 2012). The review concludes that benefits are indicated for both 'comprehensive psychotherapies', where individual psychotherapy constitutes a substantial part of the treatment, and for 'non-comprehensive psychotherapies', which do not include a substantial portion of individual work. Psychotherapy in

general is supported for the treatment of BPD, but the further replication of existing findings is recommended.

Despite a growing evidence base for effective psychotherapies for BPD these tend to be provided within specialist services to which there remains limited access through real-life clinical settings. On the basis of BPD clients' high usage of community mental health services it has been suggested that innovation and improvement in the interventions provided in such non-specialised services is warranted (Crawford *et al.*, 2007; Koekkoek *et al.*, 2009). Priorities for service development identified through the evaluation of 11 pilot community services for BPD in England were outpatient psychological services and consultation services (Crawford *et al.*, 2007). Staff across these pilot services agreed upon important components of basic service provision including: the validation of service users' experiences; flexibility alongside consistency and reliability; the promotion of autonomy and choice; the delivery of a variety of interventions of varying intensity; facilitation of access to peer support and group work; and the generation of short- and long-term goals. Similar aspects were spoken about by users of the services who also appreciated opportunities for a range of therapeutic options and involvement in the negotiation of rules in treatments, associated with a feeling of ownership. The Solution-Focused therapy (SFT) approach is highly consistent with these identified service characteristics, and a group approach was considered appropriate both in terms of facilitating peer support and in delivering resource efficiency.

Solution-focused therapy (SFT) emerged from the practice of family-based systemic psychotherapy at the Milwaukee Brief Family Therapy Centre during the 1980s. SFT is an inductively developed, strengths-based approach which focuses on creating a detailed vision of how things would be different in the absence of a problem, rather than on an analysis of the problem itself (Lipchik, 2002; de Shazer *et al.*, 2007; Sharry, 2007).

SFT is essentially a social constructionist approach underpinned by the epistemological position that meaning is created through social interaction and negotiation (O'Connell, 1998). In therapeutic terms constructionism emphasises the client's perceptions and experiences, rather than attempting to establish "facts".

This creates opportunities within therapy for the exploration of meanings and a co-construction of reality and meaning between therapist and client (O'Connell, 1998).

SFT is a collaborative and non-pathological approach involving a reorientation from a focus on problems to a focus on solutions. There is an emphasis on strengths as opposed to deficits, and on exceptions to problems rather than on problem analysis.

There is a co-construction in the interaction between client and therapist of the client's goals and preferred future (Sharry, 2002).

The current modest evidence-base for the use of individual SFT in severe and enduring mental health is promising. Its conception as a 'brief therapy' has contributed to a misunderstanding that it is synonymous with short-term therapy

and therefore inappropriate for use with individuals suffering from more severe and enduring mental health difficulties. A small number of published studies acknowledge and evaluate its application to more complex mental health populations (Kok & Leskela, 1996; MacDonald, 1997; Sharry *et al.*, 2002). A paper comparing outcomes in short-term psychodynamic therapy, long-term psychodynamic psychotherapy and SFT demonstrated that SFT was as effective as short-term psychodynamic psychotherapy in reducing psychiatric symptoms over two years of follow-up with nearly 50 per cent less SFT sessions (Knekt *et al.*, 2008). In terms of the appropriateness of group therapy for BPD a recent literature review identified four relevant randomised-controlled trials (RCTs) (Boudreau *et al.*, 2009). All group interventions were based on different psychotherapies: schema-focused therapy; DBT skills training; Systems Training for Emotional Predictability and Problem Solving (STEPPS); and acceptance-based emotion regulation. The report concludes that there is some tentative evidence to suggest the effectiveness of groups based on these treatment modalities for up to one year following treatment completion.

The conception of group therapy for BPD is not new and groups based on psychoanalytic and social learning theory have been reported since the late 1970s. Horowitz (1977) suggested the utility of the dilution of transference reactions in group settings, as well as opportunities for in vivo reality orientation, strengthening

of ego identity, and mediation of social responses (Nehls, 1991). More recent examination of the process and outcome of group therapy for BPD within a community mental health centre has suggested experiences of Yalom's (1975) common therapeutic factors in group therapy, or "curative factors", of *Universality* and *Existentialism* as helpful. *Universality* refers to the sense of shared experience and of not being alone, and *Existentialism* involves recognition of the unfairness of life, the lack of escape from pain associated with life, being ultimately alone in the world, and having ultimate responsibility for the way we choose to live.

The group facilitators in the study did not align themselves with a specific model of therapy, but rather employed a variety of therapeutic techniques based on clinical judgement, including: empathy; reassurance; clarification; direct feedback; and problem-solving. The primary focus of group sessions was on the self-defined issues and goals of group members. The author suggests acknowledgement that existential concerns are of importance to those with BPD and that interventions which facilitate "curative factors" may be usefully considered. It is also suggested that the group provided corrective emotional experiences for members, and that expecting clients with issues around self-identity to clarify their own goals helped to shift the locus of responsibility for change to the individual members (Nehls, 1991).

Coding of eight video-taped sessions of the group by independent raters to identify therapists' level and type of verbal activity indicated the meaningful exchange of

information within the group as a crucial component. It is acknowledged that this contrasts with many traditional approaches that have a significant focus on the past and early experience (Nehls, 1992).

Few studies have assessed the specific mechanisms of change associated with experimental interventions for personality disorders, however, the BPS highlights group processes as crucial with regard to addressing difficulties in interpersonal and social functioning (Alwin et al., 2006; Levy & Scott, 2007).

In addition to factors associated with group interventions generally the SFT model has a specific emphasis on interaction and the co-construction of meaning which may serve to enhance those crucial group processes relating to social function. Important factors identified by Nehls (1991), such as the pursuit of individual goals and lack of focus on the past are synonymous with the SFT approach.

A body of qualitative research suggests that individuals with BPD are often viewed negatively by staff in health services and have negative experiences in relation to contact with services (Katsakou et al., 2012; Koekkoek et al., 2009; Miller, 1994; Webb & McCurran, 2008). Negative experiences of services may also contribute to difficulties in engaging those with BPD in treatment. The BPS recognise that this is a challenge and that drop-out rates tend to be high both in clinical and research settings (Alwin et al., 2006). Also thought to contribute to poor engagement are emotional instability, insecure attachment styles, and self-destructive impulsivity.

Attendance may be dependent upon current emotional state or the activation of attachment systems (Alwin et al., 2006; Swift, 2009).

Despite a lack of clear theoretical understanding of the causes of BPD it is widely accepted that the aetiology of BPD involves some disruption in early attachment processes with an effect on the development of social cognition (Alwin et al., 2006; Fonagy et al., 2003; Koekkoek et al., 2009; Leichsenring et al., 2011; Linehan, 1993).

BPD has been suggested as being characterised by severe social impairment and interpersonal therapeutic approaches with an emphasis on the interpersonal context of therapy have been suggested as potentially useful (Alwin et al., 2006; Lieb et al., 2004). This conceptualisation is highly consistent with the centrality of the interactional component in SFT, and opportunities for interpersonal learning are likely to be amplified within a group situation.

The focus on the development of a collaborative therapeutic alliance in SFT, and client identification of meaningful goals, may also facilitate engagement. The stance of respectful hope and curiosity inherent to SFT, along with identification and amplification of clients' strengths and resources, may represent an explicit departure from any past negative experiences of services which may also encourage attendance.

In terms of the early experiences common amongst those with BPD Linehan (1993) emphasised invalidating family environments in the development of BPD, in which

individuals must tolerate a systematic undermining of their experience of their own mind. SFT's emphasis on the social construction of reality within therapy may provide an opportunity for those with BPD to experience themselves in a new way. Miller (1994) highlights the therapeutic relationship as the first context in which those with BPD may have experienced themselves in an alternative way, and thus the importance of avoiding reinforcement of feelings of inadequacy and powerlessness due to a power imbalance between the therapist and the client. The emphasis within SFT on clients' strengths and resources, and on the client as the expert, may serve to address this issue as well as creating an opportunity to co-construct a positive alternative view of the self.

Horn et al. (2007) suggest social constructionist formulations as a potentially useful alternative to a focus on the BPD diagnosis. Through qualitative analysis of interviews the BPD diagnosis was found to be viewed by service users as a negative, static label involving unhelpful views relating to being judged, rejected, and bad. Helpful views of the self that were identified incorporated possibilities of change, involved being valued and accepted, and could develop within relationships. The combination of these perspectives is suggested as consistent with a social constructionist understanding, as one that exists between people rather than within them. The useful ways of viewing the self identified in the study were clearly associated with defining and redefining the self through social interaction. An essentialist diagnosis was viewed as rejecting and associated with hopelessness

which also appeared linked with a subsequent withdrawal from or rejection of services.

With its roots in social constructionism, SFT may represent an approach ideally suited to addressing the issues identified in relation to negative influences on engagement and treatment for those with BPD.

There is currently no published research which has addressed either the efficacy or the effectiveness of an SFT group for people with BPD either empirically or qualitatively.

Purpose of study

The purpose of the study was to investigate the effectiveness of an SFT-based group treatment for BPD when delivered adjunctively as a part of routine clinical practice within a National Health Service (NHS) Community Mental Health Team (CMHT). Effectiveness is assessed both in terms of change in clinical symptoms and by qualitative exploration of the subjective experiences of participants with regard to the intervention.

Hypotheses

1. Group participants' clinically relevant symptoms, as measured by empirically validated outcome measures, will significantly reduce during the course of the intervention.

2. Group participants' self-rated quality of life, as measured by The EuroQol (EQ-5D, the EuroQol Group, 1990), will significantly increase during the course of the intervention.

Method

Design

A naturalistic service-evaluation design was adopted with two SFT groups, each affiliated with one of two NHS Community Mental Health Services. Clients who were interested in participating in the group intervention attended for an initial assessment, and those who went on to join the groups were subsequently assessed on clinical outcomes following session 8 and again after the groups ended at a maximum of 16 sessions. Quantitative data was collected by the chief investigator. Qualitative data was collected post-group only, and interviews were conducted by two psychologists who had no prior involvement with the intervention.

Basic inclusion and exclusion criteria stipulated that participants must meet criteria for BPD, as assessed by the SCID-II, and that they must not be involved in a concurrent psychotherapeutic intervention at the outset. Participants were also excluded if they were non-English speaking.

Ethics

The study protocol was reviewed by a local NHS Research Ethics Committee who agreed that the project was best categorised as a service evaluation.

Group Intervention

Groups were developed based on the SFT approach, and were 90 minutes long and delivered on a fortnightly basis. This arrangement yielded an approximate treatment duration of seven months which was also considered appropriate in the context of the NICE guidelines for the treatment of BPD (NICE, 2009).

The role of the facilitator was to maintain a solution-focused stance of positivity, hope and respectful curiosity (de Shazer et al, 2007). Sustaining and instilling an awareness of the basic assumptions of SFT was also integral to the intervention:

- Change is constant and inevitable;
- Small changes result in bigger changes;
- You cannot change the past so concentrate on the future;
- Everyone has the strengths and resources necessary to help themselves, and they are the experts;
- Every person, situation and relationship is unique;
- Everything is interconnected;
- Every problem has at least one exception;
- If it's working keep doing it, and if it's not working stop doing it.

