Title:

Adapting dialectical behaviour therapy in forensic learning disability services: A grounded theory informed study of "what works".

Authors:

Dr Claire Browne[a], Dr Gill Brown[b] and Dr Ian C. Smith [a]

Corresponding author:

Dr Ian C. Smith

Affiliations:

[a] Clinical Psychology Programme, Faculty of Health and Medicine, Furness Building
Lancaster University, Lancaster, LA1 4YT, United Kingdom
i.smith@lancaster.ac.uk
Tel: +44 1524 592282
[b] Mersey Care NHS Foundation Trust, Liverpool, UK.

Declaration of interest and funding

There are no competing interests. This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Abstract

BACKGROUND: Emerging evidence indicates effectiveness of dialectical behaviour therapy (DBT) for people with intellectual disabilities (PWID) in forensic settings; however, little is known about "what works" facilitating engagement and change.

METHODS: Eleven interviews were conducted with nine service-users across two secure inpatient services. Grounded theory was used to develop a model of perceived engagement and change.

RESULTS: The model provides insights into how change occurs during DBT delivered in forensic settings. DBT constitutes a challenging journey, yet provides the motivation and means to address individual's intra/interpersonal aggression and progress towards release. Participants experienced engaging with DBT as difficult and coercive, moving from compliance and avoidance to acceptance and change. Key factors included participants' motivation, beliefs about safety and ability to change, and interactions with staff.

CONCLUSION: Recommendations for increasing intrinsic motivation, reducing perceived coercion and distress, and for future research to address potential aversive elements and enhance effectiveness.

Keywords: Intellectual disabilities; Forensic; Emotion regulation; Dialectical behaviour therapy; Process of change; Qualitative methods

Introduction

Dialectical Behaviour Therapy (DBT; Linehan, 1993a; 1993b) is a comprehensive, habilitative and multi-modal psychological treatment that combines cognitive and behavioural principles with dialectic philosophy and the Zen practice of mindfulness. Developed as a specific treatment for persons assigned the diagnosis of Borderline Personality Disorder (BPD), DBT has amassed empirical evidence of improvements in emotion regulation difficulties, including self-injurious and parasuicidal behaviour, suicidal ideation, low mood, anxiety, substance dependence, anger and aggression, and service use (Cristea et al., 2017; Kliem, Kröger, & Kosfelder, 2010; Frazier & Vela, 2014; Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Panos, Jackson, Hasan, & Panos, 2014; Stoffers et al., 2012).

One specific population regarded as commonly experiencing problems with emotion regulation are people with intellectual disabilities (PWID) (Arthur, 2003; McClure, Halpern, Wolper, & Donahue, 2009; Oxnam & Gardner, 2011). Indeed, the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) highlights that individuals with mild ID may have, “difficulties regulating emotions” (p.34). While not all such difficulties will manifest in actions that threaten quality of life and physical safety, emotional dysregulation is an important predictor of behaviours that PWID can display that challenge services, family members and carers (Melville et al., 2016; Sappok et al., 2014). Challenging behaviour can include aggression towards self, others and property, stereotypic behaviour and withdrawal, and in the UK and America has been found to be prevalent in 5-15% of PWID in the community and 30-40% of those in hospital settings (National Institute for Health and Care Excellence, 2015). Challenging behaviours can, however, overshadow or be misinterpretations of mental health difficulties (Nylander, Fernell, & Gillberg, 2016).

the prevalence of mental health difficulties in PWID is considered at least consistent with rates in the general population (Lindsay et al., 2015), if not greater due to the pervasive traumas and social exclusion commonly sustained by this population (Wigham & Emerson, 2015). Such exposure to adverse life events is one of the primary determinants of deficits in emotion regulation (Dunn, Nishimi, Gomez, Powers, & Bradley, 2018), and many mental health problems are developed and maintained as consequences of emotion dysregulation (Sheppes, Suri, & Gross, 2015). With such findings consistent with DBT's theory of emotion dysregulation as a product of an individual's dispositional vulnerability and their invalidating environment (Linehan, 1993a), and given the emotion regulation difficulties that are prevalent in this population, it is not surprising that DBT has been introduced as a psychological intervention for PWID.

The adaptations often introduced to maximise the accessibility of DBT for PWID can make outcome generalisations difficult; however, an emerging body of community-based research has tentatively shown encouraging preliminary results. Early case studies utilising DBT techniques with PWID and BPD (Esbensen & Benson, 2003; Mavromatis, 2000; Wilson, 2001) reported marked improvements in aggressive and self-injurious behaviours; however, conclusions on the effectiveness of DBT as a standalone intervention were precluded. More recent pre-post case series delivering full DBT adapted programmes report significant reductions in aggression, risk-taking and/or self-harm (Brown, Brown, & Dibiasio, 2013; Charlton & Dykstra, 2011; Lew, Matta, Tripp-Tebo, & Watts, 2006; McNair, Woodrow, & Hare, 2016) and the prevention of community placement breakdown (Baillie & Slater, 2014). An unpublished study of adapted DBT by McNair (2014) found significant reductions in levels of depression, anxiety and anger, and significantly improved mindfulness skills, yet participants' anxiety remained within the clinical range. In the one qualitative study located, PWID regarded DBT positively and described sustained behavioural improvements

(Hall, Bork, Craven, & Woodrow, 2013). Community studies of this type, however, do suffer from methodological limitations, including small sample sizes and, in the study by Brown et al., (2013), the inclusion of individuals without ID.

In parallel with community studies, recent years have seen the application of full DBT programmes, more akin to that set out by Linehan (1993b), for people in forensic ID services (PFID)[1]. The most prevalent problems reported in the histories or current presentations of PFID[2] are indicative of emotion dysregulation (Lindsay, Hastings, & Beail, 2013). Higher rates of anxiety, depression and low self-esteem have also been found in this population than in PWID residing in the community (Hogue et al., 2007). In 2010, Sakdalan, Shaw and Collier reported on outcomes of a pilot DBT-informed skills group for five men and one woman with mild to moderate ID, five of whom had previous charges or convictions for violence, and all residing in either ID forensic community accommodation or a medium secure unit (MSU) in New Zealand. Significant reductions in risk factors and improvements in protective factors and global functioning were measured post-treatment, and non-significant improvements in interpersonal coping skills also observed. Data on incidents of aggression were collected but compromised, precluding conclusions. Qualitative participant feedback included recommendations for further use of visual aids, simplification of handouts and more homework assistance.

In their 2011 paper, Morrisey and Ingamells described the evolution of their adapted group and individual session DBT programme for males with mild ID in a UK High Security ID service. Preliminary results indicated significant reductions in overall psychological

---

[1] Although the terminology *ID offender* is frequently employed within the literature, this paper instead utilises *people in forensic ID services* (PFID) in reference to intellectually disabled adults who are subject to forensic service pathways. This distinction acknowledges that many such individuals have not committed or been convicted of criminal offences but are deemed to have forensic needs due to judgements around the risk of harm they pose to others.

[2] Although the terminology *ID offender* is frequently employed within the literature, this paper instead utilises *people in forensic ID services* (PFID) in reference to intellectually disabled adults who are subject to forensic service pathways. This distinction acknowledges that many such individuals have not committed or been convicted of criminal offences but are deemed to have forensic needs due to judgements around the risk of harm they pose to others.

distress and, in comparisons with a waiting list control group, participants were more likely to progress to conditions of lower security. No significant differences in aggressive incidents were reported; however, baseline rates were generally low, likely due to the highly supervised and restrictive environment. While participant feedback was not described, the authors comment on how, despite extensive revisions to their adapted DBT programme, there remained an issue in respect of "language and concepts that are too complex for some" (p.15).

An evaluation of the aforementioned adapted DBT programme (Ingamells & Morrissey, 2014) delivered in a UK medium secure ID setting has recently been conducted, assessing pre- and post-treatment change in one male with diagnoses of mild ID and emotionally unstable personality disorder. This case study by Ashworth, Mooney and Tully (2017) describes some improvements to the participant's emotion regulation skills but, overall, no reduction in his violence risk post-treatment. Indeed, the participant perpetrated a violent incident during the course of treatment, resulting in him no longer being able to attend the group and having to complete the programme via individual sessions. Among the methodological weaknesses highlighted by the authors were the addition of several further adaptations to those already made to their programme, alongside the recommendation for this adapted DBT programme to be brought more in line with Linehan's (2015) standard DBT.

Again mirroring the community-based literature, only one published study appears to have employed a qualitative methodology. Following interviews with female ID participants in a UK MSU, Johnson and Thomson (2016) described the importance of building trust within the DBT group, and the difficulties experienced with learning and applying skills. Nonetheless, participants regarded their perseverance as worthwhile, in terms of improved self-belief and progression towards lower security conditions. Finally, Verhoeven (2010) and

Sakdalan and Collier (2012) described adapted DBT for PFID displaying sexual risk factors and indicated improvements in target behaviours as well as general aggression and self-harm.

