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A roadmap to recovery and a life worth living: An interpretative phenomenological analysis of adolescent experiences of dialectical behaviour therapy in child and adolescent mental health services

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Abstract: This research explores adolescents' lived experience of 24 weeks of Dialectical Behaviour Therapy (DBT), designed to address severe mental health difficulties including suicidal and self-harming behaviour. There is a lack of published literature regarding adolescent lived experiences of 6 months comprehensive DBT. A qualitative design in the form of Interpretative Phenomenological Analysis (IPA) is an appropriate fit for research questions concerned with individual phenomenology. Six adolescent service users self-selected to take part in the research. One superordinate theme around recovery of mental health and wellbeing was characterised as 'building a roadmap to recovery and a life worth living'. Three subordinate themes depict the steps on the road and describe how individuals travelled from 'alienation to insight', 'isolation to connection', and from 'passive disempowered recipient of intervention to proactive engagement as empowered service users'. Novel links between DBT, identity process theory, attachment theory and critical psychology are made.

Keywords: Dialectical Behaviour Therapy (DBT), Adolescent mental health, Suicide, Recovery, Interpretative Phenomenological Analysis

There is a lack of adolescent voices in published research regarding their lived experience of mental health intervention. Adolescents are viewed in the literature as a unique and high-risk population, and the importance of their feedback and experiences regarding psychological interventions are self-evident (Cha et al., 2018; Coyne et al., 2015; Das et al., 2016; Dooley & Fitzgerald, 2012; Dooley, O'Connor, Fitzgerald, & O'Reilly, 2019; Gates, 2016; Patton et al., 2016).

This research focuses on the lived experiences and understanding of suicidal adolescents attending Child and Adolescent Mental Health Services (CAMHS), who received a specialist therapeutic intervention in the form of Dialectical

Behaviour Therapy for adolescents (DBT-A). The participants are viewed in this study as 'experts by experience' of mental health and services.

The intervention at the centre of this research - DBT-A - has been shown to be an effective treatment for this population using quantitative outcome measures (DeCou, Comtois, & Landes, 2019; Flynn et al., 2020). To extend these findings, this research utilises qualitative methods to explore the subjective experiences of adolescents themselves. The qualitative method chosen, Interpretative Phenomenological Analysis (IPA), allows the researcher to make interpretative links between individual adolescent experiences and psychological literature (Smith, Flowers, & Larkin, 2009).

The aim is to provide insight into the personal phenomenology of mental health difficulties that led to referral into this specialist treatment, as well as insight into adolescent experiences of the intervention itself. This research asks the following question: What are adolescent service-users' experiences of DBT-A with reference to its impact on their mental health?

Background

A Lancet global review of adolescent health and wellbeing identifies adolescence as the time in the life span when mental health difficulties are first expressed and experienced, and the time when young people are best positioned to respond to intervention due to neurocognitive development and plasticity (Patton et al., 2016). Another study within the Lancet review points to mental health difficulties as accounting for the second highest death rate in adolescents worldwide (Mokdad et al., 2016). The need to provide evidence-based effective interventions to address mental health difficulties in this population seems clear.

The adolescent population has been viewed as uniquely difficult to engage and unrepresented with regard to service user feedback (Cha et al., 2018; Coyne et al., 2015; Patton et al., 2016). Qualitative research, detailing individual adolescent accounts regarding a mental health intervention can give voice to treatment fit for this population from the perspective of the service-users themselves.

DBT is predominantly a behavioural treatment, designed to treat severe psychiatric presentations characterised by high risk emotional and behavioural dysregulation, including suicidal and self-harming behaviours (Linehan, 1993a). DBT aims to treat severe mental health problems and suicidal behaviour by empowering individuals to build a life worth living, through skills training and insight building (Linehan, 1993a; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). DBT is designed as a comprehensive intervention encompassing four modes of treatment; three to address clients' needs; i) skills training group treatment, ii) individual therapy, iii) phone coaching; and one mode to support the therapist; iv) consult meetings for therapists to promote adherence and prevent burnout (Linehan, 1993a, 1993b).

DBT for Adolescents (DBT-A) is an adaptation of adult treatment (Miller, Rathus, & Linehan, 2006; Miller, Rathus, Linehan, Wetzler, & Leigh, 1997). Adolescent adaptations to DBT, involve the inclusion of caregivers in skills-training, a fifth module of skills addressing conflict within families, meaning that DBT-A skills training runs for 24 weeks (contrasted with adult 16 week program) and a fifth optional mode of family therapy sessions alongside the traditional four modes of treatment (Miller et al., 2006). Extensive and robust research shows DBT-A to be effective in reducing high risk suicidal behaviours in adolescents (DeCou et al., 2019; Flynn, Kells, Joyce, Suarez, & Gillespie, 2018; Hawton et al., 2015; Iyengar et al., 2018).

In a 2019 review of psycho-social treatments for self-injurious thoughts and behaviours in youths, DBT-A was found to meet criteria for the highest standard intervention (Glenn, Esposito, Porter, & Robinson, 2019). In a 2019 review and meta-analysis, DeCou et al, found that DBT-A reduced self-directed violence and frequency of crisis attendances at psychiatric services (DeCou et al., 2019). Iyengar et al (2018) similarly found that DBT-A was associated with a significant reduction in the frequency of self-harm behaviours, suicidal ideation, and depression post-treatment and at 6-months follow up, when compared with other suicide intervention programs, mirroring the findings of the 2015 systematic review of Hawton et al., 2015. Iyengar and colleagues (2018) propose that the elements which make DBT-A an effective treatment include self-directed involvement (individual therapy) and socially driven components (family skills training). DeCou and colleagues emphasise the behavioural focus of DBT (DeCou et al., 2019) while Groves and colleagues suggest that DBT-A addresses the emotional regulation problems underpinning mental health difficulties in general (Groves, Backer, van den Bosch, & Miller, 2012). Brent et al (2013) found that symptom reduction in DBT was correlated with number of sessions (dose), this means that the risk, for those engaged in DBT-A, decreases as the treatment/dose builds up. DBT-A can be delivered on an outpatient basis and encourages a recovery focus in the community, in line with the recovery model being adopted by health services in general in Ireland and across Europe (Davidson & Strauss, 1995; Flynn, Kells, Joyce, Corcoran, et al., 2018; McMahon et al., 2019; MHC, 2005).