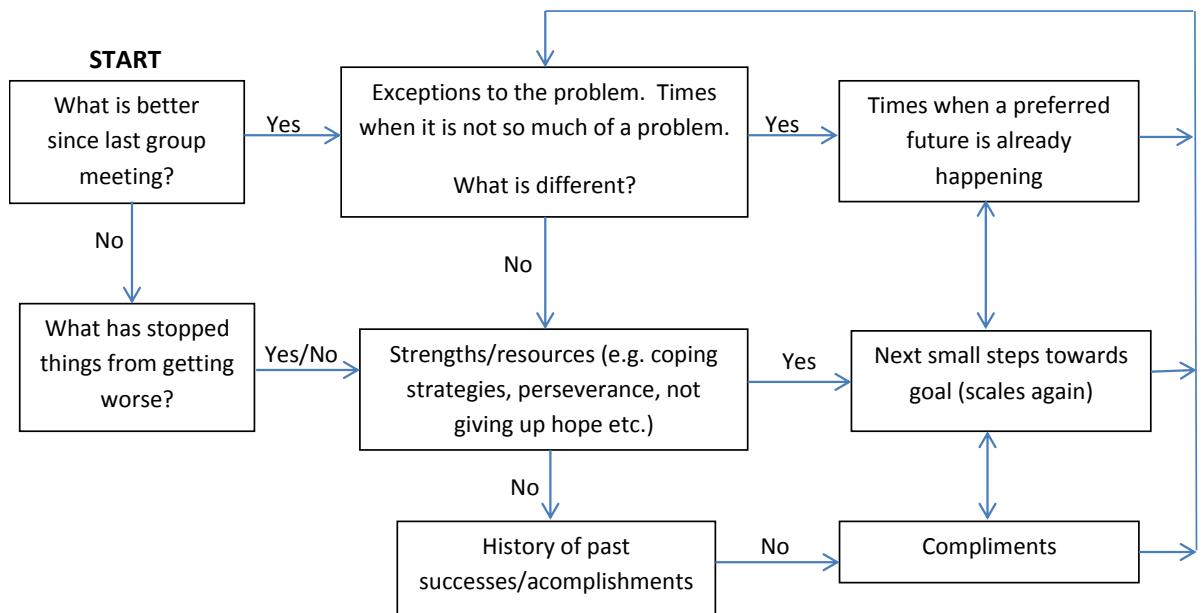
(DeJong & Berg, 1998; de Shazer *et al.*, 2007; O'Connell, 1998).

The therapeutic process was guided by the facilitator's encouragement of 'change discourse', 'solution discourse', and 'strategy discourse' within the group (O'Connell, 1998, pp 35-40). The SFT acronym 'EARS' was employed frequently in sessions (DeJong & Berg, 1998).

The initial two sessions involved: basic introductions, an introduction to SFT, discussion of and agreement on ground rules and structure for the group, sharing of best hopes and expectations for attending the group, and establishing specific individual goals for each group member. The 'miracle question' was used to specify goals in detail and solution-focused scaling was used where this was helpful.

The remaining sessions followed the structure illustrated in Figure 1

Figure 1 - Process map for group sessions 3 – 16 (based on Iveson, 2002)



The Group Facilitator

The group was facilitated by the chief investigator, a Trainee Clinical Psychologist/Specialist Psychological Practitioner who had undergone a year-long specialist training placement in SFT. The facilitator received regular supervision.

Participants

Participants were recruited from two NHS CMHSs within the same NHS board area to form two groups, each associated with one CMHS. The groups will be referred to as Group A and Group B. A total of 25 potential participants were referred of whom 12 (48%) did not attend when invited for individual pre-group assessment. A further 4 (16%) who did attend for initial assessments did not attend for group meetings. Of the remaining 9 (36%) participants who went on to attend for group

meetings 8 (88.9%) were women and one (11.1%) was a man. The mean age of the participants was 32.3 years (standard deviation [SD] 10.7 years, range 20-49 years). 3 (33.3%) were employed, and 3 (33.3%) were married.

Thirteen referrals were made to Group A and twelve to Group B. In Group A eight (62%) attended for initial screening and five (38%) went on to attend group meetings. For Group B five (42%) attended for screening and four (33%) went on to attend group meetings.

Outcome Measurement

The study was mixed-methods including both quantitative and qualitative outcome measurement.

To allow the results of the current study to sit within the context of existing BPD research five outcome measures were selected on the basis of those used most consistently across prominent RCT studies examining the efficacy of treatments for BPD (Bateman & Fonagy, 1999; Blum *et al.*, 2008; Clarkin *et al.*, 2007; Davidson *et al.*, 2006; Linehan *et al.*, 1991; Giesen-Bloo *et al.*, 2006). NICE have also highlighted that outcomes in BPD research thus far have not adequately addressed patient experience (NICE, 2009).

Quantitative Outcome Measures

The diagnostic status of potential group participants was assessed using the relevant section of the Structured Clinical Interview for DSM-IV Axis II (SCID-II) at baseline and following completion of the group. The remaining five empirically validated outcome measures were administered at baseline, following eight sessions of the group, and post-group (following a maximum of 16 sessions).

Psychiatric symptoms were assessed using the Beck Depression Inventory (BDI-II, Beck, Steer & Brown, 1996), Spielberger State-Trait Anxiety Inventory (STAI, Spielberger, *et al.*, 1970) and Brief Symptom Inventory (BSI, Derogatis & Melisaratos, 1983). Social and interpersonal functioning were measured by the Inventory of Interpersonal Problems - Short form (IIP-32, Horowitz *et al.*, 1988). The EuroQol (EQ-5D, the EuroQol Group, 1990) was administered as a general measure of quality of life.

Qualitative Outcome Measures

At initial assessment participants completed a written self-report form covering three questions:

1. What are your best hopes from attending the group?
2. What things would you most like to be different by the end of the group?

3. What change would make the most difference to your life that you think the group could help you with?

The SFT approach encourages clients' to consider their own interpretation of meaningful change for themselves, rather than focusing on clinically pre-defined treatment goals. The purpose of this baseline qualitative assessment was to provide a context for the post-group qualitative data in terms of evaluating whether clients' initial hopes and goals were met through the intervention, irrespective of clinically relevant outcomes.

Semi-structured, audio-taped interviews following completion of the group sought to address the following questions:

1. What were group members' subjective experiences of attending the groups?
2. What aspects of the groups did individual members find helpful/unhelpful?
3. What has changed subjectively for those who attended the group?

Procedure

Referrals were held by the chief investigator until such time as at least ten referrals had been received for each of the two groups. Referred participants were then contacted and invited to attend for initial assessment with the chief investigator, who was also the group facilitator. At the assessment meeting further information

about the group was provided and potential participants were given the opportunity to ask questions or voice any concerns. The clinically-relevant outcome measures were administered, as well as the brief qualitative self-report form. The nature and purpose of the service-evaluation was explained to participants, who opted to sign a consent form allowing their data to be used for the present study. Participants who did not consent were not excluded from attending the group. Groups commenced immediately following completion of the initial assessments.

Power Calculation

An *a priori* power calculation showed that a sample of 20 would be required to achieve a power of 0.8 in detecting an effect size of 0.3. Taking into account the potential for attrition further calculations demonstrated that to achieve 0.8 power to detect an effect size of 0.5 9 participants would be required, and 12 participants would increase the power to 0.95.

Results

Baseline Data

Baseline data for all quantitative outcome measures for all participants are presented in Table 1. It is notable that overall the baseline severity of symptoms generally appears higher for those who were screened and went on to attend a group than for those who were screened and did not attend. When baseline data was examined for each group separately the mean scores for STAI State Anxiety, the BSI Anxiety Subscale, and the BSI Phobic Anxiety Subscale were found to be higher for those who were screened and subsequently did not attend Group A, than for those who did attend Group A. The standard deviations suggested that the relevant means were unlikely to have been affected by one extremely anxious participant. As all these measures relate to anxiety it is possible that high levels of anxiety may have discouraged or prevented these participants from attending. This is not true for the one participant who did not attend Group B.

Table 1 – Baseline Measurements for All Group Participants on All Outcome Measures

	Screened Mean (SD) n = 13	Attended Mean (SD) n = 9	Did not attend Mean (SD) n = 4
SCID-II	6.77 (1.64)	7.33 (1.32)	5.5 (1.73)
EQ-5D	39.08 (17.52)	36.67 (20.31)	44.5 (8.43)
BDI	37.62 (12.81)	41.67 (12.11)	28.5 (10.25)
STAI State	60.85 (12.93)	62.78 (13.30)	56.5 (12.66)
STAI Trait	66.85 (9.79)	68.67 (9.88)	62.75 (9.5)
IIP-32	70.08 (25.68)	77.67 (21.61)	53.00 (28.83)
BSI GSI	2.38 (0.78)	2.63 (0.71)	1.83 (0.71)
BSI PST	46.08 (5.88)	48.56 (3.71)	40.50 (6.46)
BSI PSDI	2.69 (0.64)	2.84 (0.63)	2.34 (0.59)
BSI Som	1.73 (1.18)	2.03 (1.30)	1.04 (0.43)
BSI Obs	2.79 (0.91)	3.02 (0.81)	2.29 (1.02)
BSI Int	2.75 (0.88)	3.00 (0.76)	2.19 (0.99)
BSI Depr	2.55 (0.95)	2.74 (0.95)	2.13 (0.92)
BSI Anx	2.54 (0.88)	2.57 (0.87)	2.46 (1.04)
BSI Host	1.85 (1.14)	2.38 (0.92)	0.65 (0.44)
BSI Phob	2.83 (0.80)	2.87 (0.64)	2.75 (1.22)
BSI Para	2.12 (0.95)	2.51 (0.70)	1.20 (0.86)
BSI Psyc	2.54 (0.92)	2.82 (0.93)	1.90 (0.53)

Structured Clinical Interview for DSM-IV Axis I; EQ-5D, The EuroQoL overall health state; BDI, Beck Depression Inventory; STAI State, Spielberger State-Trait Anxiety Inventory State Anxiety; STAI Trait, Spielberger State-Trait Anxiety Inventory Trait Anxiety; IIP-32, Inventory of Interpersonal Problems; BSI GSI, Brief Symptom Inventory Global Severity Index; BSI PST, Brief Symptom Inventory Positive Symptom Total; BSI PSDI, Brief Symptom Inventory Positive Symptom Distress Index; BSI Som, Brief Symptom Inventory Somatisation Scale; BSI Obs, Brief Symptom Inventory Obsessive-Compulsive Scale; BSI Int, Brief Symptom Inventory Interpersonal Sensitivities Scale; BSI Depr, Brief Symptom Inventory Depression Scale; BSI Anx, Brief Symptom Inventory Anxiety Scale; BSI Host, Brief Symptom Inventory Hostility Scale; BSI Phob, Brief Symptom Inventory Phobic Anxiety Scale; BSI Para, Brief Symptom Inventory Paranoid Ideation Scale; BSI Psyc, Brief Symptom Inventory Psychoticism Scale.

Quantitative Analysis

Repeated Measures ANOVA was used to assess differences in scores on outcome measures across time. Where a significant effect of Time was demonstrated contrast tests, using one-way ANOVA, were used to compare scores at the different assessment points.

An intention-to treat (ITT) analysis was conducted including the nine participants who had attended beyond the initial assessment. Two of these nine group members attended only a small number of group sessions (two/three) and were lost to follow-up both at the 8-session midpoint and post-group. This missing data, as well other missing values, were replaced in the analyses using one of two methods. Intended as a conservative approach, the last occasion carried forward (LOCF) method of missing value replacement was adopted and, as a less conservative comparison, replacement with the occasion mean (OM). It has been demonstrated that the method of replacement of missing values (RMV) can have an influence on the results of statistical analyses (Power & Freeman, 2012). More complex approaches to RMV, such as expectation maximisation (EM) and multiple imputation (MI), were not employed as the missing data was not deemed to be missing-at-random (MAR).