These positive preliminary findings indicate that the provision of adapted DBT for this population may be beneficial in reducing behavioural difficulties associated with emotion regulation. This is encouraging given the overall relevance of DBT for PWID, coupled with additional factors, present in the sub-group of PWID who have criminogenic needs, which may further increase the merits of DBT. However, the available literature also highlights the difficulties service users experience with DBT despite varied and extensive adaptations.

Furthermore, it has been questioned whether the reported efficacy of mainstream DBT is derived from its unique treatment components or from factors common to all psychotherapies (see Wampold, 2015), with calls having been made, over almost the last two decades, for research into DBT's specific processes and mechanisms of change (American Psychiatric Association, 2001; Linehan, 2000; Rizvi & Thomas, 2017). Several potential change mechanisms have been posited (see Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006), with reviews highlighting evidence for common factors of increased skill use and therapeutic relationship (Forster, Berthollier, & Rawlinson, 2014; Little, Tickle, & Nair, 2018; Rizvi & Thomas, 2017; Rudge, Feigenbaum, & Fonagy, 2017). Empirical support for DBT-specific factors remains inconclusive due to the limited studies that have been conducted, which typically lack consistency in the definitions and measurements of change processes, do not 'disentangle' the contribution of the various skills taught, or have not set out to specifically assess change mechanisms (Boritz, Zeifman, & McMain, 2017). Such understanding of the mechanisms of change is certainly absent within the ID field, given the limited investigations into adapted DBT.

Our study aims to begin to fill the gap in the current literature by generating a clinically relevant theory, drawn from service user perspectives, of the process of engagement with DBT and how this relates to perceived change. Such focus on the individual's experience is lacking in the existing literature, thus by employing a qualitative methodology the research will start to address this deficit and meet the call for researchers to go beyond global measures when seeking service user feedback (Francis, 2013).

Method

Setting and participants

Two UK National Health Service (NHS) low / medium secure ID units in the North and South of England acted as research hosts. Twelve service users opted into the study, three of whom later withdrew for personal reasons. Five females and four males therefore participated. The participant inclusion and exclusion criteria can be found in Table A.1. Table A.2 details participants' demographics.

[INSERT TABLES A.1 & A.2]

Design

A qualitative design using semi-structured interviews was employed. Constructivist grounded theory (GT; Charmaz, 2014) was employed as it facilitates generation of explanatory theory from the data, rather than simply exploring and describing personal narratives (Birks & Mills, 2011). Charmaz (2006) argues that GT offers an interpretive portrayal of the studied world, with participants' data and researchers' resultant theories considered not as mirroring reality but producing knowledge that is useful to practitioners in explaining what they can see (Oliver, 2012).

Recruitment and consent

Appropriate ethical approval for the study was obtained. Service users at each site meeting the inclusion criteria were approached by a field contact and introduced to the study via discussion of a participant information sheet (PIS). Interviews took place at least one week after first contact using a protocol to assess comprehension and voluntariness adapted from Thomas and Stenfert Kroese (2005). All potential participants were deemed able to provide consent. The PIS, consent form and study debrief sheet were developed in line with Mencap easy-read guidance (2009), and accessibility reviewed by a self-advocacy group of PWID.

Data collection and analysis

Eleven audio-recorded semi-structured interviews were conducted by the first author, each lasting up to one hour, and these were then transcribed verbatim. To minimise acquiescent response patterns (Beail, 2002), guidelines for interviewing PWID were adhered to (Prosser & Bromley, 2012). During the interview process, participants provided a pseudonym, which was applied to their transcript to preserve anonymity.

Data collection and analysis took place simultaneously (Charmaz, 2014). Three interviews were initially undertaken, transcribed and subjected to initial coding. This involved line-by-line analysis at a descriptive level, using participants' language and gerunds, to identify processes closely grounded in the data. Reoccurring initial codes were subsumed through focussed coding into tentative conceptual categories to explain larger segments of the data at a more abstract level. This focussed coding process enabled the interview guide to be modified to explore emerging concepts and gaps in participants' accounts.

A further cluster of three participants were then interviewed, with the initial and focussed coding steps repeated and the interview guide adjusted, followed by the final cluster of participants (see Figure A.1). During this iterative process, the constant comparison of data in and between transcripts highlighted similarities and differences in the emerging codes and conceptual categories. These were explored within subsequent interviews and, if appropriate, revised through analysis. Reflections and interpretations prompted during constant comparison and the creation of codes and categories were recorded in memos to further guide and enhance theory development. This process facilitated refinement of the final conceptual categories, the conditions in which they operated and their processual links, from which the theoretical model of the process of DBT engagement and change, grounded in participants' data, was built.

Theoretical sampling of participants was planned to further "elaborate and refine…emerging theory" (Charmaz, 2014, p. 192); however, the small pool of potential participants meant all who consented were interviewed. Two follow-up interviews comprising confirmatory questions to test categories were instead conducted as a means of shaping the emerging theory. These follow-up interviews were undertaken with two participants—one from each study site—whom had both volunteered at the end of their first interview, without prompting, to speak with the interviewer again if this would be useful. Furthermore, the sample included individuals who had completed, dropped out, or were currently undertaking DBT, thereby providing negative case comparisons and increasing conceptual variation to enable a comprehensive theoretical understanding of the mechanisms affecting engagement.

[INSERT FIGURE A.1]

Quality and reflexivity

Charmaz (2014) argues for recognition by the researcher of their own values and interpretations as impacting the theory developed. Contemplations were recorded within memos of potential biases influenced by experience of delivering group psychotherapy in forensic settings, albeit with a non-ID population. To promote reflexivity and responsivity within the analytic process, these considerations along with all emerging codes and conceptual categories were critically reviewed with the research supervisor during regular supervision. These meetings facilitated reflection on previous interviews, emerging areas of interest and any personal assumptions, enabling revision and improving credibility of the GT.

Results

From the analysis, a model was developed of the process of service user engagement with DBT, how this was perceived to relate to personal change, and the elements that were seen as impeding service users' understanding and use of DBT skills. The description of the model in this section should be read alongside its diagrammatic representation (Figure A.2).

The core category of *uphill and downhill journey of skill use* explains how participants engaged with DBT and began to learn and apply its skills. It provides an explanatory and predictive account of all categories and their relationships within the model and, accordingly, of the core experience of participants undertaking DBT. The category comprises a number of subcategories conceptualised as stages, each of which must be passed through before an individual can move on to the next. This, however, was not a unidirectional process, rather a progressive and regressive journey that also highlights potential sticking points, thus explaining variation in participants' level of engagement and change. Key factors included participants' motivation, perceived threats to safety and belief in their ability to change, and their interactions with DBT facilitators and ward staff. These factors exerted influence at various points throughout the process, and are discussed accordingly and in relation to the categories in which they operated.

The core category is set within the wider context of three supporting categories: *extrinsic compliance*, *sense of safety*, and *belief in self.* These shall be discussed first to delineate this context and their function in relation to the *uphill and downhill journey of skill use.*

Extrinsic compliance

This initial category of the model focussed on individuals' motivation to commence DBT. Although DBT was not a mandatory treatment, engagement was viewed as a non-choice. Prior to undertaking the programme, participants described themselves as not attempting to control the aggressive behaviour they directed towards themselves or others and as not seeking emotional support: "I didn't have no skills to use" (Miss Ward #2). From introductory explanations provided by facilitators and care team staff, participants understood that by completing DBT they could stop behaving aggressively and be permitted transfer to a lower security unit. Despite seeing no intrinsic benefit to ceasing their aggression, all were aware that non-aggression was a prerequisite to progression towards release: "No, I didn't need to change. Thought I had no choice though to get out" (Beyoncé). Participants considered themselves unable to make the required behavioural changes and thus compliance with DBT became regarded as the only viable means of achieving progression.

This extrinsically motivated compliance remained pertinent throughout participants' engagement with DBT, maintaining perseverance, the attendance of individuals who considered quitting, and the continuation of skill use by those making progress towards release: "if I don't use them I'll get in trouble and be straight back in here" (Katie).

Sense of safety

This category referred to how individuals' perceived vulnerability altered over the course of the programme. This was conceptualised as a cycle in which developing trust that others would not abuse their vulnerability was either promoted, thus initiating safety within group, or obstructed, leading to perceptions of being unsafe becoming heightened and eventually intolerable.

Upon commencing DBT, participants experienced anxiety being part of a group with their peers: “Nerve-wracking…didn’t know if I could trust them” (Alesha). This *lack of trust* stemmed from fear of negative judgement: “They might talk about me behind my back and with people not on the group and what they’d think of me” (Miss Ward #2). *Lack of trust* linked to initial difficulties comprehending the DBT material: “I couldn’t focus…more concerned about…watching my back” (Charlie).