Quantitative research has established that DBT is an effective treatment for suicidal and self-harming behaviour in adult and adolescent populations (DeCou et al., 2019; Flynn, Kells, Joyce,

Suarez, et al., 2018; Hawton et al., 2016). There is a gap in the literature regarding the phenomenological understanding of DBT from the subjective view of individuals taking part. There is a small body of qualitative papers exploring participants' experiences of DBT across adult and adolescent populations (Chugani, Seiler, & Goldstein, 2017; Cunningham, Wolbert, & Lillie, 2004; McCay et al., 2015; McSherry, O'Connor, Hevey, & Gibbons, 2012; Pardo et al., 2020; Perseius, Öjehagen, Ekdahl, Åsberg, & Samuelsson, 2003). The qualitative literature pertaining to DBT with adolescents is explored below.

McCay and colleagues, used mixed methods to investigate the impact of DBT with street involved youth. They found it to be an effective intervention in comparison to waitlist controls. Young people in this research were noted to engage in DBT, in contrast to previous interventions. The mediating factors in the success of the intervention included; the motivation to engage in treatment, the experience of the treatment and of its impact on their lives (McCay et al., 2015).

Pardo and colleagues published qualitative research regarding adolescent experience of 16 weeks of DBT-A skills training. They used focus groups to collect data from 24 individual adolescents about their experiences of DBT. This research identified four main themes; i) problems that prompted referral into DBT (emotion dysregulation, identity issues, functional deterioration and lack of environmental supports) ii) motivations for therapy (timing, personal issues, DBT attendance as a mark of motivation and resistance to change) iii) experiences in treatment (learning skills, relationships with group members and skills trainers), iv) positive appraisal of DBT (skills acquisition, growth in self-reflection and meaning making). The research noted that the skills of mindfulness, validation, distress tolerance were most helpful. They found that the process of attending the group was therapeutic in and of itself (Pardo et al., 2020).

IPA and Adolescent Mental Health Intervention

The current research uses IPA methodology to explore participant interpretations of a mental health intervention. When IPA methodology is applied to a particular population it can capture rich detail of specific phenomena or lived experience, such as adolescent mental health and experiences of intervention (Noon, 2018; Smith, 2004; Tuffour, 2017). There are a small number of published papers using IPA methodology, exploring adolescent service user experiences of treatment. Two investigations closely match the current question (experiences of mental health intervention) and are discussed below.

Newton et al (2007) investigated eight adolescents' experiences of a group intervention for psychotic symptoms (Newton, Larkin, Melhuish, & Wykes, 2007). These adolescents were found to take a passive or a proactive interpretative stance towards their mental health problems. Those who interpreted symptoms proactively felt they had power and control over their recovery and were able to engage in treatment in a more productive manner, than those with passive interpretations.

Donnellan, Murray, & Harrison (2013) engaged IPA analysis with three adolescents regarding their experiences of Cognitive Behaviour Therapy (CBT). Adolescents reported change in the form of increased self-control alongside improved self-esteem. The more active they were in treatment, the more their outcome improved.

IPA methodology can highlight specific aspects of lived experience and identify areas in need of further investigation to better inform future research and treatment/theory development (Smith, 2004). The IPA studies cited above note the issue of identity and power in adolescent treatment and highlight the importance of engaging the adolescent as an active participant in treatment and addressing power imbalances overtly (Johnstone & Boyle; McMahon et al., 2019; Parker, 2007) The results of IPA analysis can provide a foundation for future research questions and build on existing psychological theory (Binder, Holgersen, & Moltu, 2012; Larkin, 2006; Smith et al., 2009; Willig, 2012). This study utilises IPA methodology to offer qualitative insight into adolescent experiences of comprehensive DBT. It gives voice to their expertise by experience, which as yet is underexplored by the literature.

Method

Design

This research study employs a qualitative design, in the form of Interpretative Phenomenological Analysis (IPA), following the approach outlined by Jonathan Smith (Smith et al., 2009). IPA has its roots in three strands of the philosophy of knowledge: phenomenology, hermeneutics and idiography (Larkin, 2006; Smith et al., 2009). *Phenomenology* could be described as how we construct, or experience, reality informed by context over time. *Hermeneutics* refers to interpretations of our experiences of reality and how that meaning (interpretation) is co-constructed between speaker and listener. *Idiography* denotes the uniquely individual nature of experience. Experiences of phenomena (both present and absent) are seen as specific and particular rather than general, they are interpreted and made sense of by the individual themselves. IPA involves a multi-layered cycle of making

meaning of phenomena within the individual, between the researcher and participant and across participants through the researcher's interpretative lens (always returning to the data as reference point). It involves a hermeneutic and iterative process of interpreting phenomena.
Taking a more relativist, constructivist approach to the interpretation and analysis of the data, individuals are understood as meaning makers within relationships, power dynamics, contexts, and cultures (Chen, Shek, & Bu, 2011; Foucault & Rabinow, 2001; Potter, 1996). Meaning-making is viewed as interpretative and ongoing over time (Habermas & Bluck, 2000; Heidegger, 1977; Jaspal & Breakwell, 2015; Smith et al., 2009).

IPA is deemed a fitting methodology for small populations whose voices are not widely represented within the literature. Participants are viewed as experts by experience. This method best fits research questions which relate to personal phenomena (particularly those rarely discussed publicly), such as mental health and its treatment (Larkin, 2006; Smith et al., 2009). This method enables the researcher to explore some of the following types of questions; what is the lived experience of an intervention? What meaning do individuals attach to an intervention within their life experience, values, culture and context? It fits the current research question relating to the lived experience of DBT-A with reference to its impact on mental health.

When there are three or more participants IPA methodology can be used to explore convergence and divergence of experiences between participants (Banister, 2011; Larkin, 2006). The intervention in question (DBT-A) is more usually discussed in terms of effectiveness. IPA allows exploration of what experts by experience find most impactful and meaningful within DBT-A, pointing to potential mechanisms of change, illuminating further research questions and links with broader psychological theory (Lyons & Coyle, 2007; Smith et al., 2009; Willig, 2013).