Due to the amount of RMV necessary in the ITT analysis (29.35%), the two participants who had not fully engaged with the intervention and accounted for a

high proportion of missing data (10.48%) were removed to allow a comparison with the results for those participants who had attended at least four sessions (ALFS).

Descriptive statistics for each subset of participants used for analyses, and all 13 potential participants who attended for initial assessment, are detailed in Table 2. A summary of the results of analyses, and indications of effect sizes for significant overall ANOVAs, are presented in Table 3. Figures 2 and 3 illustrate the differences in means for all outcomes measures across all assessment points for the RMV OM ITT analysis which is similar to patterns in the other conducted analyses.

Table 2 – Demographic data, rates of group attendance, and levels of missing data for all participants initially assessed and for each subset of participants used in statistical analyses

Subset	n	Age (mean, range, SD)	Gender (% female)	Employment (% employed)	Marital status (% married)	Sessions attended (mean, range, SD)	Missing data (%)
All screened	13	33.15, 20-49, 9.81	92.3	23.1	23.1	-	-
Intention- to-treat	9	32.33, 20-49, 10.78	88.9	33.3	33.3	7.44, 2-14, 3.84	29.35
Attended >4 sessions	7	31.29, 20-49, 10.44	100	42.9	42.9	8.86, 6-14, 3.02	18.87

Table 3 – Results of repeated measures analyses for all data and data subsets, and with each RMV method

Included Cases RMV Method	Intention to treat (n=9)		Attended >4 sessions (n=7)	
	OM	LOCF	OM	LOCF
SCID-II	X (0.58)	-	X (0.51)	-
EQ-5D	-	-	-	-
BDI	X (0.37)	X (0.33)	-	X (0.42)
STAI State	-*	-	-	X (0.33)
STAI Trait	X (0.35)	-	-	-
IIP-32	X (0.59)	(x)*	X (0.63)	(x)*
BSI GSI	X (0.55)	-	X (0.52)	X (0.42)
BSI PST	X (0.47)	-	X (0.42)	-
BSI PSDI	X (0.41)	(x)*	X (0.41)	(x)
BSI Som	-	X (0.37)	(x)	X (0.48)
BSI Obs	X (0.45)	-	X (0.50)	(x)
BSI Int	X (0.60)	(x)*	X (0.57)	X (0.43)
BSI Depr	(x)	-*	-	-
BSI Anx	X (0.35)	-*	(x)	-*
BSI Host	X (0.42)	-	(x)	-
BSI Phob	X (0.65)	X (0.37)	X (0.63)	X (0.48)
BSI Para	X (0.59)	(x)*	X (0.57)	X (0.43)
BSI Psyc	X (0.50)	X (0.38)	X (0.53)	X (0.49)

*Huynh-Feldt or Greenhouse-Geisser used for overall within-subjects ANOVA due to violation of the sphericity assumption. Huynh-Feldt used when $\epsilon > 0.75$ and Greenhouse-Geisser when $\epsilon < 0.75$ (Girden, 1992).

(x) – significance found for at least one *a priori* contrast test, but not for overall repeated measures ANOVA

X – significance found for overall repeated measures ANOVA and at least one *a priori* contrast test.

η^2 - indicated in brackets for significant overall ANOVAs.

RMV, Replacement of Missing Values; OM, Occasion Mean; LOCF, Last Occasion Carried Forward; SCID-II, Structured Clinical Interview for DSM-IV Axis II; EQ-5D, The EuroQol overall health state; BDI, Beck Depression Inventory; STAI State, Spielberger State-Trait Anxiety Inventory State Anxiety; STAI Trait, Spielberger State-Trait Anxiety Inventory Trait Anxiety; IIP-32, Inventory of Interpersonal Problems; BSI GSI, Brief Symptom Inventory Global Severity Index; BSI PST, Brief Symptom Inventory Positive Symptom Total; BSI PSDI, Brief Symptom Inventory Positive Symptom Distress Index; BSI Som, Brief Symptom Inventory Somatisation Scale; BSI Obs, Brief Symptom Inventory Obsessive-Compulsive Scale; BSI Int, Brief Symptom Inventory Interpersonal Sensitivities Scale; BSI Depr, Brief Symptom Inventory Depression Scale; BSI Anx, Brief Symptom Inventory Anxiety Scale; BSI Host, Brief Symptom Inventory Hostility Scale; BSI Phob, Brief Symptom Inventory Phobic Anxiety Scale; BSI Para, Brief Symptom Inventory Paranoid Ideation Scale; BSI Psyc, Brief Symptom Inventory Psychoticism Scale.

Figure 2 - Means across the three assessment points for ITT data using RMV with OM for those measures with larger score ranges

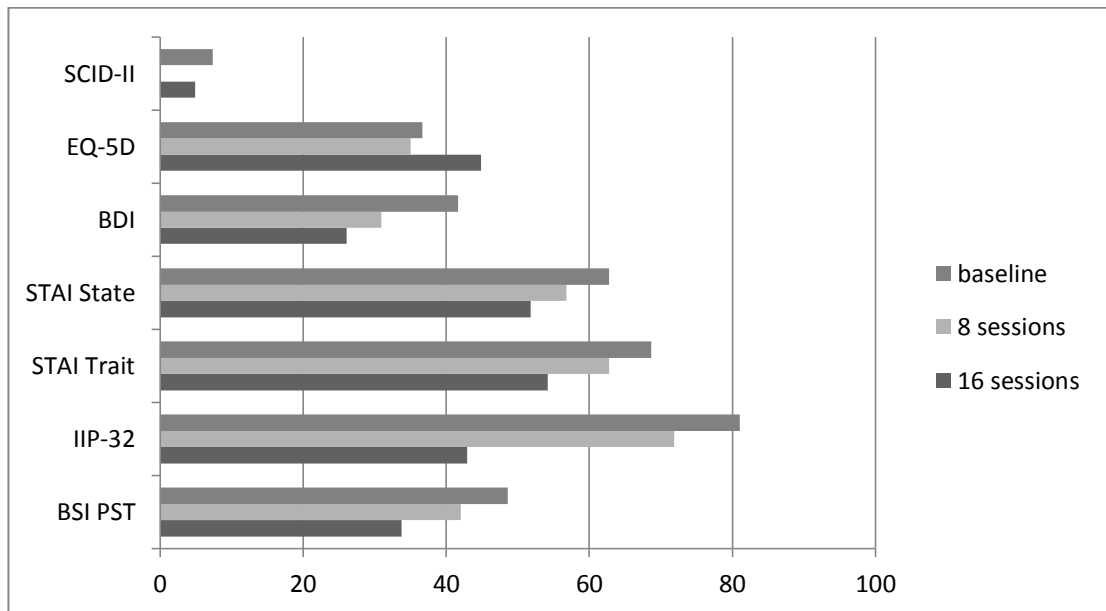
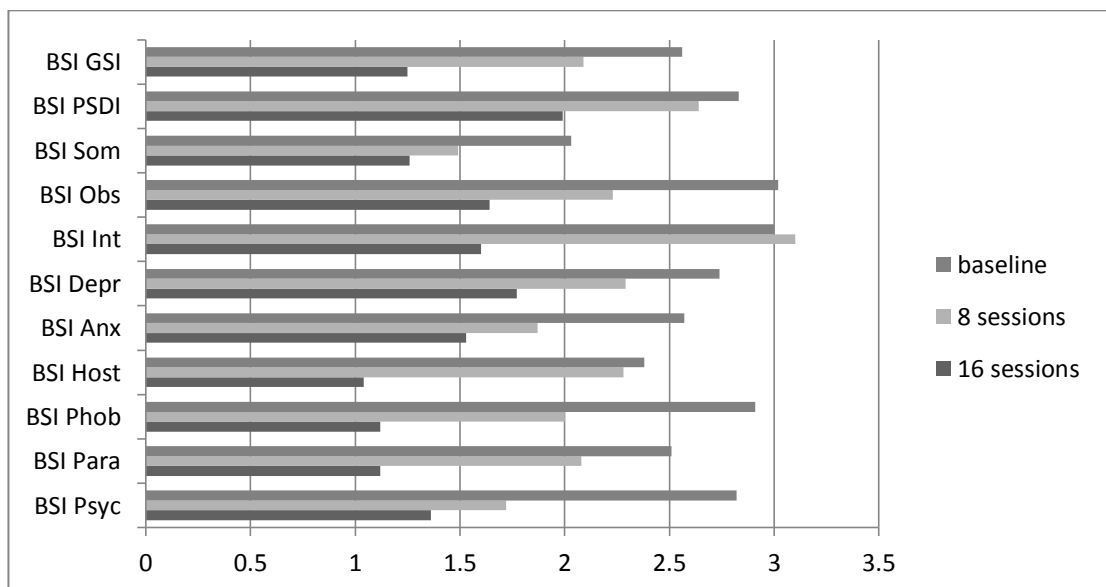


Figure 3 - Means across the three assessment points for ITT data using RMV with OM for those measures with smaller score ranges



All results showed improvements in scores over the course of the intervention, apart from for the EQ-5D overall health state which was seen to deteriorate between baseline and session 8 in the ITT analyses.

SCID-II

The RMV OM analyses demonstrated significant reductions in SCID-II criteria met between baseline and 16 sessions for both ITT ($F(1,8) = 11.00, p < 0.05$) and ALFS ($F(1,6) = 6.26, p < 0.05$) analyses.

EQ-5D Overall Health State

No significant effects of Time were found in any analyses.

BDI-II

Significant effects of Time were found for scores in RMV OM ITT ($F(2,16) = 4.63, p < 0.05$), and in RMV LOCF ITT ($F(2,16) = 3.94, p < 0.05$) and ALFS ($F(2,12) = 4.42, p < 0.05$) analyses. Contrast tests showed significant reductions between baseline and 16 sessions for all analyses (RMV OM ITT, $t = 3.120, df = 24, p < 0.01$; RMV LOCF ITT, $t = 2.138, df = 24, p < 0.05$; RMV LOCF ALFS, $t = 2.332, df = 18, p < 0.05$), and between baseline and 8 sessions for RMV OM ITT ($t = 2.162, df = 24, p < 0.05$).

IIP-32

Significant improvements across Time were demonstrated in both RMV OM analyses (ITT, $F(2,16) = 11.53, p < 0.05$; ALFS, $F(2,12) = 10.00, p < 0.01$). Both analyses showed significant improvements between session 8 and 16 (ITT, $t = 4.600, df = 24, p < 0.001$; ALFS, $t = 4.532, df = 18, p < 0.001$), and between baseline and 16 sessions (ITT, $t = 6.046, df = 24, p < 0.001$; ALFS, $t = 2.525, df = 18, p < 0.001$).

STAI Trait Anxiety

Scores were shown to significantly reduce in the RMV OM ITT analysis only ($F(1,8) = 4.26, p < 0.05$), with contrasts demonstrating significant improvement only between baseline and 16 sessions ($t = 2.808, df = 24, p < 0.05$).

STAI State Anxiety

None of the analyses showed a significant effect of Time for the reductions in scores.

BSI GSI

Significant effects of Time were shown for scores in both the RMV OM ITT ($F(2,16) = 9.61, p < 0.01$) the RMV OM ALFS ($F(2,12) = 6.61, p < 0.05$) analyses, and in the RMV LOCF ALFS analysis ($F(2,12) = 4.32, p < 0.05$). Contrasts showed significant reductions between 8 and 16 sessions and between baseline and 16 sessions for both the RMV OM ITT ($t = 3.155, df = 24, p < 0.01$; $t = 4.916, df = 24, p < 0.001$) and ALFS analyses ($t = 2.466, df = 18, p < 0.05$; $t = 4.916, df = 24, p < 0.001$). A significant

reduction between baseline and 16 sessions was found in RMV LOCF ALFS analysis ($t = 3.194$, $df = 18$, $p < 0.01$).