To minimise the threat of vulnerability created by *lack of trust*, participants employed *silence*, contributing to discussions only when directed by facilitators and providing superficial answers. This maintained *lack of trust* by precluding counter-evidence and quickly presented its own risk to safety, with facilitators emphasising proactive contributions as necessary and asking individuals to discuss recent incidents. Participants endeavoured to alleviate the consequences of these prompts by sharing fictitious versions of events: “I’d blag the real reason I got angry if it was embarrassing” (Emmanuel). Despite all acknowledging using this strategy, none seemed aware that others might be doing the same and regarded what was shared when *someone speaks* as genuine and exposing.

Some observed *negative consequences* of contributions: “they’d laugh at what people said…putting yourself in a vulnerable situation they’d use to wind you up” (Iyaz #2). *Negative consequences* reinforced *lack of trust* and maintained participants’ *silence*, thus preventing group safety being achieved. This cycle was broken by those members identified by facilitators as contravening the group confidentiality rules being deselected. However, this did not occur for one participant who subsequently never felt safe, leading to her decision to quit: “I just couldn’t…put up with how much more stressful being in group was than doing nothing” (Charlie).

Most participants recognised *no negative consequences* of contributing, which began to shift perceptions of peer trustworthiness: “It grew as they didn’t share things or laugh and they were saying things too they wouldn't want people to say…to others not on DBT" (Alesha). This set in motion a gradually developing *sense of safety*, initially fragile yet strengthened each time evidence of trustworthiness was provided by group members, and further influenced by events occurring within, and that shall be discussed under, the core category of *uphill and downhill journey of skill use*.

Belief in self

This category acknowledged individuals' core sense of lacking the capability to learn and utilise new information and skills, and details how this shifted during their engagement with DBT. However, rather than a linear improvement, these changes in perception undulated in parallel with events in the core category that challenged or reinforced individuals' initially low belief in their ability.

Upon commencing the group, all believed the DBT skills they were introduced to could overcome aggression as this is what they were told by staff; however, participants doubted their ability to effectively implement these skills and achieve such change: "I didn't think I'd be able to do it…It'd all go wrong" (Beyoncé). This pervasive low *belief in self* was underpinned by recollections of perceived failures, stemming from struggling to comprehend and retain learning at school, and accepted as an inherent deficit: "I just struggle" (Beyoncé); "you've got to make it easy for me to understand" (Pete). Some explicitly located these difficulties within an identity of themselves as intellectually disabled: "I think because we've got learning disabilities we find it hard to understand things as well as other people" (Emmanuel).

Individuals' ingrained low *belief in self* was exacerbated by the written and discussed DBT content, with this "too confusing, not explained clear enough" (Katie) and having "all these big names…abbreviation of loads of different things" (Emmanuel). Moreover, participants felt insufficient time was provided for them to understand skills, and struggled learning a new skill each session: “I can’t keep it all in my head” (Ziziu).

Uphill and downhill journey of skill use

The journey through this core category involves participants’ initial dilemma around using DBT skills, the strategy employed to appear compliant and avoid reprimand, the subsequent rewards they obtained, followed by the pressures created by using DBT, the shift to an internalised belief in skills, and the destabilising effect of unfamiliar situations.

Having to do what I cannot

From the first group session, participants entered a vicious cycle of perceiving themselves as incapable yet having to use DBT skills. Consequently, they felt unable to undertake roleplays in session or complete their homework and manage their aggressive behaviour outside of group. Not wanting to highlight their incomprehension and therefore heighten their vulnerability, participants hid their confusion and remained unaware that others were also struggling, which perpetuated their low *belief in self*: “I’d be embarrassed explaining in front of everyone. I’d feel silly as the only one not getting it” (Alesha).

Participants quickly learnt that any display of aggression, non-completion of homework or refusal to roleplay would be scrutinised, with facilitators requesting explanation and using incidents to encourage skill use. This was experienced as punishing and demeaning: “I’d get told off for not doing it…Then they give me today’s homework and I’ve got two to do” (Beyoncé); “…get moaned at by tutors, ‘why didn’t you do this?’ or ‘why didn’t you ask for help?’ and that’s annoying, well embarrassing really” (Pete); “they keep saying go on, roleplay it! I feel even more stupid after” (Katie). Participants blamed themselves for these negative experiences, reflecting on how facilitators were “just trying to help and didn’t know I was struggling because I didn’t say” (Ziziu).

Fear of using skills was exacerbated by the requirement to begin demonstrating behavioural change: “they tell you…they’ll know you’re using skills because you won’t behave as bad…You’ve got not be aggressive at all to make progress” (Iyaz #2). Prior to this, participants had not considered the active role they would need to take to cease their aggression, instead assuming this would be an automatic product of completing DBT: “I just needed to finish the group” (Miss Ward #2).

Isolation

To exit this highly pressured cycle of being expected to employ skills they did not understand, participants decided they had no choice but to take some action to manage their aggression: “I was even more worried about not moving on…so you pick the lesser of two evils” (Pete). However, they were unwilling to reveal their incomprehension by seeking help or incorrectly attempting skills for fear of jeopardising progression: “staff would see you weren’t doing well at DBT and you’d look bad” (Katie). Instead, participants avoided becoming, or being observed as, aggressive by isolating themselves: “I’d self-harm if I went in my room so I sat on my own in the quiet lounge, so staff could see me doing something different, reminding myself of getting out by looking at family photos” (Alesha);

> I had paranoia of doing skills wrong…just did what I knew would give enough evidence, go to my room, stay there. I’d be angry and hit my pillow but no one knew so it looked good for me, I wouldn’t be kicked off for not learning or lose my leave. (Iyaz, #2)

Positive reinforcement

Isolation came to be viewed positively due to the rewards it generated. Although participants whose aggression resulted from a more gradual culmination of negative emotions more consistently avoided incidents than those whose aggression was easily triggered and instantaneous, all improved in their behaviour and ward staff and DBT facilitators thus expressed approval: “by not getting dragged into arguments I would get praise from staff for keeping my head down” (Charlie). Participants were also able to complete homework entries which further elicited praise: “they said I did it right and I’d feel proud”. Consistent reduced aggression led to participants being considered for or granted community access and home visits, bringing them closer to their extrinsic goals: “I was told if I wasn’t getting into bother I’d get my leave. And I did. I felt proud and it motivated me because I knew I’m moving on” (Iyaz, #2).

These benefits improved participants’ *belief in self*: “It felt good, thought I wouldn’t be able to do it but I’m actually learning and doing well using it for the first time ever” (Emmanuel). This was reflected on as “a new thing, feeling proud of my behaviour instead of ashamed” (Pete). Participants’ understanding of what it meant to utilise DBT was shaped by these experiences, despite them engaging in isolation rather than DBT skill use which created new challenges. Their belief in the effectiveness of skills also shifted from credulous faith to personal confidence: “I understood why they said DBT was so good” (Katie).

The pressure cooker

This sub-category reflects how following rewards, participants experienced pressure to exert greater control over their behaviour, moving them back to the initial cycle of this core category.

Observing success in the reduction of aggression, ward staff increased their encouragement of participants to use DBT skills. This was experienced as a withdrawal of care, with independent self-management promoted ‘too soon’: “Rather than comforting or helping me like they did, they’re constantly just saying ‘use your DBT skills’…It’s like they can’t be bothered anymore” (Miss Ward #1). In parallel, facilitators also prompted participants to expand their repertoire by utilising more complex relational skills: “They said I had to start using the other skills to be more assertive” (Alesha). In contrast with perceptions of ward staff, this was perceived by participants as facilitators' expert investment in participants: "they know what they're doing because they've trained in DBT, not like nurses, and they're just trying to help us to get out in the community" (Katie).

The responses of facilitators and ward staff led participants to feel under increased pressure to consistently and effectively use DBT skills. With emphasis now on skills that necessitated interaction with others, participants recognised they could no longer hide their difficulties using *isolation*. *Belief in self* again reduced and participants re-entered the initial cycle of *having to do what I cannot*, yet the rewards gained so far compelled them to maintain their progression towards release by attempting the complex DBT skills. They initially experienced failure which amplified the perceived pressure and reduced care from staff. With reliance on *isolation* having precluded acquisition of non-aggressive strategies to manage such stress, participants' likelihood of becoming aggressive increased.

This created a sticking point within the cycle for individuals whose aggression was easily and regularly triggered, and prompted them to abandon complex skill use and resume *isolation*:

> I'd get stressed, mind would go blank so I'd end up going to my room…then I'd be worrying or angry about doing it wrong and end up self-harming or kicking off so I'd lose my trips out anyway. Staff would ask why I didn't use my skills and inside I was like I tried but I couldn't! ...I just stopped trying them skills and stayed in my room (Charlie)

In contrast, those with a greater ability to resist engaging in aggressive behaviour had more easily eliminated their observed aggression and obtained greater rewards using *isolation*. Their progression towards release thus appeared more tangible, providing greater motivation to endure the pressures accompanying the use of new skills and resist the urge to alleviate stress through aggression. These participants experienced ward staff and facilitators as sympathetic to their difficulties with the complex skills and, recognising their efforts were appreciated, found a way out of *the pressure cooker* by drawing on staff support: “I didn’t have a clue so couldn’t use them right…that’d look like I wasn’t trying…so I had to ask for help” (Pete).