Ethical Considerations and Reflexive Discussion

The research passed review and scrutiny by Ethics Committees at the National University of Ireland Galway and Saint John of God Hospitaller Ministries, Ireland. The first author (Clodagh Ní Mhaoláin) acknowledges that research with vulnerable populations such as adolescents, and individuals with diagnosed mental health conditions involves risk and must follow strict ethical guidelines (Biddle et al., 2013; Lloyd-Richardson, Lewis, Whitlock, Rodham, & Schatten, 2015).

Participants were selected purposively by criterion selection in order to meet inclusion criterion, (completion of six months of comprehensive DBT-A). Potential participants (all aged between 16-18 years) and their parents were offered written information on the research project and invited to call the researcher and/or her service sponsor to ask questions. They were asked to wait at least one week before deciding to take part. Both parental consent and adolescent assent, where relevant (when the participant was under 18 years of age) was a condition of participation in the research. Power structures relating to service use or provision, constructs of power regarding expertise and age or experience were overtly labelled. Participants were reminded that this research was interested in their expertise by experience and that they could take the lead, the researcher would follow, they could withdraw from the research at any time and that this would not impact on-going clinical intervention or treatment planning (Dwyer & Buckle, 2009).

Explicit and informed consent/assent (as applicable) from both guardian and adolescent was a condition of participation. In order to mitigate risk, parents/ guardians and participants were asked to agree to a safety protocol as part of the research consent process; this involved a signed commitment to tell the researcher if they were feeling upset/ or at risk, at any point in the research process and outlined the limits to confidentiality (stating clearly what the researcher would do if safety/ child protection concerns were raised during the interview) (Lloyd-Richardson et al., 2015). Parents and adolescents were encouraged to ask questions to clarify any points which were unclear to them. The principal investigator talked to each young person and parent about what they had agreed to, ensuring that they understood. Consent/assent was gained in writing and participants were informed and understood that it could be withdrawn at any time.

Participants and parents understood that their engagement in the research was separate to their clinical care and had no impact on it. They also understood that although they may have met the researcher as a clinician, she was wearing a different hat as a researcher and would refer to a member of the clinical team if an issue of risk or clinical care arose during the research interview. Each participant was debriefed at the end of the interview by the researcher. A Consultant Psychiatrist and a DBT therapist were on hand available to meet them on request (Lloyd-Richardson et al., 2015). Parents were asked to wait for their young person on site and would be informed of any risk/ child safety concerns. Participants and parents were encouraged to contact the researcher if they felt any increase in risk in the aftermath of the interview and she would inform their clinical team for a risk assessment. Biddle and colleagues (2012) noted that experiences of engaging in qualitative research related to self-harming or suicidal behaviour in fact improved wellbeing for the majority of participants and those who experienced distress reported

that it was counterbalanced by a desire to contribute to the research and therefore not a negative experience (Biddle et al., 2013).

As previously referenced, the primary researcher is also a DBT therapist and known to some participants as a skills trainer in DBT. Participants were reminded that the focus of the research was on their expertise and that the researcher was learning from them and would follow their lead. The risk of assuming shared meaning was also named. Adolescents were informed that the researcher might ask them to clarify meaning where they think something is obvious, and they were encouraged to also ask clarification questions.

The position of researcher-practitioner is justified by the literature on reflexivity (Banister, 2011; Dwyer & Buckle, 2009; Hay-Smith, Brown, Anderson, & Treharne, 2016). The research is influenced and inspired by Phelan and Kinsella's (2013) conceptualisation of research reflexivity as "living ethical practise". As principal investigator, I (Clodagh Ní Mhaoláin) maintained open lines of communication with my research supervisor (Pádraig MacNeela) and kept a research journal to ensure transparency and to probe my interpretative process. Reflexive journaling includes, interpretations, questions, emotions, and thoughts, throughout the research process. The journal reflects the process of interpretation, filtered by previous knowledge, privileges, and dual role as practitioner-researcher (Riach, 2009; Shaw, 2010).

As the first researcher, I identify as female, white-Irish, middle-class, university educated, a clinical psychologist and DBT therapist. My research question is informed by 15 years' experience as a clinician and an interest in respectfully reflecting adolescent service user feedback. As a researcher, I hope to capture the phenomenology of young people and understand their experiences of DBT-A. I view the young people and families attending CAMHS as experts in their own mental health and am highly motivated to add their voices and interpretations to the evidence base. I have my own lived experience of the intervention in question. My own experience of this intervention adds another layer of interpretative depth to the hermeneutic making-meaning of meaning-making.

I wanted to understand how adolescents experience their mental health, its treatment and what works or does not work for them. I was moved by participants' willingness to engage in the research process and am keen to reflect their perspectives with integrity. I wanted their words to inform not only my own practice but services for young people and to bring the evidence base alive.

Procedure

The research took place in Ireland in a Health Service Executive (HSE) funded Child and Adolescent Mental Health Service (CAMHS) outpatient setting in 2017. This CAMH public service was located in multiple outpatient clinic sites, across an urban location, covering a wide geographic area and population of approximately 600,000 individuals (Executive, 2014). Six individuals took part in the research, from a population of 27 who had completed six months of comprehensive DBT-A. All 27 participants (and their parents) were written to with information in relation to the research study and six self-selected to take part by contacting the researcher and expressing an interest in participating. The small number of participants is entirely acceptable with IPA methodology (Lyons & Coyle, 2007). Participants were all white-Irish living in an urban, middle-class location, attending St John of God Community Services, CAMHS, for severe mental health difficulties and suicidal behaviour. Gender was reported in terms of preferred or identified gender (Willig, 2012). Two participants identified as male and four identified as female (there were no identified gender fluid participants). Names were changed in order to protect participant identity to Deirdre (17 years), Ben (16 years), Larry (19 years), Laura (17 years), Ciara (18 years) and Sara (16 years). At the time of the research project, all participants were enrolled in full-time education.

Participants had been attending CAMHS for between two and four years, when they were referred to DBT. Experiences of CAMHS treatment as usual (TAU) included inpatient hospitalisation (two participants), day hospital attendance (five participants), overnight hospital admission (two participants), weekly individual supportive (CBT informed) psychotherapy (six participants), medication and regular psychiatry reviews (six participants). Inpatient admissions were external to the CAMH service delivering DBT; all other treatments were delivered as part of outpatient CAMHS. Due to the small population from which participants had self-selected, to ensure anonymity, certain demographic details are not included.