BSI PST

Both RMV OM analyses showed a significant effect of Time (ITT, $F(2,16) = 11.73$, $p < 0.05$; ALFS, $F(2,12) = 4.31$, $p < 0.05$). Contrasts demonstrated significant improvement for ITT between sessions 8 and 16 ($t = 2.168$, $df = 24$, $p < 0.05$) and between baseline and 16 sessions ($t = 3.896$, $df = 24$, $p < 0.05$). For ALFS contrasts demonstrated a significant difference in scores only between baseline and 16 sessions ($t = 3.064$, $df = 18$, $p < 0.01$).

BSI PSDI

Both RMV OM analyses showed a significant effect of Time (ITT, $F(2,16) = 5.65$, $p < 0.05$; ALFS, $F(2,12) = 4.20$, $p < 0.05$). Contrasts demonstrated significant improvement for ITT between sessions 8 and 16 ($t = 2.548$, $df = 24$, $p < 0.05$) and between baseline and 16 sessions ($t = 3.304$, $df = 24$, $p < 0.01$). For ALFS contrasts demonstrated a significant difference in scores only between baseline and 16 sessions ($t = 2.920$, $df = 18$, $p < 0.01$).

BSI Somatisation Scale

Significant effects of Time were shown in both RMV OM analyses (ITT, $F(2,16) = 4.71$, $p < 0.05$; ALFS, $F(2,12) = 5.46$, $p < 0.05$). Contrasts demonstrated significant

decreases in somatisation scores between baseline and 16 sessions for both the ITT ($t = 2.093$, $df = 24$, $p < 0.05$) and ALFS analyses ($t = 2.565$, $df = 18$, $p < 0.05$).

BSI Obsessive-Compulsive Scale

Both RMV OM analyses showed a significant effect of Time (ITT, $F(2,16) = 6.65$, $p < 0.01$; ALFS, $F(2,12) = 5.91$, $p < 0.05$). Contrasts showed reductions were significant between baseline and 8 sessions (ITT, $t = 3.669$, $df = 24$, $p < 0.01$; ALFS, $t = 2.142$, $df = 18$, $p < 0.05$), and between baseline and 16 sessions (ITT, $t = 2.090$, $df = 24$, $p < 0.05$; ALFS, $t = 3.443$, $df = 18$, $p < 0.01$).

BSI Interpersonal Sensitivities Scale

Significant effects of Time were shown for both RMV OM analyses (ITT, $F(2,16) = 12.14$, $p < 0.01$; ALFS, $F(2,12) = 7.83$, $p < 0.01$) and for the RMV LOCF ITT analysis ($F(2,12) = 4.55$, $p < 0.05$). Contrasts showed significant improvements between 8 and 16 sessions (RMV OM ITT, $t = 4.936$, $df = 24$, $p < 0.01$; RMV OM ALFS, $t = 3.770$, $df = 6.615$, $p < 0.01$; RMV LOCF ALFS, $t = 3.194$, $df = 18$, $p < 0.01$) and between baseline and 16 sessions (RMV OM ITT, $t = 3.590$, $df = 24$, $p < 0.01$; RMV OM ALFS, $t = 2.973$, $df = 11.4$, $p < 0.05$; RMV LOCF ALFS, $t = 3.194$, $df = 18$, $p < 0.01$).

BSI Depression Scale

No significant effects of Time were found in any analyses.

BSI Anxiety Scale

A significant effect of Time was shown only in the ITT analysis ($F(2,16) = 4.34, p < 0.05$) with contrast tests demonstrating that scores reduced significantly between baseline and 16 sessions ($t = 2.975, df = 24, p < 0.01$).

BSI Hostility Scale

A significant effect of Time was shown only in the ITT analysis ($F(2,16) = 5.80, p < 0.05$) with contrast tests demonstrating that scores reduced significantly between baseline and 16 sessions ($t = 3.034, df = 24, p < 0.01$) and between sessions 8 and 16 ($t = 2.812, df = 24, p < 0.05$).

BSI Phobic Anxiety Scale

Significant effects of Time were found across all analyses (RMV OM ITT, $F(2,16) = 14.81, p < 0.001$; RMV OM ALFS, $F(2,12) = 10.02, p < 0.01$; RMV LOCF ITT, $F(2,16) = 4.71, p < 0.05$; RMV LOCF ALFS, $F(2,12) = 5.46, p < 0.05$). Contrasts with RMV OM ITT data showed that scores lessened significantly between baseline and 8 sessions ($t = 2.369, df = 24, p < 0.05$), between 8 sessions and 16 sessions ($t = 2.288, df = 24, p < 0.05$), and between baseline and 16 sessions ($t = 2.090, df = 24, p < 0.05$). There was significant improvement between baseline and 16 sessions for the remaining analyses (RMV OM ALFS, $t = 3.801, df = 18, p < 0.01$; RMV LOCF ITT, $t = 2.368, df = 24, p < 0.05$; RMV LOCF ALFS, $t = 2.494, df = 18, p < 0.05$).

BSI Paranoid Ideation Scale

Significant effects of Time were shown for both RMV OM analyses (ITT, $F(2,16) = 11.71, p < 0.01$; ALFS, $F(2,12) = 7.80, p < 0.01$) and for the RMV LOCF ALFS analysis ($F(2,12) = 4.57, p < 0.05$). Contrasts showed a significant reduction in scores between baseline and 16 sessions (RMV OM ITT, $t = 4.719, df = 24, p < 0.001$; RMV OM ALFS, $t = 3.886, df = 18, p < 0.01$; RMV LOCF ALFS, $t = 3.123, df = 18, p < 0.01$), and between 8 and 16 sessions for RMV OM ITT ($t = 3.257, df = 24, p < 0.01$).

BSI Psychoticism Scale

Significant effects of Time were found across all analyses (RMV OM ITT, $F(2,16) = 8.12, p < 0.01$; RMV OM ALFS, $F(2,12) = 6.87, p < 0.05$; RMV LOCF ITT, $F(2,16) = 4.99, p < 0.05$; RMV LOCF ALFS, $F(2,12) = 5.85, p < 0.05$). Contrasts showed significant reductions in scores between baseline and 8 sessions for RMV OM ITT ($t = 2.868, df = 24, p < 0.01$) and RMV OM ALFS ($t = 2.690, df = 18, p < 0.05$), and significant decreases between baseline and 16 sessions across all analyses (RMV OM ITT, $t = 3.804, df = 24, p < 0.01$; RMV OM ALFS, $t = 3.464, df = 18, p < 0.01$; RMV LOCF ITT, $t = 2.313, df = 24, p < 0.05$; RMV LOCF ALFS, $t = 2.648, df = 18, p < 0.05$).

Qualitative Analysis

Four participants were interviewed and qualitative data was transcribed and analysed using an inductive, semantic-level, thematic analysis approach, following the guide described by Braun and Clarke (2006). The analysis was conducted by the chief investigator, also the group facilitator, which is likely to have had some influence on the interpretations drawn.

Repeated rounds of reading the data made it possible to identify themes which were then examined, re-examined and refined. Figure 4 shows the initial thematic map resulting from the analysis, with the final thematic map detailed in Figure 5.

Figure 4 – Qualitative Analysis: Initial Thematic Map

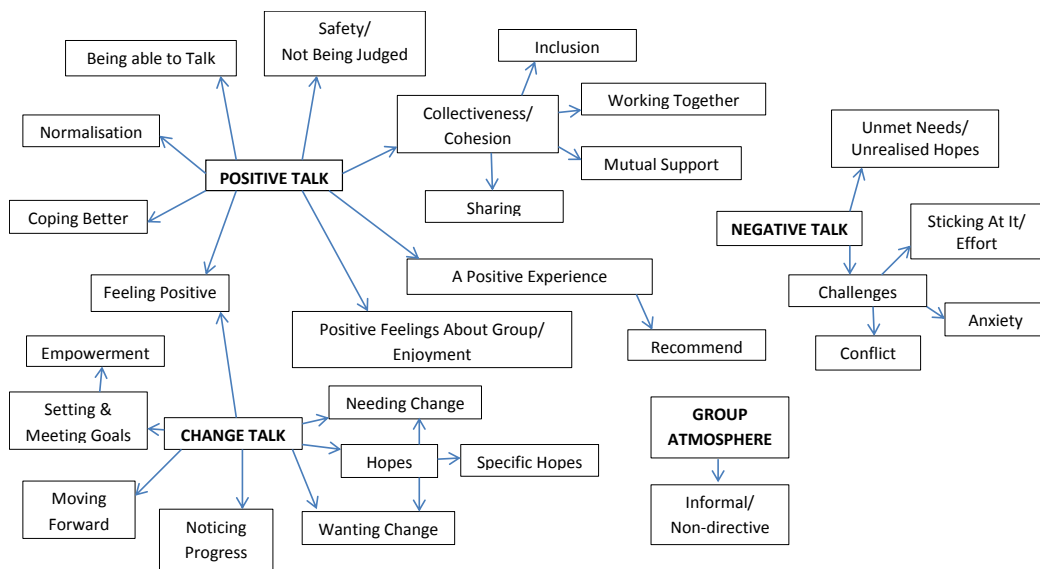
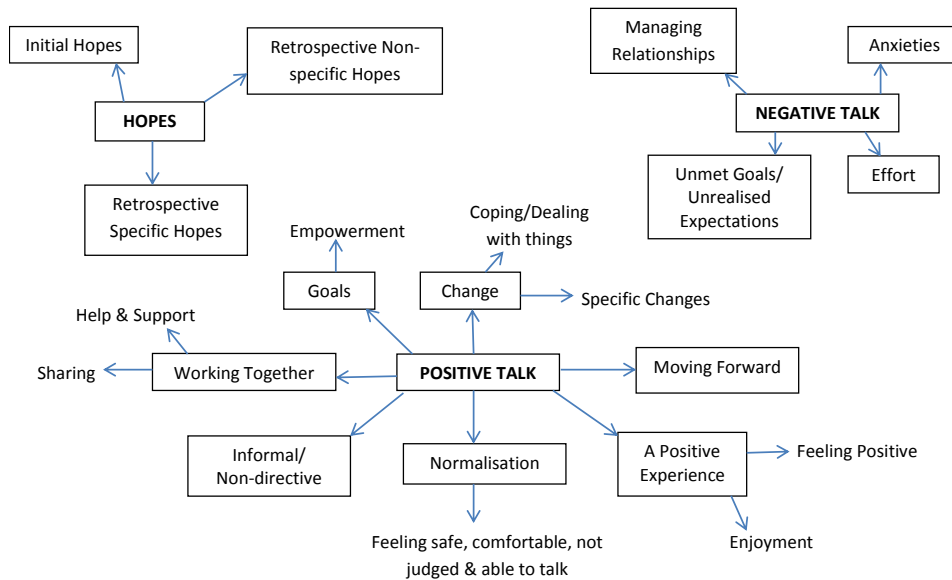


Figure 5 – Qualitative Analysis: Final Thematic Map



Hopes

The main initial hopes were identified as: *Coping or dealing with things better* ('...learn to cope better'); *Feel better* ('I will feel more positive about life'); *More positive view of self* ('Feel a bit more likeable. Feel better about myself'); *Improved Interpersonal Relationships* ('To help how I come across to people'); *Better relationship with BPD* ('To change my opinions about my diagnosis'); *Less anger/aggression* ('To help with anger outbursts'); and *Normalisation* ('To meet other people with BPD...'). All those interviewed mentioned hopes relating to a general sense of improvement such as being 'normal', 'happy', or 'better', with some interviewees expressing specific personal hopes.