Although pressure to use more complex skills exacerbated participants’ difficulties, as these were no longer hidden by *isolation*, anxiety reduced: “I saw others struggling too so didn’t feel as bad” (Beyoncé) and *sense of safety* increased: “we were all in it together” (Ziziu). This enabled those stuck in *the pressure cooker* and considering quitting to remain on the group.

Deconstructing “a better person”

This sub-category refers to how participants who started to seek support became able to comprehend and apply skills. This was largely achieved through the deconstruction of their difficulty with skills using diary cards and chain analyses within one-to-one sessions, which previously had been ineffective as participants were unwilling to acknowledge barriers. Through deconstruction, these participants gained insight into their struggles, providing motivation and dissipating *the pressure cooker*:

> I was still nervous using skills…But [facilitator] said it was better to try…I felt less worried doing it wrong and looking bad as staff knew I was trying, and I tried other skills because I thought they might work too now I was less worried. (Alesha)

Participants’ skill use was refined through this coaching process and they reflected on managing situations that would previously have resulted in restraint, and recognising situations where if they had used a skill, the outcome would have been more positive. Although still motivated by their extrinsic goal of release, participants’ *belief in self* also greatly improved, with all stating that DBT enabled them to become “a better person”. Reliance on *isolation* reduced as they now felt equipped to manage interpersonal interactions, and homework and roleplays became a safe means of trying out skills. All described strong attachments towards facilitators, which reflected their experience of having someone consistently willing to listen to and not judge them as novel.

These participants' growing openness and confidence in self and skills transferred to group sessions: "I wanted everyone to learn and benefit as much as me" (Beyoncé). They offered advice to other group members on how to effectively use skills, which was empowering: "they allow us to be the therapists just as much as they are" (Emmanuel), and further increased participants' *belief in self*: "It felt good knowing I've helped someone and they've gone away and used it better" (Pete). This augmented the *sense of safety* within the group and motivated those who had not reached this stage to also seek help from facilitators, thus moving them from being stuck in *the pressure cooker* to the *deconstruction* stage.

Setbacks and motivation

This final sub-category accounts for why relapses in aggression or a decline in motivation can occur for individuals who appear to have made significant progress in DBT. Although participants fully embraced DBT due to its "life changing impact" (Katie), aggression still arose in some situations either unintentionally, due to high arousal following distressing news, or intentionally due to perceptions that it would be more effective in response to aggression from other service users. Despite awareness of the repercussions, participants identified benefits of aggression that DBT could not provide, including catharsis and "feeling powerful" (Iyaz #1). Other situations led participants to feel demotivated and wary: when skills did not work it was "disappointing and frustrating" (Pete) or they created unwanted consequences: "They said instead of them saying for me, I should raise it with my consultant as it'd be good practice…I refused and never told them anything important again as it was too scary" (Alesha).

If staff were viewed as responding to these setbacks with punishment they became a ‘sticking point’ for individuals and moved them back into *the pressure cooker*. At all stages, however, participants remained extrinsically motivated, acknowledging that without their goal of release, they would be unlikely to invest the effort required to employ DBT skills.

[INSERT FIGURE A.2]

Discussion

This study provides an understanding of the process of service user engagement with DBT and how this influences change. Fundamentally, DBT was seen by participants as providing the motivation and means to address their intra or interpersonal aggression in order to progress towards release. Through enabling such behavioural (and a degree of cognitive) change, this temporal process is ultimately extrinsically—and, for those who reach the final stages, intrinsically—rewarding. However, the model also illuminates mechanisms that are of concern in respect of the difficulties individuals endure to achieve such change.

The model’s opening category, *extrinsic compliance*, provides context to the overall process and difficulties therein. Consistent with previous accounts of PWID in secure services (Burns & Lampraki, 2016; Griffith, Hutchinson, & Hastings, 2013), participants regarded their aggression as functional, and subsequently were not intrinsically motivated to desist. The perceived forced-choice of undertaking DBT to achieve release reflects the culture of compliance within forensic services, where non-compliance with authority and treatment targets is considered indicative of risk of recidivism and prohibits release (Weaver, 2014). Indeed, McCann, Ball and Ivanoff (2000) acknowledged forensic service users’ dialectical dilemma of “freedom to participate in treatment versus the experience of treatment as coercion” (p.455).

Within this context, participants' difficulties within the model resonate with Atherton's (1999) theory of "supplantive learning" (SL): acquiring new skills to replace previous ways of acting. SL incurs psychological cost by diminishing self-esteem and prior competence (here, coping through aggression), which further reduces skill "feasibility" (Gollwitzer, 1990). This perception informs self-efficacy and is based on past experiences, which for participants constituted failures. When SL is coercive, it leads to avoidance of situations that may reveal incompetence and incur judgement, as with participants' *isolation* (Blackwell, Trzniewski, & Dweck, 2007). Although SL relates to the categories of *belief in self*, *having to do what I cannot* and *the pressure cooker*, as a theory of individual learning it does not account for group *sense of safety*. Furthermore, its suggestion that learning is embraced following introduction of a facilitative environment (Atherton, 2013) echoes *deconstructing "a better person"*, yet does not explain how this occurs.

Comparison of the model with self-determination theory (SDT; Deci & Ryan, 2008) offers more coherent similarities. In contrast with other theories of motivation and change, such as the transtheoretical model (Prochaska & DiClemente, 1986), SDT alone considers the influence of internal versus external motivation. Parallel to *extrinsic compliance*, SDT suggests individuals lack motivation for therapy when perceiving no benefits of change or their incompetence as rendering skills ineffective, yet engage due to coercive reward, such as release from services (Ryan, Lynch, Vansteenkiste, & Deci, 2011). Aligned with *having to do what I cannot*, *isolation* and *the pressure cooker*, SDT posits that feeling obliged to successfully execute skills is strongly associated with fear of negative evaluation and failure, leading to thoughts and emotions being hidden (Sideridis, 2006) and barriers to change experienced as more formidable.

Within SDT, individuals become active and willing, rather than coerced, therapy members who internalise behavioural change when supported to gain basic psychological needs for autonomy, relatedness and competence; the latter two reflecting the model categories of *sense of safety* and *deconstructing "a better person"*. Indeed, feeling listened to and not judged has been described by PWID as a key positive experience of group-based psychological interventions (Stenfert Kroese et al., 2016), with this sense of feeling heard perhaps reflecting the epistemic trust that develops from recognising the personal relevance of evidence-based content shared by another due to it being helpful and validating (Fonagy & Allison, 2014). Autonomy develops from individuals using their personal values to guide choices without pressure, therefore, praise is experienced as undermining when used to motivate specific behaviour, as by ward staff within *the pressure cooker*. It could be argued that participants never fully gained autonomy as, indicative of their forensic setting, compliance with behavioural expectations is required. Thus, SDT departs from the model in suggesting that autonomy is required for competence to develop, whereas for participants the successful application of coerced skills enabled intrinsic motivation to develop. Nonetheless, SDT again converges in arguing that insofar as rewards/punishments are exerted and change externally motivated, behaviours are unlikely to be maintained once contingencies are removed (Lamberti et al., 2014), as highlighted by participants within *setbacks and motivation*.

One recurrent element within SL, SDT and the current model is the destabilising impact of new learning on *belief in self*. This echoes the skill struggles and considerations of dropout reported by ID DBT participants in this and other studies (Baillie & Slater, 2014; Johnson & Thomson, 2016; Morrisey & Ingamells, 2011; Sakdalan et al., 2010). Difficulty with the learning, retention and assimilation of new skills is a characteristic inherent to ID (Carr, Linehan, O'Reilly, Walsh, & McEvoy, 2016). However, whereas PWID often reject their ID label (Dorozenko, Roberts, & Bishop, 2015), some participants attributed these difficulties to having an ID. This may reflect internalisation of the DBT principle of self-acceptance or, with identities of PWID complex constructions based on their social roles (Dorozenko et al., 2015), reflect a less stigmatising and more tolerable account of their aggression and detention than an offender identity. Moreover, it is likely difficult to reject an ID identity when detained in an ID-specific unit and receiving ID-adapted therapy that you are struggling to learn and apply.

Participants' reluctance to use skills necessitating interpersonal interaction resonates with negative social situations being the greatest source of stress for PWID in both community and forensic settings, who subsequently employ avoidant isolation as a coping strategy (Hartley & MacLean, 2008; Burns & Lampraki, 2016). Although *isolation* could be presumed to impact on participants' psychological wellbeing (Kuster et al., 2015), the *positive reinforcement* it elicited moderated adverse effects and rewarded its continuation. This echoes the findings of Hartley and MacLean who suggested isolation may benefit PWID who typically have limited interpersonal control over their environment, particularly in forensic settings. However, they further cautioned against prolonged isolation, highlighting the potential for disempowerment and distress. Participants perhaps avoided such outcomes as they were unable to rely indefinitely on *isolation*, being moved into *the pressure cooker* where they did experience distress and again coercion.