Data was collected by semi-structured interview in which the interview followed the participant's lead. This process allows the participant to influence what is discussed (Smith et al., 2009). The interview questions centred on experiences of mental health and a specialist intervention (DBT-A). Participants could end the interview and withdraw consent at any time and they were invited to give feedback on the interview process (Banister, 2011; Binder et al., 2012). One participant wished to offer more information and was met a second time (Banister, 2011; Lyons & Coyle, 2007; Riach, 2009). This material was viewed, for purposes of the research, as an interview in two parts (Banister, 2011).

Interviews with individual participants were scheduled for a time which suited them in an outpatient clinic they were comfortable attending. Each interview lasted for approximately an hour's duration. Interviews were transcribed onto password protected files on an encrypted laptop which remained in a locked drawer in a locked and coded room in an outpatient clinic location. Pseudonyms were used in order to anonymise participants and others in transcripts (i.e. names of therapists/family/friends/ etc.). All other identifying factors such as location names were left blank. Participants were offered access to transcripts on request.

The analysis procedure followed the stages of analysis (see table one, Appendix A) outlined by Smith et al., 2009. The stages of an IPA study are described as iterative and inductive (Smith et al., 2009). The iterative process involved returning to the raw data (i.e. participant transcript) at each stage of interpretation, to remain as close to the experience of the participant as possible. The inductive process required the researcher to apply psychological and philosophical theory to interpretations of the participant transcripts. The participant's experience and meanings are interpreted through the lens of epistemological theory and the researcher's response to the text. Therefore, the interpretation and analysis are produced between the researcher and the participant (a double hermeneutic) anchored by the data in the form of the transcribed text.

Transcripts were read and initial responses were noted in the right-hand margin. The initial responses were described and conceptualized; emergent themes were noted in the left-hand margin. Emerging themes were synthesized and integrated in the initial round of coding. Subordinate themes emerged and were batched and clustered, the text was returned to again and again in an iterative process of theme saturation. Sub-themes were collapsed into each other and superordinate themes emerged, these super-themes were supported by examples from the transcribed data. Individual themes were compared and contrasted between participants across the data set as a whole. Superordinate themes for the entire research project were identified and validated with examples from the transcribed texts across the data set as a whole. See table one, Appendix A, for the six steps involved in IPA analysis.

Quality and Validation

Evaluation of the research follows the quality guidelines outlined by Lucy Yardley (2000). The research analysis was checked for: a) sensitivity to context where the analysis was linked to the raw data, current literature, theory, sociocultural context and ethical issues; b) commitment and rigour where the participant's interpretations were foregrounded and the double hermeneutic of meaning-making between researcher and participant informed the analysis while rigour was engaged in the methodological care taken from data collection to analysis, c) transparency and coherence - The analysis was careful to include participant identification, researcher bias and a reflexive exploration of the research journal and include idiographic content to illustrate how individual phenomenology's interact and form themes across the data set and d) impact and importance - Research findings were linked to relevant theory and practical clinical implications. Examples of data are included in the results section to illustrate and support themes, allowing the reader to form their own opinions and check the validity of results and interpretations.

Results

Participant interviews were analysed for themes or patterns of meaning (Smith et al., 2009). Themes emerged from the data in the form of one over-arching superordinate theme which was captured in the metaphor of building a roadmap to recovery and a life worth living. Three subordinate themes emerged as belonging to their roadmap: stabilisation of self-identity, connections to others and personal empowerment through language and skills. These themes are discussed in more detail below. They were present in the narratives of all the participants while also reflecting each participant individually. See Appendix B, table two, for a depiction of the superordinate theme and the subordinate themes nested within.

Building a Roadmap to Recovery and a Life worth Living

'Building a roadmap to recovery and a life worth living' refers to the participants' sense of positive change over time resulting from their DBT-A. This superordinate theme describes how individuals travelled from alienation to insight, isolation to connection and from passive receipt of intervention to proactive engagement as empowered service users. In describing their experiences of change through the treatment, participants mapped a bottom-up perception of the steps on the journey to wellness. The steps are detailed by subordinate themes nested within the super-theme. Subordinate themes exemplified the changes adolescents experienced as a result of DBT-A. See table two, Appendix B, for an outline of subordinate themes within the super-theme.

Self: Alienation to Insight and Stable Identity

All participants found that DBT-A helped them to develop insight into emotional and behavioural patterns (i.e. motives, actions, and consequences). Thanks to their insight, adolescents found their sense of self / identity stabilised and they felt empowered with self-efficacy, new choices and control over their behaviour. They contrasted this with the self-alienation caused by the threat of suicide.

Larry spoke to the self-alienation described by all participants as definitive of suicidality. Larry referenced himself as alienated from previously held values. He referred specifically to previously held values of respect and friendship and contrasted this with a self he did not recognise but which he had "convinced" himself was his identity. He speaks about himself at that time in a tone of surprise and confusion, which reinforces his sense of personal alienation further. The self-annihilating drive implicit in suicide, is evident in the conviction that he was the type of person who would not be concerned if his mother or friends were upset by his actions. Larry's perplexed recall of this lack of concern, points to the exact opposite being true of his value system and genuine identity.

> Yeah I had a feeling that I was a scumbag so I was like do you know what, like I don't care, that's who I am then. And I just started smoking and I wouldn't even care if their ma seen me or anything. ..... Then I'd start getting a temper with my mates because I'd just feel like I'm this angry person. I was fully convinced I was an angry person like. (Larry 1085-1102).

Participants reflected on treatment in DBT-A as if it gave them a map to themselves and helped them gain control through self-knowledge. They referenced some of the fundamental practices of DBT-A (including behaviour chain analysis, diary cards and homework in group skills training) noting that these practices improved insight and consequent personal control. They saw these changes as signifiers of positive growth. Deirdre was explicit about how these repetitive practises promoted insight over time. She referred to the routine of talking about what happened in a solution focused manner (namely, behaviour chain analysis). Deirdre reflected that this practice made her really think, helping to develop insight and promoting self-efficacy and proactive problem solving. She contrasted her previous behaviour "bottling it up" with getting problems "out there"' and "really thinking about them", implying that talking about her problems in a structured and repetitive way through behaviour chain analyses was more helpful than pushing feelings down.