Positive Talk

Working together

All those interviewed identified some positive aspects of working collectively within the group. They conveyed a sense of active involvement, negotiation and shared agreement amongst group members, with nobody being excluded ('Everybody got a chance. If we didn't want it we could say. Everybody agreed on how it was'), and the presence and value of mutual support and sharing within the group was frequently acknowledged. One participant indicated that they saw the aspect of working together as vital to a successful outcome ('...the group does work for you if you're willing to work with them').

Informal and Non-directive

Two of the interviewees talked positively about the general atmosphere and ethos of the group as informal, and alluded to the facilitator allowing autonomy within the group rather than directing it extensively. This appeared to be at odds with what these participants expected based on their knowledge or experience of services ('I thought that was good cos it wasn't just [facilitator] saying 'we're gonna do this, this and this'. It was an asking 'Right. What do you want to do in the group? What do you want to focus on in the group?' and we got to decide the certain parts that we wanted to get help with. So that was good.').

Normalisation

All the interviewees appeared to emphasise the importance of the experience of meeting and working with other people with BPD ('...there is people like you and you do see that for yourself.'). Participants spoke about the impact of this in terms of their realisations that they weren't 'crazy', that 'it's not all made up', that they are not 'weird' and that they are not 'all alone'. One group member gave a vivid description of the impact of meeting others with BPD on her by saying '...I don't have to suffer in silence or feel like I'm standing in the middle of a crowded room screaming and then nobody pays attention...'. Participants described the influence of this phenomenon on their experience of the group in terms of an unspoken sense of shared understanding and acceptance, allowing group members to feel safe and able to speak openly and honestly ('I could talk about things in the group [pause] and they would understand. But I can't talk to anybody else about because people in the group knew. Y'know it's all the same that they were going through.').

Goals

The process of setting, working towards and meeting goals was commonly referred to by all interviewees. Some of the participants reports suggested a sense of achievement and empowerment inherent to the task of taking on personal responsibility for improvement ('I don't have to have anybody helping me now.'). One participant spoke in a positive way about the novelty of making decisions

herself about how to get better ('I hadn't ever thought about it before, my own individual goals. What I needed to make myself feel better.'). Three of the interviewees conveyed a sense that they perceived the process of working towards goals as ongoing ('Like I'd worry about getting on a bus. I dinnae as much worry about that anymore...and like I still get worry and like I got a bike and I'd love to go on it, but I just have this thing where I cannae do it, but I think to myself 'I've done it with the bus' so it'll come, ken what I mean? It's like wee bits at a time ken? Like something that seemed impossible before, or you can't do it yet, it seems like it could be possible in the future.').

Change

As well as talking about change indirectly through dialogue about achieving goals two of the participants spoke in general terms about noticing change that they attributed to attending the group, with one group member citing this as the reason that they continued to attend ('And I think when I started to go I could see a change, that's why I kept coming back.'). Three of the participants referred to a sense of seeing themselves coping better while attending the group. All the interviewees described more specific changes ('I would have said that I was probably a stronger person...I could probably cope with more.').

Moving Forward

All the participants mentioned at least one aspect of the group that they were continuing to engage with such as ongoing positive contact with another group member, the continuing use of goals, and the strategy of approaching tasks one step at a time. Two group members explicitly described a sense of hope for the future ('Hope and faith that there is a way that it can all get sorted.').

Positive Experience

All the participants reinforced their positive view of their experience of the group with frequent general comments such as: 'It was just a really really good group.'; 'It was better than what I expected... Way better.'; '...it was perfect.'; '...it was a nice place to go.'; '...it was just a, a positive experience.'; '...the group's wonderful.'. There was also a sense that the interviewees had felt more positive as a result of attending the group ('I just feel a wee bit more alive inside.'). Two of the interviewees also explicitly reported enjoying the groups ('I actually enjoyed going.').

Negative Talk

Managing Relationships

Two of the participants spoke about the challenges of managing interpersonal relationships within their groups ('It was quite hard some weeks if someone was

going through a bad patch you didn't know how to react, but it was ok, once you got to know them it was fine.').

Anxieties

Three of the participants relayed their experience of having to overcome anxiety in order to attend the group, with one describing having to brace herself before each group meeting ('I was really scared, I have to say when I first walked into that room... 'How am I gonna get on with them?' 'Are we all gonna get on ok?', 'Every time I was coming I was just like [exhale of breath].'). While anxiety was acknowledged as a challenge there were also suggestions that confronting such anxieties had been beneficial ('...to actually go in with a room full of people. That helps.').

Effort

Interviewees addressed various forms of effort related to attending the group. They described working hard ('I worked hard'), challenging themselves ('...I got really upset, but I really wanted to go back'). Some participants alluded to the amount of effort required reducing over the course of the intervention ('It became really easy after a while.').

Unmet Goals/Unrealised Hopes

Two participants expressed the view that they would have benefited from the opportunity to attend more group meetings, either because they did not attend all available sessions or because they would have liked a longer-term intervention ('Yeah, it was only every fortnight, but it would have been nice if it was every week.'). One participant who was the most regular attender in a group where attendance was frequently low commented on the additional benefits she might have expected if more people had attended more often ('Just eh it's hard to say because, cos it was only a small amount of people. It would have been good to come every week and the same people being there and building relationships with the people you're with...').

Discussion

The results demonstrate progressive improvements in symptoms over the course of the intervention across all outcome measures, other than EQ-5D overall health state or for the BSI Interpersonal Sensitivities Scale. In ITT analyses quality of life was seen to have reduced by session eight with subsequent improvement such that it had improved to above baseline levels by session sixteen. For analyses where the OM method of RMV was adopted there were increases in mean scores on the BSI Interpersonal Sensitivities Scale followed by decreases to below baseline means at session sixteen. Whilst scores on all other outcome measures consistently increased, not all of these differences were found to be significant. The most robust findings across analyses were significant improvements in phobic anxiety and psychoticism. The BSI Phobic Anxiety Scale measures a construct similar to agoraphobia involving irrational and disproportionate fear responses to specific situations, and associated disruptions to activities (Derogatis, 1993). This improvement may be related to qualitative reports suggesting a process of challenging anxieties, particularly in relation to feared situations. The BSI Psychoticism Scale refers to isolation and withdrawal associated with a schizoid lifestyle and taps into interpersonal alienation (Derogatis, 1993). The *Normalisation* theme highlighted in the qualitative analysis, along with participant reports of feeling less alone and more supported, could be associated with improvements on this scale. Opportunities for normalisation within the group may also have been instrumental in the significant

reductions in somatisation found in some analyses. Discussing similar experiences within the group may have afforded group members opportunities to reframe inaccurate or extreme interpretations of bodily sensations.

The results across all analyses suggest a significant improvement in interpersonal functioning. Qualitative themes related to this improvement may be identified as: *Normalisation, Managing Relationships, Working Together*. Some analyses also indicated a significant reduction in the number of SCID-II criteria met. Relatively consistent improvements in depressive symptoms across analyses are evident, with some reaching significance. Significant reductions in symptom severity and related distress are indicated by changes in BSI indices and may be related to participants' frequent references to generalised subjective impressions of feeling better and coping better. Less conservative analyses suggested significant improvements in both hostility and obsessive-compulsive symptoms.

Improvements in general anxiety were found to be significant in some analyses. Non-significant results appear inconsistent with qualitative reports, however, the qualitative data also suggest improved coping abilities and it is possible that group members' skills and confidence in coping with anxiety increased as opposed to anxiety symptoms being markedly reduced. A further possibility is the influence of RMV method. Differences across analyses highlight the potential impact of the level and pattern of missing data on all results. Significant differences between baseline

and 8-session scores were only found in RMV with OM analyses which could be explained by a large amount of 8-session data being replaced with baseline data in RMV with LOCF analyses.

From an alternative perspective the lack of significant differences between baseline and 8 sessions may indicate a requirement for a 16-session treatment dose. In the context of a varied pattern and level of attendance the results are difficult to interpret in relation to treatment dose, however, such attendance patterns are likely to be typical in the BPD population due to issues relating to emotional instability, insecure attachment styles, and self-destructive impulsivity (Alwin et al., 2006; Swift, 2009).

The qualitative data indicate that some group members would have liked the groups to continue for longer, and it is unclear whether or not this would have led to more significant improvements. All the participants interviewed following the group mentioned their maintenance of some aspect of the group intervention and long-term follow-up would be beneficial in assessing the level of maintenance of treatment gains.

The findings from the current study are consistent with evaluations of the effects of SFT groups for a range of presenting problems which have demonstrated the potential for impacts on: depressive symptoms; quality of life; psychological

distress; self-esteem; and the degree of perceived control over problems (Arvand *et al.*, 2012; Madigan *et al.*, 2012; Thorslund *et al.*, 2007; Quick & Gizzo, 2007).

Similar results in terms of improvements in BPD-related symptoms and depression have been found following individual psychotherapeutic interventions for BPD including DBT, transference-focused therapy (TFP), schema-focused therapy, CBT and supportive therapy (Clarkin *et al.*, 2007; Davidson *et al.*, 2006; Giesen-Bloo *et al.*, 2006; and Linehan *et al.*, 1991). Group treatments for BPD based upon STEPPS, acceptance-based emotion regulation, DBT skills, and schema-focused therapy applied to outpatients with BPD have also been demonstrated to have positive effects on BPD-specific symptoms and mood (Blum *et al.*, 2008; Farrell *et al.*, 2009; Gratz & Gunderson, 2006; Soler *et al.*, 2009). All these group interventions provided weekly group sessions and the duration of treatment ranged from 13 to 30 weeks. Group interventions were adjunctive to TAU for all but the DBT skills group, and both the schema-focused and acceptance-based emotion regulation groups required participants to be in concurrent individual psychotherapy. The exclusion criteria employed raise some questions pertaining to both the level of severity of the BPD participants involved in these studies as well as to the effectiveness of treatments for those with particular patterns of co-morbidity. The SFT group treatment delivered as part of the present study appears to have produced improvements despite being less intensive in terms of frequency, not requiring concurrent individual psychotherapy, and not excluding on the basis of either severity or co-morbidity.

A further advantage of the current study is the inclusion of systematically gathered, detailed qualitative feedback to allow the relation of empirical outcomes to the clients' experiences of the intervention. The qualitative results indicate that the majority of the participants' initial hopes were addressed by the intervention. The themes identified inductively from the qualitative data suggest that the group contributed to positive change which was associated with coping better, feeling better, empowerment, and working together towards specific, personally-defined goals. Aspects of the group which appeared to facilitate change were: *Normalisation*, *Working Together*, mutual support and sharing, the *Informal and Non-directive* nature of the intervention, the process of working towards personally meaningful goals, and the positive experience of attending the group. Fewer negative themes were induced from the data and most are likely to be inherent to the process of change through group psychotherapy. Qualitative results are consistent with the feedback gathered from clients with histories of CSA and substance abuse issues who underwent a weekly, 12-session, SFT group intervention who reported: seeing themselves more positively; benefits of normalisation; learning specific skills; the importance of sharing and support; and the experience of feeling less alone.

Nehls (1991) highlighted Yalom's common factors in group therapy as potentially important in group therapy for BPD. Some of the themes identified in the qualitative analysis in the present study are consistent with Yalom's (1975) identification of common "curative factors" associated with psychotherapeutic

groups. The *Working Together* theme identified in the present study has similarities with elements of Yalom's *Altruism* and *Group Cohesiveness* factors. Elements of the *Group Cohesiveness* factor are also present in the current study's *Normalisation* theme, which is strikingly similar to Yalom's *Universality* factor. Individual data extracts relating to being able to talk in the group and feeling better as a result could be construed as consistent with Yalom's *Catharsis*, and references to hope for further progress as relevant to Yalom's *Instillation of Hope*.