The anxiety created within *the pressure cooker* and *setbacks and motivation* by facilitators' "consultation-to-the-patient" strategies, which involve participants attempting tasks staff would usually undertake, are acknowledged as an initial yet rewarding "shock" (Linehan, 2015, p.98). However, consultation-to-the-patient appeared destabilising and threatening for participants, who may have had little prior opportunity to exert self-determination (Kelly, 2016). *The pressure cooker's* subsequent exacerbation of the urge to aggress towards others or self may elucidate the trend of an initial spike in risk-related behaviours observed in DBT groups for PFID (Brown et al., 2013; Lew et al., 2006; Sakdalan & Collier, 2012).

No participant described increased risk post-DBT; therefore, iatrogenic harm may not have been sustained (Parry, Crawford, & Duggan, 2016). This could reflect the increased *sense of safety* prompted by *the pressure cooker*: with *isolation* no longer viable, participants' struggles with skills were now observable or exposed through them seeking help, thus providing powerful awareness of others as also struggling and generating a sense of belonging. This "universality" is regarded a key therapeutic factor for enabling engagement and change (Yalom & Leszcz, 2005) and indeed created a secure base for participants' exploration of experiences, understanding and skills within *deconstructing "a better person"*. Such opportunity for self-reflection is described as particularly powerful for PWID, who previously may not have been encouraged to (re)interpret their behaviour (Verhoeven, 2010) without pejorative judgement and penalties. Furthermore, recognition of enduring the demands of DBT while improving self-regulation is likely to have further revised participants' mental representations and augmented *belief in self* (Rizvi & Linehan, 2005).

The cycle through which participants developed a *sense of safety* has similarities with Yalom and Leszcz's (2005) group cohesion loop: trust–self-disclosure–empathy–acceptance–trust. This sequence largely mirrors the findings; however, participants' initial self-disclosures were precipitated by—and negatively reinforced through removing—facilitator pressure, with trust absent prior to sharing. This starting point may, therefore, more realistically account for how trust originates in Yalom and Leszcz's loop than their suggestion of courage. Moreover, this resonates with the proclivity for distrust and insecure attachment styles of PWID (Fletcher, Flood, & Hare, 2016), particularly in forensic services (Taylor & Novaco, 2013), and clarifies the analogous finding by Johnson and Thomson (2016) of initial peer mistrust within a secure ID service DBT group.

Limitations

As in other studies of psychological interventions for PWID, one limitation relates to the participants having to retrospectively recall their experiences of DBT, with some having started the group one year prior to their involvement in the study. Thus, their recollection of events and affective states may have differed from their perspectives at the time, and been influenced by current contextual factors (e.g., progress towards release, life stressors) and potential difficulties with retrospective memory highlighted in PWID (Levén, Lyxell, Andersson, Danielsson, & Rönnberg, 2008). Longitudinal data collection, conducted at various points throughout the process of DBT, may enhance current findings.

Some argue that in grounded theory studies, data collection should continue until theoretical saturation is reached (e.g. Glaser, 1978). However, we would argue this is not congruent with constructivist GT, where the aim is not to provide an objective truth but sufficient theoretical insights into the process under study (Charmaz, 2014; Dey, 1999). The categories developed in the current study were present within all interviews and final interview data did not revise existing categories. Therefore, it would appear theoretical sufficiency was achieved. Future quantitative outcome studies could helpfully ascertain whether motivation remained extrinsically driven for ID DBT group members and if the personal shifts and progress described by participants in this study mirrored observable behavioural change.

Whilst generalisability is not the aim of qualitative research, it should be noted that the experiences of the participants and the subsequent model of change generated may hold greater relevance when transferred to individuals with mild-borderline ID, than for those with more severe difficulties.

Clinical implications

The model highlights the process of engaging with and change through DBT as largely motivated by coercion. It is perhaps antithetical to avoid focus on aggression reduction within forensic services; however, promotion of benefits other than release would likely reduce fear of failure and its perceived consequences. Moreover, developing general life-skills rather than aggression reduction is the immediate aim of DBT, with a focus on self-aggression found to increase such behaviour (Springer, Lohr, Buchtel, & Silk, 1996). Introduction of pre-treatment sessions utilising motivational interviewing techniques (Miller & Rollnick, 2002) could facilitate development of intrinsic motivation and thus increase persistence, positive affect and self-efficacy (Ntoumanis et al., 2014) and maintain improvements post-DBT (Urbanoski, 2010).

In respect of the pervasive fear of negative appraisal apparent within *having to do what I cannot*, Verhoeven (2010) acknowledges “not all individuals are willing or able to participate in a group as low self-esteem makes them reluctant to expose their cognitive challenges” (p.330). However, as detailed within the introduction to this paper, the emphasis is usually on functional adaptations to overcome these challenges rather than bolstering self-esteem or self-efficacy. The lack of attention to these psychological barriers precludes full recognition of individuals’ difficulties, the adaptations actually required, and their zone of proximal development (Vygotsky, 1962), hence prohibiting collaborative “consultation-to-the-patient” and awareness of any increased risk of harm. Thus, the potential for and consequences of participant difficulties—both functional and psychological—should be emphasised by DBT trainers, become an imperative discussion within group and in facilitators’ team consultation, and be made explicit to potential participants to promote informed consent.

Future research

The model highlights the need for exploration of possible coercion and increased desire to aggress towards others and/or self within DBT for PWID. Debaters of therapy in forensic settings acknowledge its coercive nature; however, proponents contend that it ultimately supports autonomy by providing skills required for an independent and meaningful life, whereas others suggest it departs so radically from traditional therapy so as to constitute punishment (Lamberti et al., 2014). Elements of both arguments are evident within the model; however, the findings introduce the question of whether it is the pressure to comply with DBT or actually DBT itself that produces change. What is regarded by many as the "gold standard" of therapy evaluation, randomised control trials, employ control group comparisons, yet those not undergoing treatment are not subject to the pressures highlighted within the model, thus this approach may limit conclusions of effectiveness. Future research to monitor and address potential coercion and enhance treatment evaluation should consider mixed-methods, with control conditions offering an alternative psychological intervention and thus similar potential pressure to comply, alongside phenomenological exploration of perceptions of whether coercion is a necessary part of the therapeutic process beneficial in advancing the understanding offered by the model.

A number of difficulties highlighted within the model, including extrinsic motivation, anxiety, incomprehension, and reduced self-efficacy, are acknowledged as aversive within DBT's training manual (Linehan, 2015). However, the strategies the manual proffers for overcoming these barriers were predominantly experienced as punishment by participants in the present study and elevated risk. This dissonance could reflect the manual not having been developed for PWID, or may indicate the extent and impact of aversion has been undervalued. Qualitative exploration of risk in mainstream and ID DBT would enable the current findings to be clarified and appropriately addressed, while adverse effects could be monitored using the Negative Effects Questionnaire (Rozenthal, Kottorp, Boettcher, Andersson, & Carlbring, 2016). Finally, the impact of pre-DBT motivational sessions could be evaluated through control group research.

One of the difficulties inherent in analysing data from psychological intervention studies such as this relates to the challenge of disentangling the impact of the therapeutic relationship from that of therapy-specific components such as skill use. This challenge is well recognised within the ‘common factors’ debate (Wampold, 2015), and whilst this study offers some insight into the process of change as experienced by PFID undertaking DBT, continued efforts to identify ‘active ingredients’ of DBT remain necessary.

Conclusion

The GT presents the first theoretical understanding of the process of engagement with DBT and related change for PFID. It does not constitute an absolute representation yet, in providing a substantive conceptualisation rather than description of the common process of engagement and change, may incorporate differing experiences (Glaser, 2004). The GT has identified key implications for DBT delivery, notably related to addressing group members’ motivation for commencing the programme and explicit consideration of aversion, to safeguard increased harm. Awareness of the trajectory from compliance and avoidance to acceptance and generalisation enables DBT providers to align themselves with the individual, providing support as appropriate. Further research is of vital importance to ascertain whether DBT should unquestioningly remain a primary intervention for emotion dysregulation for PFID, given the punitive experience of ‘feeling worse before getting better’ highlighted by the participants.

References

American Psychiatric Association. (2001). Practice guideline for the treatment of patients with borderline personality disorder: American Psychiatric Association Practice Guidelines. *American Journal of Psychiatry, 158*, 1–52. Retrieved from http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bpd.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.).* Washington, DC: American Psychiatric Association.