> Yeah cos I got used to going in and saying exactly what happened, instead of actually going through and doing like exactly what triggered it, what I done when it was happening, what I done when it was after it, … GOD (laughs) [ ] mmm ..because like you're getting it out there, you're really thinking about what happened and you're getting it out there instead of bottling it up (lines 646-659).

Before engaging DBT-A, Ben described feeling powerless and unable to fight. He found it difficult to put his experiences of suicidality into words and spoke about confusion and a lack of personal control, alongside desperation to access external help. In the following quote, Ben repeated "I didn't know" three times, emphasising his lack of knowledge. He ended the quote summarising how he felt helpless, with a note of despair in the final line.

> I just didn't know how to deal with anything that was happening. I didn't know how to make myself feel better. I didn't know how to work it out. I just felt helpless (lines 1690-1693).

Ben went on to describe how DBT-A gave him back words and insight into himself which helped clear his confusion. He referenced how individual therapy promoted insight he and referred specifically to how the diary cards helped him to develop insight through self-observation, improving his memory and understanding of his own life as a result.

> I think that was really helpful because I, before we started doing diary cards, I remember never remembering anything from my week at all...So the diary card made it much more like clear for me which helps me personally anyway because I like to picture things in front like. (Lines 694-701).

Participants spoke about developing personal coherence, insight and self-efficacy through the practices of DBT they went on to explore the relationships in DBT-A and how they saw them as a fundamental to the treatment.

Relationships: Isolation to Connection

Participants referred to making connections with others through DBT-A. They referred to connections with parents, therapists, and group members, and commented how each played a part in wellbeing, and re-engagement in life.

Larry remarked that his DBT-A therapist worked hard to connect with him and had gone beyond "the job". The phrase 'the job' suggested that Larry had previously felt like work or a job to clinical professionals. Larry had been in services for years before he was referred to DBT-A and had a wealth of experience with clinical staff to draw on. In contrast, he felt that his DBT-A therapist had gained his co-operation because she was being real and it felt like she was connecting with him as a person not just because it was her job.

Larry stated that a person being real and connecting with him was especially meaningful and he credited it as the reason he chose to co-operate with DBT-A.

> She seemed well into it or something. Like I'm the type of person, like you'd have to really connect with me for me to cooperate and she was like real. .. I don't know how to explain it but… [ ] Yeah it sounded like she wasn't just doing her job, she was doing it for me like. (Lines 776-787)

Larry named the therapeutic alliance as a significant factor in facilitating change. Participants in general found that this relationship promoted trust and enhanced motivation and commitment to therapy, they referenced it as the first connection out of isolation.

Participants also referred to the connections that arose with peers and parents in the skills training group. They found solidarity working with others who had similar problems and as a result felt less isolated. They liked the practicality of skills and learning from peers through homework feedback. Laura described how her mental health problems made her feel isolated in her community almost exiled. In the following quote, Laura gave the sense that she had no respite or escape: "my school was in the area, so I was being bullied in school and then outside of school too." Laura ended up imprisoned inside the walls of her house, afraid to leave. Laura attempted suicide as the only possible escape and found that this compounded her problems offering further ammunition to the bullies.

> … was being bullied; my school was in the area, so I was being bullied in school and then outside of school too. And it was just over ridiculous things. …And then that's why I was feeling suicidal and I ended up like getting really like depressed. I wouldn't leave the house or anything and I ended up trying to kill myself a few times. I did like an overdose and stuff. (Lines 131-136)

Laura's next quote directly contrasts relationships in DBT-A with her previous experiences of peers described above. Her words illustrate how a peer group in DBT-A skills training helped her to re-connect with others. Her repetition of the phrase "the only one" adds to the poignancy of her statement; she had previously felt isolated, like "the only one" in her community who had mental health problems. She felt untouchable and trapped in isolation; the only escape she could imagine was death. It helped Laura to know that she was not alone with her troubles.

> It was better, like, you know, because it made you kind of feel like you weren't the only one there, the only one who had kind of like you know difficulty with things. It felt that way. [ ] Yeah, like obviously like everyone kind of like, you know, has different reasons and feels different but like I suppose like everyone had obviously something that wasn't going well. You know, some sort of like … I don't know how to explain it like but some kind of problem. (Lines 465-479)

All participants commented on the central importance of relationships in recovery of wellbeing. Ben noted relationships were the fundamental reason he had learned anything in DBT-A, "Like they are the reason why you learn what you learn is the people helping you." (Lines 1742-1743). Participants found relational factors (with therapists, peers and parents), motivated and maintained their engagement in treatment and promoted commitment to recovery. Participants finally explored how the language and practice of DBT-A made them feel engaged in treatment in a manner that was new to them. They found this engagement to be an important factor in their progress through treatment.

Empowerment: Passive Recipient to Proactive Engagement in Mental Health Intervention

The adolescents in this research were experienced service users by the time of their referral to DBT-A. They collectively contrasted DBT-A with previous experiences of 'treatment as usual' (TAU) in CAMHS, specifically referring to how DBT-A engaged them in recovery by involving them in decision making and giving them solution focused, skills-based language for their problems. Participants noted that mental health services have unspoken rules regarding diagnosis, medication, allocation of treatments, or therapists, and admission into inpatient service. Adolescents did not feel they were made privy to those rules, or included in the decision-making, whereas their parents were included. They acknowledged that it was better to receive some help rather than none at all, but stated they had not felt part of their treatment or recovery until DBT-A.

Laura's statement below epitomised participant experiences of TAU, she was acutely aware that she would receive treatment from experts yet had no power to shape or impact that treatment. She stated that she had been hospitalised for her own safety and acknowledged that it had kept her alive. She reflected on the lack of choices or power when she was put in hospital even though she did not want to go. Laura commented that being there, only made her feel more hopeless and out of options. Laura felt confined and imprisoned, she wondered why she should stay alive if hospital was the only option. Laura emphasised "that's how I felt," as if to assert her voice and opinion over the dominance of mental health discourse.