The positive experience of the informal, non-directive ethos and pursuit of individually meaningful goals may be more associated with SFT than with other approaches. Swift (2009) points out that there may be an inconsistency in simultaneously attempting to accept the patient as they are whilst encouraging them to change in specific ways. A recent qualitative study exploring BPD clients' perspectives on recovery reported a view that psychotherapies for BPD often had an extreme focus on specific areas and that some of their personal goals were neglected (Katsakou *et al.*, 2012). Participant feedback following acceptance-based emotion regulation groups for BPD also suggested greater enthusiasm for sessions focusing on individually-meaningful goals (Gratz & Gunderson, 2006). SFT groups represent a treatment option suited to fulfilling BPD clients' desire for the pursuit of individually meaningful goals.

It has been highlighted that there is a potential issue with the availability of and access to specialised treatment programmes in real world clinical settings, and that there is a need to improve 'care-as-usual' for BPD (Crawford *et al.*, 2007; Koekkoek *et al.*, 2009). The current study demonstrates the potential benefit to clients of a resource-efficient, community-based intervention operating with limited exclusion criteria. The need to improve access to psychological therapies for individuals with severe mental illness, such as personality disorder has been recently highlighted by the DoH (2011), and NICE (2009) have recommended research to assess the relative efficacy of psychological therapies delivered in community mental health settings.

Limitations

Limitations of the research include the lack of a control or comparison condition. This is recognised as important in the context of the lack of significant differences found between treatment and TAU in relevant outcomes for two studies evaluating individual DBT and individual CBT interventions (Davidson *et al.*, 2006; Linehan, 1991). The lack of a control group prevents the assertion that the observed improvements are actually associated with receiving the intervention. The sample size is also limited, and only one therapist was involved in delivering the groups, and therefore replication is required to increase generalisability. In relation to this, the reasons that some group participants did not complete outcome measurement at all time points, or did not attend for qualitative interviews, is unclear. It is possible

that those who declined to respond had found the intervention less beneficial or differed systematically in some other way from those who participated. Differences in results from analyses adopting different RMV methods further demonstrates the potential impact of the choice of method on findings, and to an extent limits interpretation. The influence on the results of the dual role of chief investigator/group facilitator is unknown, although the qualitative interviews were conducted by psychologists independent of the intervention and research activities.

Conclusions

The study provides some preliminary evidence for the effectiveness of an adjunctive, community-based, SFT group for clients with BPD delivered in a real-world setting. The outcomes were consistent with findings from studies of other individual and group psychotherapies for BPD and showed improvements in: phobic anxiety; psychoticism; interpersonal functioning; depression; anxiety; hostility; obsessive-compulsive symptoms; somatisation; symptom severity and related distress; and the number of diagnostic criteria met. The most robust findings, in terms of effect sizes and consistency of significance across analyses, were improvements in: phobic anxiety; paranoid ideation; psychoticism; interpersonal functioning; and symptom severity. Qualitative analyses indicated the intervention successfully addressed the hopes of the participants and that they valued: normalisation; acceptance and safety; the opportunity to share and work

together; mutual support; an informal and non-directive atmosphere; and assistance with the pursuit of personally meaningful goals. Those interviewed reported noticing change, progress towards their goals, and a subjective sense that they were coping better and feeling better. Group members also recognised the inherent challenge and necessity of hard work, confronting anxieties and managing relationships in the group. All those interviewed emphasised that attending the group had been a positive experience. The SFT groups for BPD may represent a more easily-accessible, resource-efficient, less intensive alternative to specialised services that may also address client feedback that has highlighted a preference for a focus on individual goals.

Implications

As opposed to focusing on a detailed formulation of what went wrong in order to identify a remedy, the focus in SFT is on the formulation of solutions through interaction and creative processes. The improvements found in the present study indicate that, despite suggestions otherwise, a detailed exploration and understanding of causes and past experiences related to BPD may not be necessary.

The qualitative results of the present study reflect some common factors relating to group process identified by Yalom (1975). It is unclear whether it was these processes that were associated with change in this study, or something specific to

SFT groupwork. It is also possible that the SFT approach served to facilitate or enhance these group processes.

Research on individual treatments and specialised treatment programmes has failed to provide evidence for the superiority of any one approach over another for BPD.

Along with indications that effective group approaches may be tapping into inherent group processes, this raises questions about whether psychotherapy for BPD in general relies on common therapeutic factors to bring about change. Rather than seeking to establish the efficacy and effectiveness of specific therapeutic models of treatment for individuals with BPD, it may be that effort would be more usefully applied to investigating those aspects of interventions that facilitate and enhance beneficial common therapeutic factors.

Group therapy may represent an important treatment option, but may not be appropriate for all BPD clients. Findings of the current study indicate that those with high baseline anxiety scores may have been unable to tolerate attending a group.

The availability of a range of treatment models and modalities may be beneficial in allowing treatment to be offered on the basis of individual needs (Alwin et al., 2006).

The potential benefit of an SFT-based group intervention delivered within community services with minimal resources has been demonstrated in the current study. Psychologists and psychotherapists based in community teams may be well-

placed to offer similar treatment options and contribute to the improvement of care-as-usual for those with BPD. Community delivery would potentially also enhance treatment by maintaining coherence and consistency both in terms of therapeutic approach and relationships between clients and staff.

A further implication of the present study relates to inconsistencies found between quantitative outcomes and qualitative reports. For example qualitative data strongly indicated that group participants had been challenging and coping more effectively with anxiety, in contrast to a lack of significant change found on clinical measures of anxiety. The neglect of qualitative exploration of therapeutic process in existing research may be unhelpfully over-valuing symptomatic improvement over functional improvement. Both the current study and others emphasise the potential value of client-identified goals (Katsakou et al., 2012; Nehls, 1991), and attention to the treatment outcomes that are meaningful to clients, regardless of their relationship to clinical symptoms, may be beneficially emphasised irrespective of therapeutic model or stance.

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APPENDICES

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Appendix A

Psychology and Psychotherapy: Theory, Research and Practice

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Author Guidelines

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

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- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded [here](#).
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- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results,

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- All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading ‘Practitioner Points’. These should briefly and clearly outline the relevance of your research to professional practice.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.
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the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. *Human Rights Journal*. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x

Appendix B

EoSRES



East of Scotland Research Ethics Service (EoSRES)

Tayside Medical Sciences Centre (TASC)
Residency Block C, Level 3
Ninewells Hospital & Medical School
George Pirie Way
Dundee DD19SY

Miss Julie Carlisle
Trainee Clinical Psychologist
Child and Adolescent Mental Health Service
The Manor
Brown Street
Cameon
Falkirk
FK1 4PX

Date: 12 January 2012
Your Ref:
Our Ref: CYA/AG/11/GA/225
Enquiries to: Mrs Caroline Ackland
Extension: Ninewells extension: 32589
Direct Line: 01382 632589
Email: Caroline.ackland@nhs.net

Dear Julie

Re: Solution-focused therapy groups for Borderline Personality Disorder

You have sought advice from the Research Ethics Office on the above project. I have considered this and can advise that this does not require ethical review under the terms of the Governance Arrangement for Research Ethics Committees (GAfREC) in the UK. The advice is based on the following documentation provided:

Document	Version	Date
Emails	N/A	Various
Research Protocol	Version 1	15 th August 2011
Consent Form	Version 3	4 th January 2012
Participant Information Sheet	Version 3	4 th January 2012

- You are undertaking a service evaluation
- You may still require Research and Development approval

Please note that this advice is issued on behalf of the Research Ethics Service Office and does not constitute an opinion of a Research Ethics Committee (REC). It is intended to satisfy journal editors and conference organisers, who may require evidence of consideration of the need for ethical review prior to publication or presentation of your results.

You should keep a copy of this letter within your project file.

Yours sincerely,

Caroline Ackland
Scientific Officer, East of Scotland Research Ethics Service

Cc: Mrs Aileen Yell, Research Governance Manager, NHS Fife



Appendix C



PARTICIPANT INFORMATION SHEET

Solution-focused therapy groups for Borderline Personality Disorder

You are invited to participate in a study that will evaluate the group you are attending. We believe the study to be of potential importance, however, before you decide whether or not you would like to participate, we need to be sure that you understand why we are doing the study, and what it will involve if you participate. You are therefore being provided with the following information. Please read it carefully and be sure to ask any questions you may have. If you want you can discuss it with others before making a decision. We will do our best to explain the study and to provide any further information you may ask for now or later. You do not have to make a decision straight away.

What is the study about?

The study is about the effectiveness of the Solution-focused therapy group you are attending in terms of: whether or not the group helps with your symptoms; whether or not you make progress towards your goals; whether or not the group helps you in any other ways; and what your experience is of attending the group.

Why is the research being done?

We would like to know how effective/helpful the Solution-focused therapy group is for people with Borderline Personality Disorder (BPD). We will use the information to make decisions about how best to develop our services for people with Borderline Personality Disorder, and to decide whether or not continuing to provide the Solution-focused groups is worthwhile. The information from the study might also be useful for other professionals who provide services for people who have BPD.

Who is funding the study?

The study is being funded by the University of Edinburgh.

Why have I been chosen to participate in the study?

You have been chosen to participate because you are attending one of the Solution-focused groups for people with BPD.

How many other people have been asked to consider participating?

Everyone who attends one of the Solution-focused groups for BPD between August 2011 and August 2012 will be asked to participate. This could be up to 30 people in total.

What does the study entail?

Taking part in the study will not affect your treatment in any way. Your treatment will be the same whether you choose to participate or not. If you decide not to participate you can still continue to attend your Solution-focused group.

Your GP will be informed that you are taking part in the Solution-focused group.

If you do decide to take part the information from the questionnaires you have already filled out at your pre-group assessment, and the information from filling out the same questionnaire on the day of the first group meeting, and again three months and six months later, will be used to evaluate how helpful the group has been for you.

You will also be invited to come to an extra group session after the group has finished to discuss your experiences of the group together. This extra session will be audio recorded and what people say about the group will be used to help us understand group members' experiences of the group. This extra session will be optional. Even if you consent to us using the information from your questionnaires you do not have to commit to attending for this session.

Will I benefit from taking part in the study?

There will be no specific personal benefits to you from taking part in the study. You do not have to take part in the study to continue attending your group.

Taking part in the study will help us to plan future services for other people with BPD, and help us to decide whether running the Solution-focused groups is worthwhile in the future.

What are the discomforts, risks and side effects?

There are no discomforts, risks or side effects from taking part in this study.

What will happen to the information collected in the study if I take part?

All the information you provide from filling out the questionnaires is confidential. This will be stored securely in your psychology case notes for the duration of the study. These notes are available only to those with a need or right to access them. To allow us to examine the information from the questionnaires your name and address will be removed from the data and you will be assigned a code. Only Miss Julie Carlisle will have access to this data. The anonymised data will be held anonymously for five years after which it will be destroyed using appropriate methods at that time or according to the Data Protection Act, 1998.

If you attend the final optional group session which will be audio recorded, the recording will be stored securely. Only Miss Julie Carlisle will have access to this recording. In any written documents that record information from this session all participants will be assigned an anonymous code.

What will happen to the results of the study?

The results will be written up as a thesis document and may be published in a scientific journal.

No participant will be identified in any report or publication.