Arthur, A. R. (2003). The emotional lives of people with learning disability. *British Journal of Learning Disabilities, 31,* 25–30. doi:10.1046/j.1468-3156.2003.00193.x

Ashworth, S., Mooney, P., & Tully, R. J. (2017). A case study demonstrating the effectiveness of an adapted-DBT program upon increasing adaptive emotion management skills, with an individual diagnosed with mild learning disability and emotionally unstable personality disorder. *Journal of Forensic Psychology Research and Practice, 17*(1), 38–60. doi:10.1080/15228932.2017.1251098

Atherton, J. (1999). Resistance to learning: A discussion based on participants in in-service professional training programmes. *Journal of Vocational Education and Training*, *51*(1), 77-90. doi:10.1080/13636829900200070

Atherton, J. S. (2013). *Doceo; Learning as Loss 3*. Retrieved from http://www.doceo.co.uk/original/learnloss_3.htm

Baillie, A., & Slater, S. (2014). Community dialectical behaviour therapy for emotionally dysregulated adults with intellectual disabilities. *Advances in Mental Health and Intellectual Disabilities, 8*(3), 165-173. doi:10.1108/AMHID-05-2013-0033

Beail, N. (2002). Interrogative suggestibility, memory and intellectual disability. *Journal of Applied Research in Intellectual Disabilities, 15*(2), 219–237. doi:10.1046/j.1468-3148.2002.00108.x

Birks, M., & Mills, J. (2011). *Grounded theory - A practical guide.* London, UK: SAGE.

Blackwell, L. S., Trzniewski, K. H., & Dweck, C. S. (2007). Implicit theories of intelligence predict achievement across an adolescent transition: A longitudinal study and an intervention. *Child Development, 78*(1), 246–263. doi:10.1111/j.1467-8624.2007.00995.x.

Boritz, T., Zeifman, R. J., & McMain, S. F. (2017). Mechanisms of change in dialectical behaviour therapy. In M. A. Swales (Ed.), *The Oxford handbook of dialectical behaviour therapy* (pp.). Oxford, UK: Oxford University Press. doi:10.1093/oxfordhb/9780198758723.013.42

Brown, J. F., Brown, M. Z. & Dibiasio, P. (2013). Treating individuals with intellectual disabilities and challenging behaviours with adapted dialectical behaviour therapy. *Journal of Mental Health Research in Intellectual Disabilities, 6*, 280-303. doi:10.1080/19315864.2012.700684

Burns, J., & Lampraki, A. (2016). Coping with stress: The experiences of service-users with intellectual disabilities in forensic services. *Journal of Intellectual Disabilities and Offending Behaviour, 7*(2), 75-83. doi:10.1108/JIDOB-09-2015-0031

Carr, A., Linehan, C., O'Reilly, G., Walsh, P. N., & McEvoy, J. (2016). *The handbook of intellectual disability and clinical psychology practice*. Oxford, UK: Routledge.

Charlton, M., & Dykstra, E. (2011). Dialectical behaviour therapy for special populations: treatment with adolescents and their caregivers. In R. J. Fletcher (Ed.), *Psychotherapy for Individuals with Intellectual Disability* (pp. 13-16). New York, NY: NADD Press.

Charmaz, K. (2006). *Constructing grounded theory. A practical guide through qualitative research.* London, UK: Sage.

Cristea, I. A., Gentili, C., Cotet, C. D., Palomba, D., Barbui, C., & Cuijpers, P. (2017). Efficacy of psychotherapies for borderline personality disorder: A systematic review and meta-analysis. *JAMA Psychiatry, 74*(4), 319–328. doi:10.1001/jamapsychiatry.2016.4287

Charmaz, K. (2014). *Constructing grounded theory*. London, UK: Sage.

Deci, E., & Ryan, R. (2008). Self-determination theory: A macrotheory of human motivation, development, and health. *Canadian Psychology/Psychologie Canadienne, 49*(3), 182-185. doi:10.1037/a0012801

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry*. San Diego, CA: Academic Press.

Dorozenko, K. P., Roberts, L. D., & Bishop, B. (2015). The identities and social roles of people with an intellectual disability: Challenging dominant cultural worldviews, values and mythologies. *Disability & Society, 30*(9), 1345-1364. doi:10.1080/09687599.2015.1093461

Dunn, E. C., Nishimi, K., Gomez, S.H., Powers, A., & Bradley, B. (2018). Developmental timing of trauma exposure and emotion dysregulation in adulthood: Are there sensitive periods when trauma is most harmful? *Journal of affective disorders, 227*, 869–877. doi:10.1016/j.jad.2017.10.045

Esbensen, A. J., & Benson, B. A. (2003). Integrating behavioral, psychological and pharmacological treatment: A case study of an individual with borderline personality disorder and mental retardation. *Mental Health Aspects of Developmental Disabilities, 6*, 107-113. Retrieved from http://media.wix.com/ugd// e11630_ 8745f74529321032d67ae8852660d158.pdf

Fletcher, H. K., Flood, A., & Hare, D. J. (2016). *Attachment in intellectual and developmental disability: A clinician's guide to practice and research.* Chichester, UK: John Wiley & Sons.

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy, 51*(3), 372–380. doi:10.1037/a0036505

Forster, C., Berthollier, N., & Rawlinson, D. (2014). A systematic review of potential mechanisms of change in psychotherapeutic interventions for personality disorder. *Journal of Psychology & Psychotherapy, 4*, 133. doi:10.4172/2161-0487.1000133

Frazier, S. N., & Vela, J. (2014). Dialectical behavior therapy for the treatment of anger and aggressive behavior: A review. *Aggression and Violent Behavior, 19*, 156–163. doi:10.1016/j. avb.2014.02.001

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London, UK: The Stationery Office. Retrieved from http://www.midstaffspublicinquiry.com/report

Glaser, B. G. (1978) *Theoretical Sensitivity*. Mill Valley, CA: The Sociology Press.

Glaser, B. G. (2004). Naturalist inquiry and grounded theory. *Forum: Qualitative Sozialforschung/ Forum: Qualitative Social Research 5,* 2. Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/607/1315

Gollwitzer, P. M. (1990). Action phases and mind-sets. In E. T. Higgins & R. M. Sorrentino (Eds.), *The handbook of motivation and cognition: Foundations of social behavior* (pp. 53–92). New York, NY: Guilford Press.

Griffith, G. M., Hutchinson, L., & Hastings, R. P. (2013). “I’m not a patient, I'm a person”: The experiences of individuals with intellectual disabilities and challenging behavior—A thematic synthesis of qualitative studies. *Clinical Psychology Science and Practice, 20*(4), 469–488. doi:10.1111/cpsp.12053

Hall, L., Bork, N., Craven, S., & Woodrow, C. (2013). People with learning disabilities' experiences of a dialectical behaviour therapy skills group: A thematic analysis. *Clinical Psychology & People with Learning Disabilities, 11*(1&2), 7-11. Retrieved from http://shop.bps.org.uk/publications/publication-by-series/dcp-faculty-for-learning-disabilities/clinical-psychology-people-with-learning-disabilities-vol-11-nos-1-and-2-april-2013.html

Hartley, S. L., & MacLean, W. E. (2008). Coping strategies of adults with mild intellectual disability for stressful social interactions. *Journal of Mental Health Research in Intellectual Disabilities*, *1*(2), 109–127. doi:10.1080/19315860801988426

Hogue, T. E., Mooney, P., Morrissey, C., Steptoe, L., Johnston, S., Lindsay, W. R., & Taylor, J. (2007). Emotional and behavioural problems in offenders with intellectual disability: Comparative data from three forensic services. *Journal of Intellectual Disability Research, 51*, 778–785. doi:10.1111/j.1365-2788.2006.00938.x

Ingamells, B., & Morrissey, C. (2014). *I Can Feel Good: Skills training for people with intellectual disabilities and problems managing emotions*. Hove, UK: Pavilion Publishing and Media Ltd.

Johnson, P., & Thomson, M. (2016). Journeys into dialectical behaviour therapy (DBT): Capturing the staff and service-user experience. *Journal of Intellectual Disabilities and Offending Behaviour, 7*(2), 84-93. doi:10.1108/JIDOB-09-2015-0027

Kelly, C. (2016). *Disability politics and care: The challenge of direct funding*. Vancouver, Canada: University of British Columbia Press.

Kliem, S., Kröger, C., & Kosfelder, J. (2010). Dialectical behavior therapy for borderline personality disorder: A meta-analysis using mixed-effects modeling. *Journal of Consulting and Clinical Psychology, 78*(6), 936–951. doi:10.1037/a0021015

Kuster, M., Bernecker, K., Backes, S., Brandstätter, V., Nussbeck, F. W., Bradbury, T. N., … Bodenmann, G. (2015). Avoidance orientation and the escalation of negative communication in intimate relationships. *Journal of Personality and Social Psychology, 109*(2), 262-75. doi:10.1037/pspi0000025

Lamberti, J. S., Russ, A., Cerulli, C., Weisman, R. L., Jacobowitz, D., & Williams, G. C. (2014). Patient experiences of autonomy and coercion while receiving legal leverage in forensic assertive community treatment. *Harvard Review of Psychiatry, 22*(4), 222-30. doi:10.1097/01.HRP.0000450448.48563.c1.