> I just felt like life was a waste. I was constantly in these places and I was suicidal as it was and I felt kind of like even more worse being confined in psych ward, like, why should I not feel suicidal, it's not a great quality of life anyway like. That's how I felt. (Lines 294-297)

The experiences of hospitals, doctor rotations and high staff turnover meant that Laura and others had experienced having to retell their stories over and over. All participants reported feeling frustrated and disempowered because they were not remembered. Laura again evocatively notes that there were "so many people," a phrase she repeats emphasising the impact of the number of people and times she had been asked to recount her story.

> Looking back, like it's fine in the moment when you talk to the people, looking back on it, I'm like God, so many people know like me like from so many people I've talked to like this. God. Yeah. [ ] There were so many people. (Lines 407-416)

Laura contrasted this experience with the consistency of DBT-A. She noticed that it had been "traumatic" to have to re-tell her story to so many people about such personal things and it was better to have one consistent person in the form of a DBT-A therapist:

> Just one person, like, yeah, it was a bit more like not as traumatic like, in a way. [ ] Yeah, it was much better than having to go to explain to twenty different people this and tell everyone the same thing. You know (Lines 535-543).

The consistency of DBT-A helped Laura to engage in treatment, she felt that she was going somewhere rather than always at the beginning telling the same 'traumatic' story over and over to different people.

Ben spoke for all participants describing the journey through DBT-A, from powerlessness to empowerment, he specifically referenced the fact that DBT-A gave him language for his difficulties in terms of skills deficits. Ben referenced how the term "recovery" was introduced into his lexicon by DBT-A; "just even using new terms like, 'recovery'. Like different terms like that made me feel like validating like I'm taken serious", (lines 1023-1024). Ben found that the language of DBT-A enabled him to feel that what he had to say was valid and worth taking seriously.

Ben felt involved in his intervention by being asked to speak for himself and given a language and confidence to do so. He contrasted his inability to articulate his own experiences before DBT-A with empowerment he experienced through the language and practises of DBT-A. He commented that everyone has thoughts and feelings but nobody talks about it so he felt powerless to affect change before he had words for how he felt. The language of skills deficits and acquisition engaged him in his intervention and empowered him towards change.

> [ ] Yeah. And I think it just reminds you of the ways of thinking that most people have. Because nobody talks about these ways of thinking anywhere else. Nobody talks about how you deal with those specific issues. So it helps you learn that, you know what I mean? [ ] Well now I see the problems I've had with mental health as being solvable and being things that you can overcome, before I didn't believe that I could overcome the problems that I had but now I feel that I can and I have. Yeah. (Lines 1626-1793)

Ben was an articulate participant in relation to a theme referenced by all young people in the study. They found that they were socially empowered and involved in their own treatment in DBT-A in a way that they had not previously been. They found this involvement implicitly encouraged a proactive engagement in therapy and recovery.

Figure 1 illustrates the subordinate themes nested within the superordinate theme and depicts how experiences reflect recovery over time.

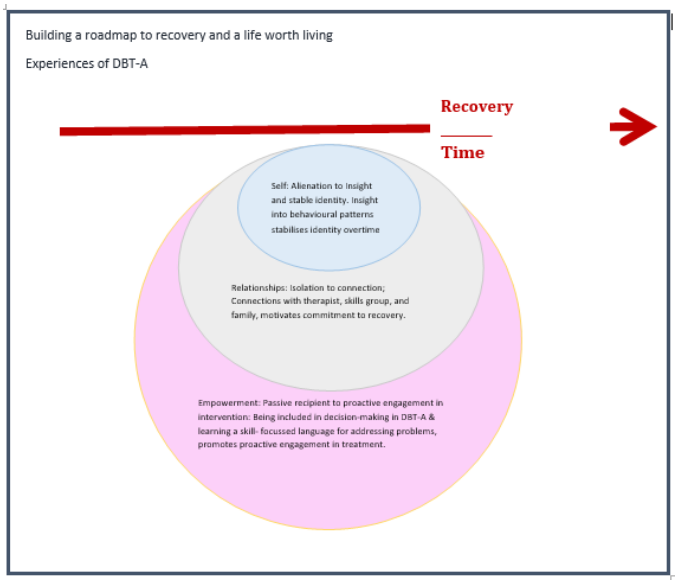

Figure 1:
Overview of themes. This figure illustrates how subordinate themes nested within the superordinate theme in a trajectory heading towards recovery over time.

Discussion of Themes and Clinical Implications

Participants in this study describe how DBT-A supports positive change over time, helping them to build a roadmap to recovery and ultimately a life worth living. The changes they describe offer insight into adolescent interpretations of the constituents of wellness namely: a) a stable identity, b) connections with others and c) empowerment through proactive engagement in treatment (Davidson & Strauss, 1995; MHC, 2005).

The superordinate theme of a roadmap to recovery refers to how DBT-A helped the adolescents to construct a life worth living and is linked to literature regarding the recovery model (Davidson & Strauss, 1995; MHC, 2005). Three intersecting theoretical links emerged across the subordinate themes: a) identity process theory; b) attachment theory; and c) critical psychology in the form of social construction theory (i.e., power and language in mental health) (Andrew, Williams, & Waters, 2014; Jaspal & Breakwell, 2015; Parker, 2007; Potter & Wetherell, 1987).

DBT-A Stabilises Identity in Adolescence

DBT-A is designed to stabilise and regulate emotions, cognitions, behaviour and identity (Linehan, 1993a; Miller et al., 2006). Participants in this research felt that suicidality and severe mental health problems had alienated them from themselves. DBT-A stabilised their identity so that they no longer felt under threat from self-alienation as a result of suicidality (Jaspal & Breakwell, 2016). This research links DBT-A to Identity Process Theory and finds that identity stabilisation is a significant aspect of the suicidal adolescent lived experience of DBT-A. Identity Process Theory provides a model for the changes experienced by the individual through the practice of DBT-A. The use of repetitive self-monitoring practices in DBT were referenced by all participants, (diary cards, chain analyses, and group skills training homework). These practises are found to develop insight into emotional, behavioural patterns. Insight increases self-control, reduces psychological threat and is empowering; it builds psychological coherence, continuity, confidence and efficacy (Jaspal & Breakwell, 2015). Participants found that attending the clinic twice a week, with phone contact in between, helped them to generalise the learning gained in DBT-A. The repetition of practises and structures are viewed as mechanisms of change in DBT-A. They enhance capabilities and generalise learning across contexts with risk decreasing as dose builds up over time (Brent et al., 2013; Cunningham et al., 2004). The practises and structures of DBT repeated over time are found to stabilise identity in adolescents and reduce the identity-threat inherent in suicidality and mental health problems.