The results will be made available to participants who wish to have a copy.

What are my rights?

We are aware that participants may want further information. If you would like more information please contact Miss Julie Carlisle or Dr Humera Millar.

You do not have to take part, and you can change your mind later even if you decide to take part now.

If you decide not to take part your treatment will not be affected.

Participation in this study is entirely voluntary and you are free to refuse to take part or to withdraw from the study at any time without having to give a reason and without this affecting your future medical care or your relationship with medical staff looking after you.

What if there is a problem?

If you think that you have been harmed in any way by taking part in this study, you have the right to make a complaint and ask for compensation from the University of Edinburgh, who are sponsoring this research. You can get details about this from the research team.

Also, as a patient of the NHS, you have the right to make a complaint through the NHS process. To do this, you can make a complaint in writing to the NHS Forth Valley Patient Relations and Complaint Service, Falkirk Community Hospital, 01324 678 530. If you think

you have been harmed because someone has not done their job properly during the study, you may have grounds for legal action against NHS Forth Valley, but you may have to pay your legal costs.

If you have any questions you can contact the researchers

Principal Researcher:

Miss Julie Carlisle

Trainee Clinical Psychologist/Specialist Psychological Practitioner

01324 614347

Supervisors:

Dr Humera Millar

Chartered Clinical Psychologist

01324 614347

Prof. Mick Power

Professor of Clinical Psychology

mjpower@staffmail.ed.ac.uk

Appendix D

Semi-structured Interview Schedule

Main research questions to be addressed during interview (for interviewer):

1. What were group members' subjective experiences of attending the group?
2. What aspects of the group did individual members find helpful/unhelpful?
3. What has changed subjectively for those who attended the group?

Purpose of interview (explanation for interviewee):

We would like to know about your personal experience of attending the Solution-focused group for Borderline Personality Disorder. We are interested in any differences the group has made to you, and we would also like to know what aspects of the group you found helpful, and if there was anything that you found unhelpful about the group.

Examples of general prompts to encourage elaboration:

What did you mean when you said....?

Can you tell me more about that?

Introducing Interview

Explain purpose (as above).

Remind about audio-recording (to ensure we have an accurate record of their responses).

Ask if this was the first group they have attended?

Specific questions:

1. **Main Question:**
I'd like you to tell me 'the story' of your Solution-focused group, beginning with when you first heard about it?

Follow-up

- a. What made you come to the Solution-focused group?
- b. What were your best hopes for coming to the group?
- c. Was there anything that surprised you about the group?
- d. Does it feel to you that attending the group has been helpful for you? (if so) in what ways?
- e. What positive things were there about the group?
- f. What negatives were there?

2. **Main Question:**
Was the group what you expected?

Follow-up

Only if attended group(s) before:

- a. You mentioned that you have been to (a) group(s) before? Was the Solution-focused group different to what you were expecting based on your past experience of groups? If so, in what ways?
- b. In the Solution-focused group it was discussed and decided together how to structure the group sessions. How did you find that?
- c. What was it like for you being involved in decisions about how the group was set-up and structured?
- d. In the group everyone was working towards their own individual goals. How did you find that?
- e. Does it feel that you have met the goals you set for yourself?

3. **Main Question:**
What difference, if any, has the group made to you?

Follow-up:

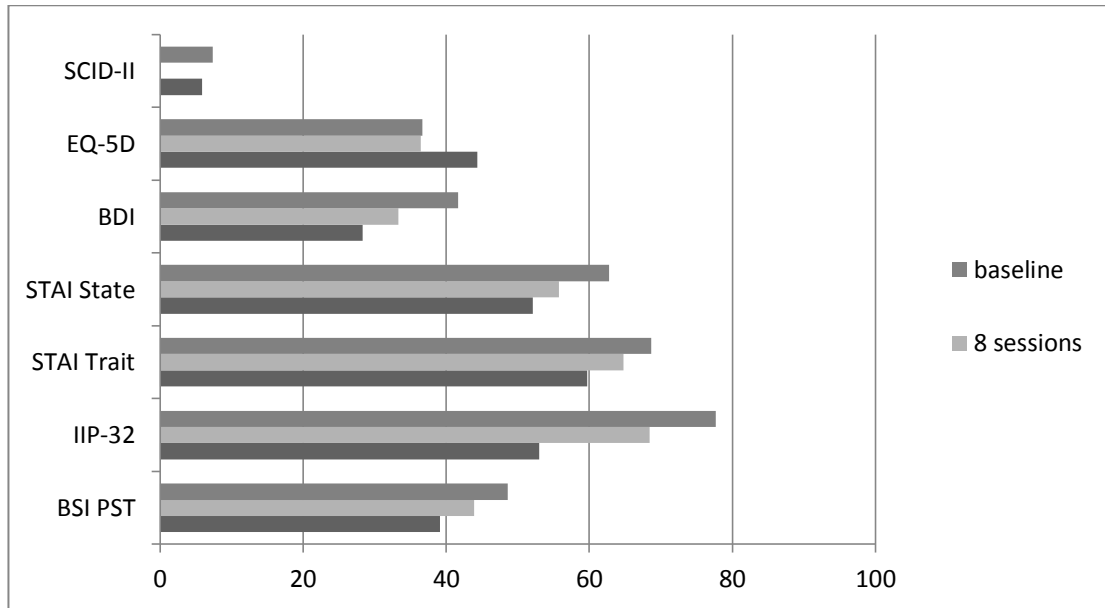
- a. In what ways, if any, do you feel you have benefited from attending the group?
- b. What, in your opinion, might have made the group more beneficial to you?
- c. Would you recommend the group to other people with similar difficulties? If so, what would you tell them about your experience of the group?

4. **Wrapping up the interview**
What will you remember most about your time in the group?

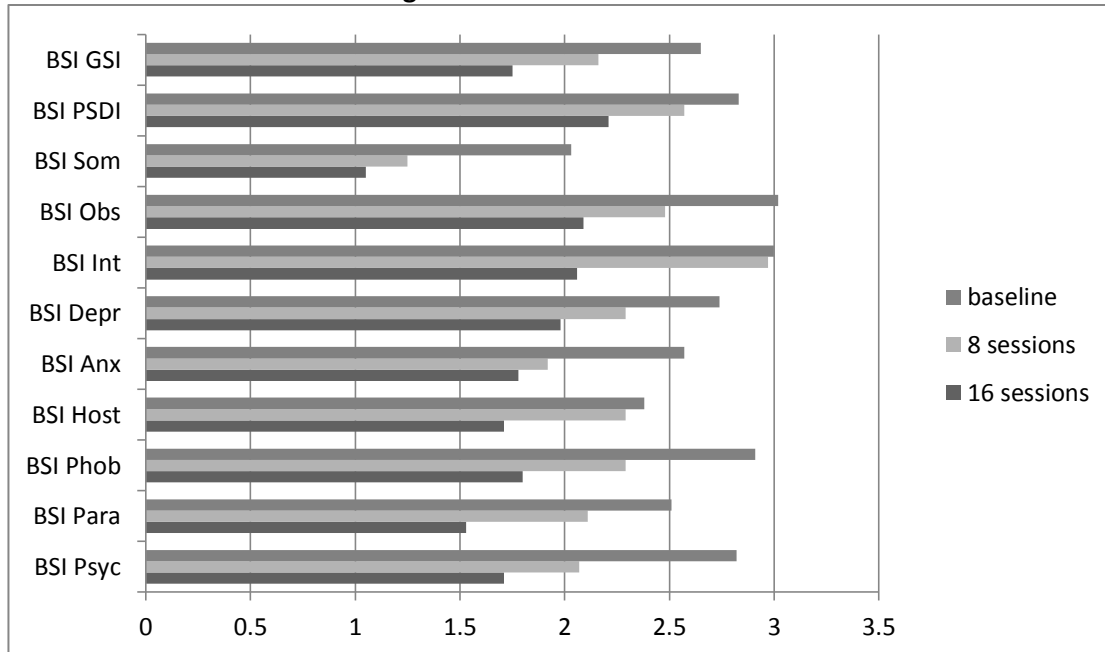
Is there anything else you'd like to tell me about the group?

Appendix E

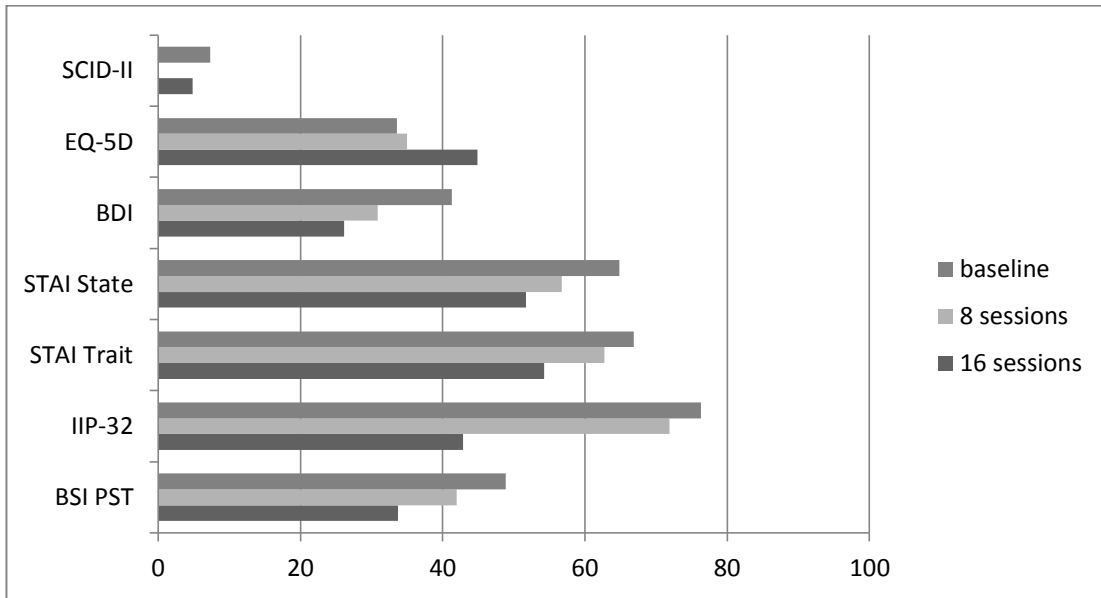
Means across the three assessment points for ITT data using RMV with LOCF for those measures with larger score ranges



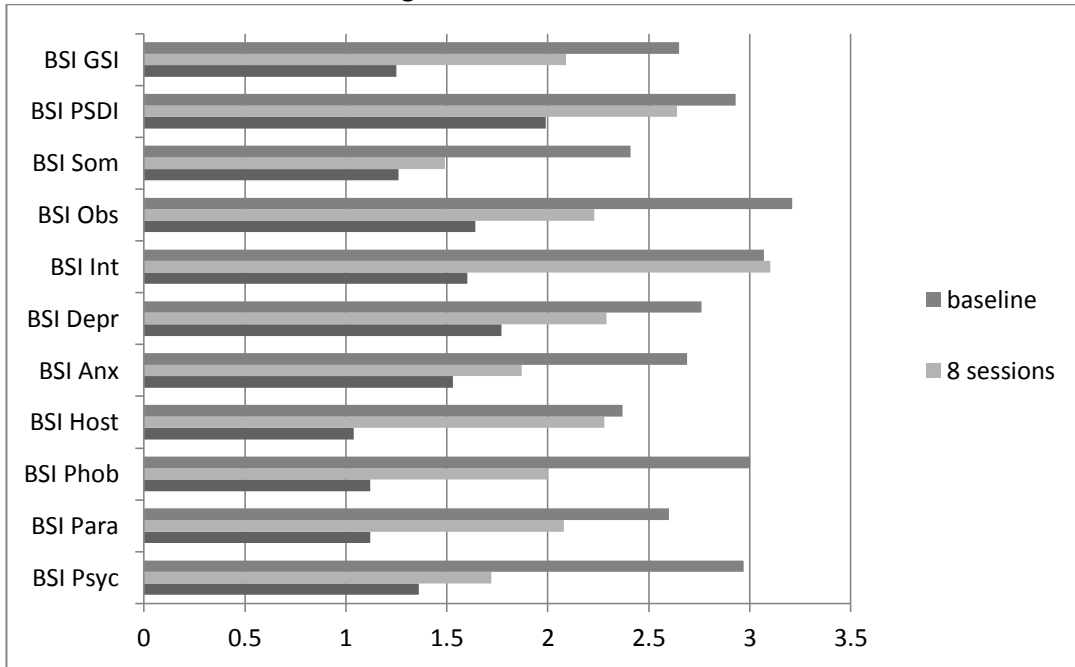
Means across the three assessment points for ITT data using RMV with LOCF for those measures with smaller score ranges