Leichsenring, F., Leibing, E., Kruse, J., New, A. S., & Leweke, F. (2011). Borderline personality disorder. *Lancet, 377*(9759), 74-84. doi:10.1016/S0140-6736(10)61422-5

Levén, A., Lyxell, B., Andersson, J., Danielsson, H., & Rönnberg, J. (2008). Prospective memory, working memory, retrospective memory and self-rated memory performance in persons with intellectual disability. *Scandinavian Journal of Disability Research, 10*(3), 147-165. doi:1080/15017410802144444

Lew, M., Matta, C., Tripp-Tebo, C. & Watts, D. (2006). Dialectical behaviour therapy (DBT) for individuals with intellectual disabilities: A programme description. *Mental Health Aspects of Developmental Disabilities, 9,* 1-12. Retrieved from http://media.wix.com/ugd//e11630_9e3096356408d1123e09a5074cfbd2f8.pdf

Lindsay, W. R., Hastings, R. P., & Beail, N. (2013). Why do some people with intellectual disability engage in offending behaviour and what can we do about it? Editorial. *Journal of Applied Research in Intellectual Disabilities, 26,* 351-356. doi:10.1111/jar.12042

Lindsay, W. R., Tinsley, S., Beail, N., Hastings, R. P., Jahoda, A., Taylor, J. L., & Hatton, C. (2015). A preliminary controlled trial of a trans-diagnostic programme for cognitive behaviour therapy with adults with intellectual disability. *Journal of Intellectual Disability Research, 59*, 360–369. doi:10.1111/jir.12145

Linehan, M. M. (1993a). *Cognitive behavioral therapy of borderline personality disorder.* New York, NY: Guilford Press.

Linehan, M. M. (1993b). *Skills training manual for treating borderline personality disorder.* New York, NY: Guilford Press.

Linehan, M. M. (2000). The empirical basis of dialectical behaviour therapy: Development of new treatments versus evaluation of existing treatments. *Clinical Psychology: Science and Practice, 7,* 113–19. doi:10.1093/clipsy.7.1.113

Linehan, M. M. (2015). *DBT skills training manual* (2nd ed.). New York, NY: Guilford Press.

Little, H., Tickle, A., & das Nair, R. (2017). Process and impact of dialectical behaviour therapy: A systematic review of perceptions of clients with a diagnosis of borderline personality disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, *91*, 278–301. doi:10.1111/papt.12156

Lynch, T., Chapman, A., Rosenthal, M., Kuo, J., & Linehan, M. (2006). Mechanisms of change in dialectical behavior therapy: Theoretical and empirical observations. *Journal of Clinical Psychology, 62*, 459–480. doi:10.1002/jclp.20243

Mavromatis, M. (2000). The diagnosis and treatment of borderline personality disorder in persons with developmental disability- 3 case reports. *Mental Health Aspects of Developmental Disabilities, 3*, 89-97. Retrieved from http://www.mh-idd.com/#!journal/c1jxp

McCann, R. A., Ball, E. M., & Ivanoff, A. (2000). DBT with an inpatient forensic population: The CMHIP forensic model. *Cognitive and Behavioral Practice, 7*(4), 448–456. doi:10.1016/S1077-7229(00)80056-5

McClure, K. S., Halpern, J., Wolper, P. A., & Donahue, J. J. (2009). Emotion regulation and intellectual disability. *Journal on Developmental Disabilities, 15*(2), 38–44. Retrieved https://oadd.org/wp-content/uploads/2009/01/McClure_15-2.pdf

McNair, L. C. (2014). *Dialectical behaviour therapy for adults with intellectual disabilities* (Unpublished doctoral thesis, University of Manchester). Retrieved from https://www.research.manchester.ac.uk/portal/files/54554959/FULL_TEXT.PDF

McNair, L., Woodrow, C., & Hare, D. (2016). Using repertory grid techniques to measure change following dialectical behaviour therapy with adults with learning disabilities: two case studies. *British Journal of Learning Disabilities, 44*(3), 247–256. doi:10.1111/bld.12142

Melville, C., Johnson, P., Smiley, E., Simpson, N., Purves, D., McConnachie, A., & Cooper, S. (2016). Problem behaviours and symptom dimensions of psychiatric disorders in adults with intellectual disabilities: An exploratory and confirmatory factor analysis. *Research in Developmental Disabilities, 55*, 1–13. doi:10.1016/j.ridd.2016.03.007

Mencap. (2009). *Make it clear: A guide to easy read materials*. London, UK: Mencap. Retrieved from https://www.mencap.org.uk/sites/default/files/documents/2008-04/make%20it%20clear%20apr09.pdf

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing*. New York, NY: Guilford Press

Morrissey, C., & Ingamells, B. (2011). Adapted dialectical behaviour therapy for male offenders with intellectual disability in a high secure environment: six years on. *Journal of Learning Disabilities & Offending Behaviour, 2*, 110-117. doi:10.5042/jldob.2011.0024

National Institute for Health and Care Excellence. (2015). *Challenging behaviour and learning disabilities: Prevention and interventions for people with learning* *disabilities whose behaviour challenges.* London, UK: NICE. Retrieved from http://www.nice.org.uk/guidance/ng11

Ntoumanis, N., Healy, L. C., Sedikides, C., Duda, J., Stewart, B., Smith, A., & Bond, J. (2014). When the going gets tough: The "why" of goal striving matters. *Journal of Personality*, *82*(3), 225–236. doi:10.1111/jopy.12047

Nylander, L., Fernell, E., & Gillberg, C. (2016). Intellectual developmental disorder in adult psychiatry: A 24-year register study. *Nordic Journal of Psychiatry.* Advance online publication. doi:10.1080/08039488.2016.1175504

Oliver, C. (2012). Critical realist grounded theory: A new approach for social work research. *British Journal of Social Work, 42*(2), 371–387. doi:10.1093/bjsw/bcr064

Oxnam, P., & Gardner, E. (2011). Stepping Stones – a group therapy programme for the treatment of emotion regulation difficulties in offenders with an intellectual disability. *Journal of Learning Disabilities and Offending Behaviour, 2*(4), 146–51.

Panos, P. T., Jackson, J. W., Hasan, O., & Panos, A. (2014). Meta-analysis and systematic review assessing the efficacy of dialectical behavior therapy (DBT). *Research on Social Work Practice*, *24*(2), 213–223. doi:10.1177/1049731513503047

Parry, G. D., Crawford, M. J., & Duggan, C. (2016). Iatrogenic harm from psychological therapies – time to move on. *The British Journal of Psychiatry, 208*(3), 210-212; doi:10.1192/bjp.bp.115.163618

Prochaska, J. O., & DiClemente, C. C. (1986). Toward a comprehensive model of change. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors* (pp. 3-27). New York, NY: Plenum.

Prosser, H., & Bromley, J. (2012). Interviewing people with intellectual disabilities. In E. Emerson, C. Hatton, K. Dickson, R. Gone, A. Caine and J. Bromley (Eds.), *Clinical*

Psychology and People with Intellectual Disabilities, Second Edition (pp. 105-120). Chichester, UK: John Wiley & Sons Ltd. doi:10.1002/9781118404898.ch6

Rizvi, S. L., & Linehan, M. M. (2005). The treatment of maladaptive shame in borderline personality disorder: A pilot study of "opposite action". *Cognitive and Behavioral Practice, 12*(4), 437–447. doi:10.1016/S1077-7229(05)80071-9

Rizvi, S. L., & Thomas, M. C. (2017). Borderline personality disorder: Underlying mechanisms and implications for treatment. In D. McKay., J. S. Abramowitz., & E. A. Storch (Eds.), *Treatments for psychological problems and syndromes* (pp. 360–375). Chichester, UK: John Wiley & Sons.