DBT-A Facilitates Connections with Others

This research notes that Identity Process Theory describes the process of identity stabilisation during DBT-A. . Attachment theory describes the context in which the stabilisation process takes place and states that meaningful relationships improve wellbeing and increase the likelihood of recovery (Andrew et al., 2014; Holmes, 2014; Norcross, 2002). Participants recounted the deep isolation from others associated with suicidality and severe mental health problems. They referred to the importance of making relational connections in DBT-A, referencing relationships with their therapist, DBT-A skills group members and the guardian/ family member attending skills group with them. These relationships were found to motivate and maintain engagement in therapy and provide a practice space for skills learned (Andrew et al., 2014; Iyengar et al., 2018; Pardo et al., 2020).

The relationship with the therapist is mentioned by all participants where they referred to feeling understood for the first time. Participants noted that the DBT principle of open reciprocity made the relationship with their DBT therapist more meaningful and real than previous therapy relationships (Linehan, 1993a). This opinion is uniquely informed by participants' positions as experts by experience (all six were long-term service-users). The DBT-A therapy relationship involves repeated contact over time (group skills-training, individual therapy and phone coaching) and offers suicidal adolescents a secure base from which to practise skills.

The adolescents referenced a unique aspect of DBT-A which was the presence of a family member in the skills training group. They described the significance of peer and parent relationships in the skills training group commenting that they found these relationships improved intrinsic motivation and commitment to building a life worth living for themselves (Iyengar et al., 2018; Pardo et al., 2020). The skills training offers a safe secure place to connect with others and practice skilful interpersonal contact. It also offers peer-based learning through homework feedback. Participants in the current study suggested that DBT-A works well because it is delivered in the context of a conflation of securing, honest/safe and readily accessible relationships. The relationships in DBT-A provide a model for healthy relating into the future. The above findings identify core elements in DBT-A indicating the role of attachment relationships in emotional regulation, behavioural change and identity stabilisation (Andrew et al., 2014; Holmes, 2014).

DBT-A Empowers by Proactively Engaging Individuals in Treatment

Donnellan (2013) argued that an active identification with treatment as an agent of change improves recovery trajectories (Donnellan et al., 2013). Proactivity has been linked to social empowerment and positive outcomes (Iyengar et al., 2018; Newton et al., 2007). Adolescent participants noted that DBT-A encourages proactive engagement by: a) framing their problems in terms of the absence of skills, which can be learned; and b) involving them in decision making, through the DBT principle of consult to the patient (Linehan, 1993a). These DBT-A elements were noted by participants as reducing the power imbalance they have previously experienced in mental health interventions. Adolescents contrasted DBT-A with experiences of treatment as usual where they described themselves as passive recipients with parents/caregivers and clinicians making decisions. Participant accounts highlight constructs of power in mental health services and within the language of expertise (Brosnan, 2012; Johnstone & Boyle; Parker, 2007; Potter & Wetherell, 1987).

Participants found that involvement in DBT-A is socially empowering, improves self-confidence, self-efficacy and enhances motivation to recover. Clinically this finding suggests that involving service-users in decisions and focussing on skill acquisition improves treatment trajectory by giving service-users a proactive role in recovery.

Evaluation of the Research and Reflexivity

The main strength of this study is that the findings are unique and fill a gap in the literature with regard to the lived experience of adolescents of comprehensive DBT-A and its impact on their mental health. This study importantly highlights one way in which qualitative research can be usefully engaged, to bring life to outcome studies on mental health intervention with the words and interpretations of service-users themselves.

Further phenomenological exploration could go deeper to capture more of the sensory texture of the lifeworld of the participants, including their embodied, temporal-spatial intersubjective relations. In noting this, we acknowledge that our use of IPA has been geared to aiding our qualitative thematic analysis rather than a more committed epistemological commitment to taking phenomenological stance during data collection as well. Further phenomenological research could usefully probe individual young people's experience, perhaps at different stages during their six months in comprehensive DBT-A.

Going beyond phenomenology, the language and collaborative practice in DBT-A, empowers participants to proactively engage in treatment. Further research into power and participation in DBT-A could help clarify the role of discourse and power in behavioural change. IPT and attachment theory provide a theoretical grounding for identity stabilisation and emotional regulation found to occur in DBT-A. Further investigation regarding the role of DBT-A in identity stabilisation, within a context of attachment relationships, could identify core change processes underpinning DBT-A.

The analysis of the data was checked against quality guidelines outlined by Yardley (2000). As researchers, we tried to maintain a transparent and coherent dialogue, foregrounding the participants' experiences, outlining current research in the area, detailing the method of analysis and including a reflexive exploration of the researcher's interpretative process.

The researcher's position, power and privilege in all its forms, particularly as a DBT practitioner, has been acknowledged throughout the research process, openly discussed with participants, explored through journaling, with the research supervisor and as part of the hermeneutic cycle of interpretation. Ethical issues were discussed thoroughly within the method section and the entire process of research was viewed as "living ethical practice" (Phelan & Kinsella, 2013). The first researcher's dual role (researcher-practitioner) was seen as a strength rather than opportunity as it meant that she had professional confidence and competence with regard to engaging with vulnerable and high risk populations and discussing limits to confidentiality with regard to risk (Lloyd-Richardson et al., 2015).

Participants self-selected to take part in this research, and it could be inferred that this ensured a positive orientation towards DBT-A. However, bias – be it positive or negative - was viewed by the researchers as part of the interpretative process of meaning-making. For those adolescents under 18 years parents gave consent for participation. In order to address this potential ethical issue, explicit and informed adolescent assent was a condition of participation and if not present the young person was not asked to participate. Adolescents were informed clearly that assent and/or consent (for those over 18 years) could be withdrawn at any time and had no impact on clinical care (Lloyd-Richardson et al., 2015).