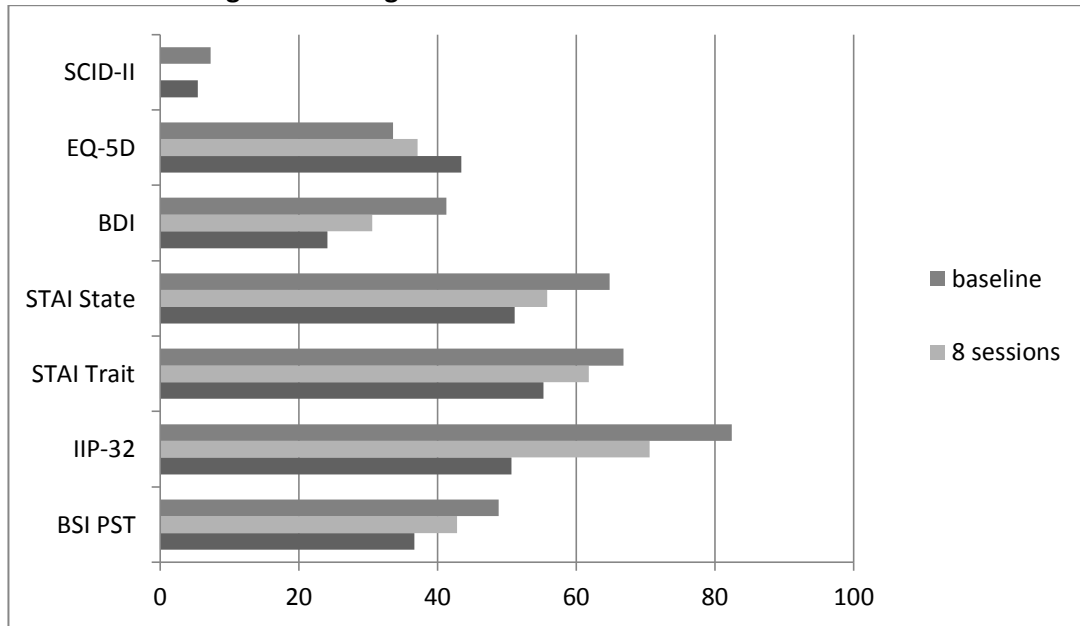
Means across the three assessment points for ALFS data using RMV with OM for those measures with larger score ranges



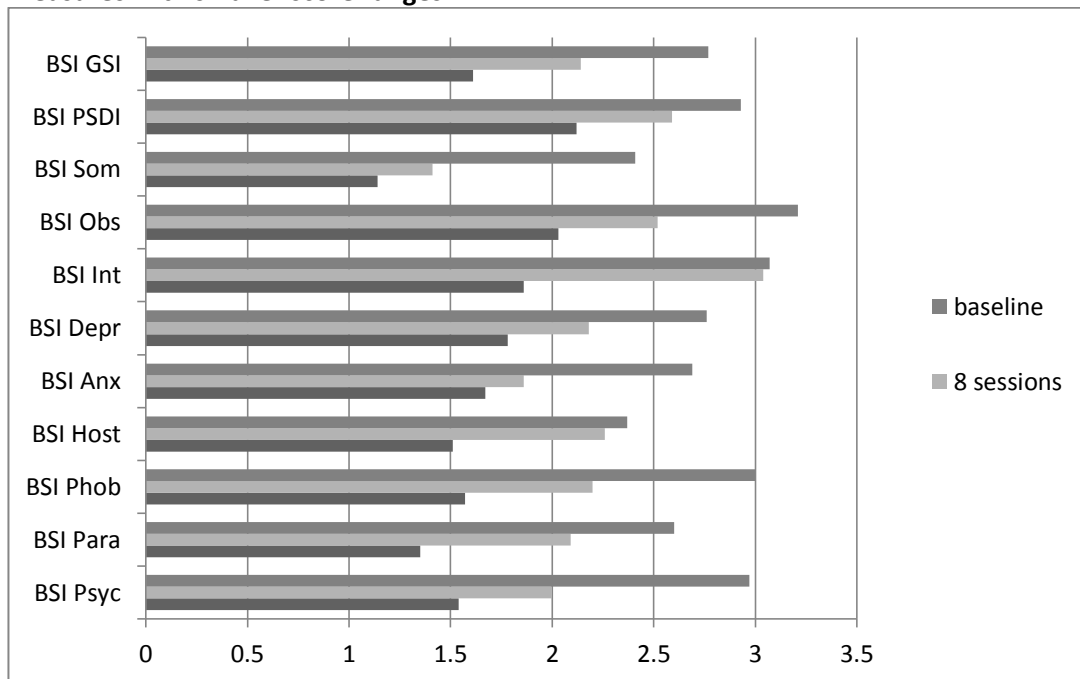
Means across the three assessment points for ALFS data using RMV with OM for those measures with smaller score ranges



Means across the three assessment points for ALFS data using RMV with LOCF for those measures with larger score ranges



Means across the three assessment points for ALFS data using RMV with LOCF for those measures with smaller score ranges



Appendix F

Non-parametric Analyses

RMV with OM

Intention-to-treat analyses (n = 9)

A number of variables were deemed likely to violate the assumption of normality for the distribution of scores on at least one measurement occasion. Non-parametric analyses using the Friedman test for related samples showed significant differences across medians at the three time points for: BDI-II total score ($\chi^2(2,9) = 6.889, p < 0.05$), IIP-32 total score ($\chi^2(2,9) = 14.00, p < 0.001$), BSI PST ($\chi^2(2,9) = 7.943, p < 0.05$), BSI Hostility Scale ($\chi^2(2,9) = 8.22, p < 0.05$), BSI Phobic Anxiety Scale ($\chi^2(2,9) = 14.114, p < 0.001$). No significant difference was found across the medians for: EQ-5D Health State ($\chi^2(2,9) = 0.743, NS$), Trait Anxiety measured by the STAI ($\chi^2(2,9) = 5.314, NS$), and BSI Somatisation Scale ($\chi^2(2,9) = 4.514, NS$).

Where significant differences in medians were observed across measurements these were investigated further by pairwise comparisons using the Wilcoxon Signed Ranks Test. Type I errors were controlled for at the .05 level using the LSD procedure. The median score for the BDI-II was significantly lower at 8 sessions than at baseline ($p < 0.05$), and also at session 16 as compared with baseline ($p < 0.05$), but not significantly different between 8 and 16 sessions. The median IIP-32 score significantly reduced between 8 sessions and 16 sessions ($p < 0.01$), and between baseline and 16 sessions ($p < 0.01$), but not between baseline and 8 sessions. For the BSI PST there was a significant decrease in median score between baseline and 8 sessions ($p < 0.05$), and between baseline and 16 sessions ($p < 0.01$), but no significant difference between 8 and 16 sessions. The BSI Hostility Scale showed significant reductions in median scores between baseline and 8 sessions ($p < 0.01$) and between baseline and 16 sessions ($p < 0.05$), but not between baseline and 8 sessions. For the BSI Phobic Anxiety Scale significant reductions in the median were more consistent, being observed between baseline and 8 sessions ($p < 0.01$), between 8 sessions and 16 sessions ($p < 0.05$), and between baseline and 16 sessions ($p < 0.01$).

At least four sessions attended (n =7)

Those variables whose distributions were likely to violate the normality assumption on one or more occasions were analysed using the Friedman test for related samples as before. Significant differences were demonstrated across the medians for the IIP-32 ($\chi^2(2,7) = 11.143, p < 0.01$) and BSI Obsessive-Compulsive Scale ($\chi^2(2,7) = 8.385, p < 0.05$). There were no significant differences found for the: EQ-5D Health State ($\chi^2(2,7) = 0.286, NS$), BDI-II total score ($\chi^2(2,7) = 0.265, NS$), STAI Trait Anxiety ($\chi^2(2,7)$

= 0.196, NS), BSI PST ($\chi^2(2,7) = 4.667$, NS), BSI Somatisation Scale ($\chi^2(2,7) = 5.407$, NS), and the BSI Hostility Scale ($\chi^2(2,7) = 5.429$, NS).

Where the Friedman test was seen to be significant this was investigated further by pairwise comparisons using the Wilcoxon Signed Ranks Test. Type I errors were controlled for at the .05 level using the LSD procedure. The median score for the IIP-32 was found to be significantly lower at 16 sessions than at baseline ($p < 0.01$), and at 16 session than at 8 sessions ($p < 0.01$), with no significant difference between baseline and 8 sessions. The median for the BSI Obsessive-Compulsive Scale was shown to be significantly lower at 8 sessions than at baseline ($p < 0.05$) and at 16 sessions than at baseline ($p < 0.05$), but no significant differences were shown between 8 and 16 sessions.

RMV with LOCF

Intention-to-treat analyses (n = 9)

Those variables that were deemed likely to violate the assumption of normality for the distribution of scores on at least one measurement occasion were analysed using the Friedman test for related samples. The test showed significant differences across medians at the three time points for the: BDI-II total score ($\chi^2(2,9) = 7.364$, $p < 0.05$) and the BSI GSI ($\chi^2(2,9) = 10.571$, $p < 0.01$). No significant effect of time was found for either the STAI Trait Anxiety score ($\chi^2(2,9) = 2.667$, NS) or the BSI PST ($\chi^2(2,9) = 4.105$, NS).

Pairwise comparisons were conducted where significant effects of time were found using the Wilcoxon Signed Ranks test. The median scores for the BDI-II were found to be significantly lower at 16 sessions than at baseline ($p < 0.05$), with no significant differences when comparing baseline and 8 sessions or 8 sessions and 16 sessions. For the BSI GSI the median score was shown to be significantly less at 16 sessions than at 8 sessions ($p < 0.05$) or at baseline ($p < 0.05$), with no significant difference between baseline and 8 sessions.

At least four sessions attended (n =7)

Both the STAI State Anxiety and BSI PST variables were deemed likely to violate the assumption of normality for the distribution of scores on at least one measurement occasion. These were analysed using the Friedman test for related samples. The test showed significant differences across medians at the three time points for the STAI State Anxiety ($\chi^2(2,9) = 6.091$, $p < 0.05$), but not for the BSI PST ($\chi^2(2,9) = 4.105$, NS). Pairwise comparisons using the Wilcoxon Signed Rank Test for the STAI State Anxiety revealed significant decreases in median scores between baseline and 16

sessions ($p < 0.05$) and between 8 sessions and 16 sessions ($p < 0.05$), but not between baseline and 8 sessions.