Rozental, A., Kottorp, A., Boettcher, J., Andersson, G., & Carlbring, P. (2016). Negative effects of psychological treatments: An exploratory factor analysis of the negative effects questionnaire for monitoring and reporting adverse and unwanted events. *PLoS ONE, 11*(6), 1-22. doi:10.1371/journal.pone.0157503

Rudge, S., Feigenbaum, J. D., & Fonagy, P. (2017). Mechanisms of change in dialectical behaviour therapy and cognitive behaviour therapy for borderline personality disorder: A critical review of the literature. *Journal of Mental Health,* 1–11. doi:10.1080/09638237.2017.1322185

Ryan, R. M., Lynch, M. F., Vansteenkiste, M., & Deci, E. L. (2011). Motivation and autonomy in counseling, psychotherapy, and behavior change: A look at theory and practice 1ψ7. *The Counseling Psychologist, 39*(2), 193-260. doi:10.1177/0011000009359313

Sakdalan, J. A., & Collier, V. (2012). Piloting an evidence-based group treatment programme for high risk sex offenders with intellectual disability in the New Zealand setting. *New Zealand Journal of Psychology, 41*(3), 6-12. Retrieved from http://www.psychology.org.nz/wp-content/uploads/Sakdalan1.pdf

Sakdalan, J. A., Shaw, J., & Collier, V. (2010). Staying in the here and now: A pilot study on the use of dialectical behaviour therapy group skills training for forensic clients with intellectual disability. *Journal of Intellectual Disability Research*, *54*(6), 568-572. doi:10.1111/j.1365-2788.2010.01274.x

Sappok, T., Budczies, J., Dziobek, I., Bolte, S., Dosen, A., & Diefenbacher, A. (2014). The missing link: Delayed emotional development predicts challenging behavior in adults with intellectual disability. *Journal of Autism and Developmental Disorders, 44*(4), 786–800. doi:10.1007/s10803-013-1933-5v

Sheppes, G., Suri, G., & Gross, J. J. (2015). Emotion regulation and psychopathology. *Annual Review of Clinical Psychology, 11*, 379–405. doi:10.1146/annurev-clinpsy-032814-112739

Sideridis, G. D. (2006). Achievement goal orientations, “oughts,”and self-regulation in students with and without learning disabilities. *Learning Disability Quarterly, 29*, 3-18. doi:10.2307/30035528

Springer, T., Lohr, N. E., Buchtel, H. A., & Silk, K. R. (1996). A preliminary report of short-term cognitive-behavioral group therapy for inpatients with personality disorders. *The Journal of Psychotherapy Practice and Research*, *5*(1), 57–71. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3330405/pdf/57.pdf

Stenfert Kroese, B., Willott, S., Taylor, F., Smith, P., Graham, R., Rutter, T., Stott, A., & Willner, P. (2016). Trauma-focussed cognitive-behaviour therapy for people with mild intellectual disabilities: Outcomes of a pilot study. *Advances in Mental Health and Intellectual Disabilities, 10*(5), 299–310. doi.org/10.1108/AMHID-05-2016-0008

Stoffers, J. M., Völlm, B. A., Rücker, G., Timmer, A., Huband, N., & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder. *Cochrane*

Database of Systematic Reviews, *89*(CD005652). doi:10.1002/14651858.CD005652.pub2.

Taylor, J. L., & Novaco, R. W. (2013). Anger Control Problems. In J. L. Taylor, W. R. Lindsay, R. P. Hastings, & C. Hatton (Eds.), *Psychological therapies for adults with intellectual disabilities* (pp. 133-155). Chichester, UK: John Wiley & Sons. doi:10.1002/9781118329252.ch9

Thomas, G., & Stenfert Kroese, B. (2005). An investigation of students' with mild learning disabilities reactions to participating in sexuality research. *British Journal of Learning Disabilities, 33*, 113–119. doi:10.1111/j.1468-3156.2005.00336.x

Urbanoski, K. A. (2010). Coerced addiction treatment: Client perspectives and the implications of their neglect. *Harm Reduction Journal, 7*, 13-22. doi:10.1186/1477-7517-7-13

Verhoeven, M. (2010). Journeying to wise mind: Dialectical behavior therapy and offenders with an intellectual disability. In Craig A., Lindsay W. R., Browne K. D., editors. *Assessment and treatment of sexual offenders with intellectual disabilities: A handbook* (pp. 317–340). Oxford, UK: Wiley.

Vygotsky, L. S. (1962). *Thought and language.* Cambridge MA: MIT Press.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*(3), 270–277. doi:10.1002/wps.20238

Weaver, B. (2014). Control or change? Developing dialogues between desistance research and public protection practices. *Probation Journal 61*(1), 8-26. doi:10.1177/0264550513512890

Wigham, S. & Emerson, E. (2015). Trauma and life events in adults with intellectual disability. *Current Developmental Disorders Reports, 2*(2), 93–99. doi:10.1007/s40474-015-0041-y

Wilson, S. R. (2001). A four stage model for management of borderline personality disorder in people with mental retardation. *Mental Health Aspects of Developmental Disabilities, 4*(2), 68-76. Retrieved from http://media.wix.com/ugd//e11630_374ef699a7ec0c030f735f30b19bd61e.pdf

Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy*. New York, NY: Basic Books.

Table 1. Inclusion and exclusion criteria

Inclusion	Exclusion
English speaking Service users who have attended and completed an ID adapted DBT skills group Service users who began attending an ID adapted DBT skills group but 'dropped out' after three sessions Service users who are currently attending an ID adapted DBT skills group and have attended a minimum of three sessions	Service users who are deemed unable to participate in interviews by their key worker/consultant psychiatrist Service users who are deemed unable to provide consent to interview following an assessment of their capacity to do so by the researcher

Table 2. Participant demographic information

Demographic	Information*
Age	Range 21-48 (*M*=30.3, *SD*=9.03)
Gender	4 males (45%) 5 females (55%)
Ethnicity	2 Asian British (22%) 7 White British (78%)
FSIQ	Range 59-72 (*M*=66.7, *SD*=4.03)
Location	5 located in a Low Secure Unit (55%) 4 located in a Medium Secure Unit (45%)

* Participant demographic information has been provided for the sample rather than individual participants as a safeguard to protect anonymity

Figure 1. Process of grounded theory analysis

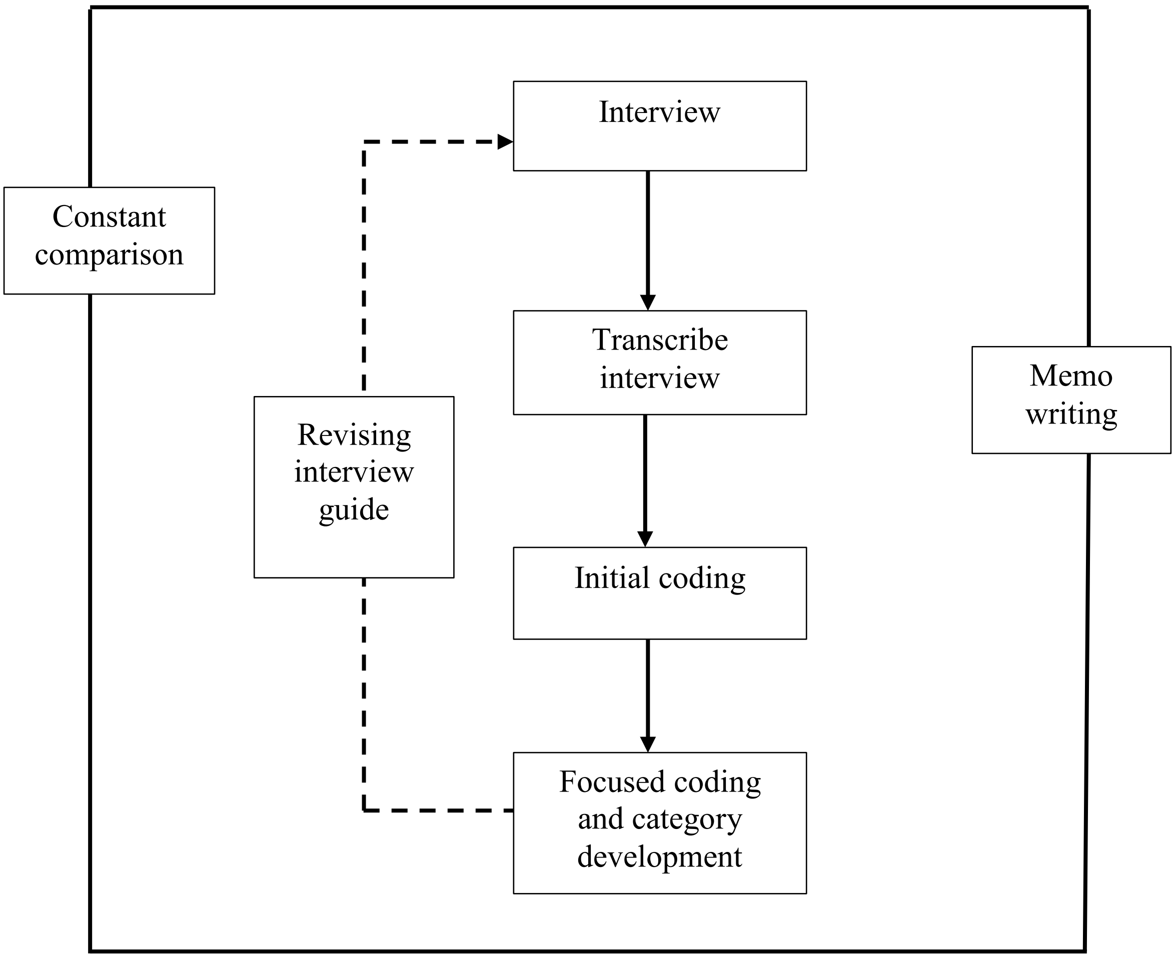

Figure 2. Model of the process of engagement and change