A parent/guardian also routinely attends DBT-A skills-training with their young person and these collateral perspectives could add further breadth to the research were it to be repeated. The current project deliberately focused only on the adolescent perspective, due to the dearth of adolescent service-user feedback regarding DBT-A.

Our study took care to maintain the rigour inherent in IPA studies. The iterative process of checking and re-checking themes against the data ensured that the findings remain closely linked to the raw data and each participant's phenomenology. Analysis of convergence/divergence of themes with reference to the research question across the data continued until common themes emerged across all participants and each theme was checked against individual accounts until saturated with idiographic content. Samples of data were included in the results section to support the findings, and to allow the reader to join in the interpretive process. The results were linked to psychological theory and are discussed with reference to clinical and theoretical implications in the section above. While this process can be seen as suitably systematic, by sticking rigorously to participants' expression we engaged less interpretation and literary flourish where deeper embodied and implicit meanings might have emerged. The reflexivity engaged below was an attempt to bring more of the feel of the participants' experience.

Reflexivity

Reflecting on the research diary maintained throughout the project in line with IPA recommendations, I (Clodagh Ní Mhaoláin) am struck by how I have changed as a result of this research journey (Smith et al., 2009). Initially I was aware that my experience of this therapy as a practitioner might influence my interpretations, particularly in the sense of presumed shared meaning. I include a synopsis of reflexive journaling below to illustrate how the process of researching through IPA changed me as a practitioner.

When the theme of alienation from self, emerged across all individuals with a practitioner hat on, I immediately reflected on the practical goals of the therapy, (one of the five problem areas DBT-A seeks to address is an unstable sense of self). I then thought about philosophical theory (theories of Marx and Hegel) regarding social and cultural alienation. Through the process of writing, I noticed how intellectual these associations were. Returning to the participants' words grounded my interpretation back into the data. I felt a growing empathic connection to the experiences of these young people. Larry spoke about not caring anymore, "…like I don't care…" (line 1085); Ben "didn't know how to work it out" (line 1692), he discussed the emptiness of "never remembering anything from my week at all" (lines 694-695); and Laura "felt like life was a waste" (line 294). Opening up emotionally to really listen to the experiences articulated by these young people , evoked for me a mental image of a yawning void; the nothingness of existing untethered to any form of meaning, unable to make memories or to care at all, living a wasted life. It illuminated the pure horror of depression and suicide to me. I intellectualise and/or focus on problems and solutions to escape the awful dread and nothingness participants described.

My emotional process led me to seek out a theory which speaks more directly to participant accounts; the alienation from and loss of, self and meaning in suicidality. Identity Process Theory understands identity in terms of psychological coherence, the utter lack of same (personal phenomenological coherence) is clear in the participant accounts.

This research made me aware of the vital importance of deeply listening to and resonating with lived experience in every fibre of my being; honouring experts by experience in all of my interactions. It has changed how I listen to and hear others across every context in my life.

Conclusion

Adolescents are generally viewed within the literature as a distinct population (Cha et al., 2018). The current research project asked adolescent experts by experience about their involvement in DBT-A and its impact on their mental health. It provides insight into the components of DBT-A that were most effective for them in supporting a life worth living.

The suicidal adolescents in our study understood the recovery of their mental health to involve interlinked positive changes over time across three dimensions: intrapsychic, interpersonal and social-environmental. These dimensions are seen to be interdependent, no one element is viewed as a stand-alone characteristic of recovery or a life worth living. When engaged in together within one comprehensive intervention (DBT-A), these elements or dimensions (stabilising identity, connections with others and social empowerment through the language of skills) are seen to enhance motivation, commitment to treatment, and proactive engagement in building their own roadmap to a life worth living. These components of recovery could usefully apply across interventions for this population.

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Appendix A

Table 1 Steps Involved in IPA Data Analysis

Stage	Procedure	Aim & Action
1	Close reading of the interview transcript while listening to the interview recording, looking for the experiences, understandings, and interpretations of participants.	Notes on the experiential meaning, understanding, and claims of each participant were made on the right-hand side of the transcript. Researcher reflections on this process were noted in the research diary.
2	Explorations of patterns within the experiences, language, understanding, and interpretations of the participant were noted.	Researcher questioned, reflected on, and described. She recorded the above in the right-hand margin of the transcript. Explorations were clustered and transcript was returned to (iterative process) to check against initial clusters.
3	Psychological and philosophical theory was invoked and applied to the initial clustered explorations of the participant in context to produce initial themes.	Dialogue was opened between interpretations offered by epistemological theory, the participant in context, the researcher, and the raw data (i.e. participant transcript). Emerging interpretative subordinate - themes were noted in the left-hand side margin. Transcript was returned to and sub-themes checked against raw data.
4	Themes were explored for emerging patterns, relationships, divergences commonalities, and nuances.	Patterns were labelled, mapped, and organized into sub-theme batches. Minor (subordinate) themes were abstracted, and major (superordinate) themes were identified. Extracts from the transcript were checked against superordinate themes for coherence.
5	The above was repeated for all participant transcripts.	Unique/ intrinsic superordinate themes for each transcript were mapped and labelled.
6	Superordinate themes for each participant were noted and explored across participants, and stages 1-4 were applied.	Themes were re-evaluated, re-interpreted, and re-labelled as appropriate across the data set. Superordinate themes across participants' transcripts (i.e. the data set as a whole) emerged and were interpreted.

Appendix B

Table 2 Superordinate Theme and Subordinate Themes

Superordinate Theme	Subordinate Themes
Building a roadmap to recovery and a life worth living	**Self**: *Alienation to insight and stable identity:* Insight reduces alienation from self, caused by the threat of self-annihilation through suicide. Insight creates a map of emotional and behavioural patterns over time and stabilises identity. **Relationships**: *Isolation to connection:* Connections with, parents, therapist, and DBT skills group, motivates and inspires commitment to the work of recovery. **Empowerment**: *Passive recipient to proactive engagement in treatment*: Being included in decision-making in DBT and learning a skills-focused language to address problems promotes proactive engagement in treatment.