

A Qualitative Methodology for Theory Elucidation, Explication, and Development Applied Within an Intensive Group Psychotherapy Program

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Abstract:

Mental health day treatment (MHDT) programs provide intensive group psychotherapy for patients with psychiatric pathology complicated by personality disorder. Recently, researchers have begun to examine specific components of these programs. Of importance is the theoretical rationale, which may be challenging to understand given the complexity of the treatment. The purpose of this project was to investigate the theory of one MHDT program. Community-based participatory research was chosen and accordingly, all stages of the project were collaborative with the MHDT clinical team. We engaged in a six-month, iterative process of weekly action-reflection cycles wherein material was discussed, analyzed for themes, and the findings presented back to the team to further the conversation. Results summarize this program's *Theories of Dysfunction* and *Therapeutic Change*, which were primarily psychodynamic, but also integrative through assimilation of elements from other paradigms. Usefulness of the research process is discussed and recommendations are provided for others wishing to undergo a similar process.

Key Words: theory development, mental health day treatment, integrative psychotherapy, group psychotherapy, community-based participatory research, personality disorders

Mental health Day Treatment (MHDT) Programs deliver intensive group psychotherapy and are considered an effective treatment option for patients with personality pathology which have been demonstrated repeatedly to reduce patient symptoms and improve functioning (Bateman & Fonagy, 1999; 2001; 2003; Howes, Haworth, Reynolds, & Kavanaugh, 1997; Karterud et al., 2003; Marshall et al., 2003; Ogrodniczuk & Piper, 2001; Piper, Rosie, Azim, & Joyce, 1993; Verheul & Herbrink, 2007; Wilberg et al., 1998; 1999). These programs are highly involved, comprising of multiple components, operating at least two days per week, and are group based (Verheul & Herbrink, 2007). Program orientation is generally psychodynamic but elements from other modalities are also incorporated (Karterud & Urnes, 2004; Piper, Posie, Joyce, & Azim, 1996).

There has been increasing emphasis on the need to understand the specific elements of MHDT, how each contributes to outcome, and how programs may be better tailored to meet the needs of unique patient populations (Karterud & Urnes, 2004; Karterud & Wilberg, 2007; Mortl & Von Wietersheim, 2008; Ogrodniczuk & Piper, 2001). Karterud and Urnes (2004) describe a number of elements that may contribute to the success of a MHDT Program including: 1) empirical support for individual program elements; 2) user satisfaction; 3) clinical experience; 4) comprehensiveness and consistency; 5) availability of resources and; 6) theoretical grounding of the program. However, many of these have yet to be evaluated and it is unclear how they may interact and affect the experience of the patient in the program. Of these factors, addressing the theoretical grounding of day treatment programs may be particularly challenging, as MHDT programs are comprised of multiple components arising from different orientations.

It has been argued that a solid understanding of theoretical models of personality, psychopathology, and therapy is of critical importance for the treatment of mental disorders (e.g., Binder, 2004; Kazdin, 1999; Roussos, Lissin, & De Duarte, 2007; Siemonsma, Schroder, Dekker, & Lettinga, 2008). Theory functions as a guide in determining the nature and extent of the problem and the appropriate course of treatment. As discussed by Kazdin (1999), *theories about dysfunction* relate to how individuals develop psychological disorders including the processes involved in the operation of the disorder, risk factors, and pathological effects resulting from early childhood events. *Theories about therapeutic change* focus on what therapy is designed to change and the processes involved. The clinician's theoretical perspective facilitates the interpretation and organization of patient information into a case formulation including an understanding of developmental pathways, risk factors and mitigating variables (Binder, 2004; Orvaschel, 1999). Theoretically-derived case formulation, in turn, informs decisions about the primary and secondary pathology and the timing of different interventions (Orvaschel, 1999). Binder (2004) notes that theory enhances skills thereby increasing clinical accuracy and efficiency. Empirically, Roussos et al. (2007) in their recent investigation indicate that the therapist's theoretical framework influences the construction of clinical and working inferences.

Purpose and Research Orientation

The purpose of this project was to systematically discuss, clarify, and elucidate the theoretical grounding of a MHDT program. This project resulted from a participatory research initiative among the MHDT program team. We sought to improve our collective understanding of how the program components theoretically fit together, facilitate a more consistent and cohesive therapeutic stance, and strengthen the basis of MHDT interventions. We were optimistic that the research process and findings would evoke real-world clinical change and potentially provide a methodology for other teams interested in engaging in a similar pursuit.

We established that a participatory, qualitative approach based on the principles of Community-Based Participatory Research (CBPR) would be most appropriate for our subject matter. CBPR has been defined as an investigation conducted with full participation by those affected by the issue; the academic and community collaborators engage in an equal partnership in all stages of the project (Israel, Schulz, Parker, & Becker, 1998) such as defining research questions, carrying out the research, interpretation of data, disseminating research findings, and using such findings to promote action (Blair & Minkler, 2009). Participants contribute to the extent that they choose given their unique skills and abilities, and clinical time constraints. Such an approach is particularly helpful when communities and concerns are multifaceted and affected by many variables (Israel, Schulz, Parker, & Becker, 2001; Jones & Wells, 2007), as is often the case in mental health settings, especially those treating patients with severe and complex pathology.

Method Setting

The Halifax-based MHDT Program provides six-weeks (4 days per week) of intensive, primarily group-based psychotherapy for individuals diagnosed with significant DSM Axis II pathology and co-morbid Axis I concerns. The structure of the program is consistent with other day treatment programs (e.g., Karterud et al., 2003; Piper et al., 1996) and patients enrolled in the program have demonstrated significant gains in terms of symptom reduction (Howes et al., 1997; Kinley, Williams, Kavanaugh, & Joyce 2010). The groups (eight weekly groups in total) are based in various modalities with the overall goal of promoting psychological well-being and increasing resilience by: working through painful emotions; increasing self-awareness; improving interpersonal relationships; enhancing coping skills; challenging dysfunctional thinking; and preventing relapse (increasing resilience). There are approximately 100 patients per year who participate in the program with about 16 at any given time. In a previous study (Kinley et al., 2010), diagnoses of a sample of 178 MHDT patients were reported. Mood disorders were the most common diagnosis (59% of the sample) followed by adjustment disorders (23%) and anxiety disorders (17%). Twenty-

three percent of patients had more than one Axis I diagnosis. Almost all (96%) had an Axis II diagnosis, most commonly Cluster B pathology (66%).

Participants (MHDT Team)

The MDHT clinical team comprised the participants for this project. The team is multidisciplinary and at the time of this project consisted of professionals from nursing ($n = 1$), occupational therapy ($n = 1$), psychiatry ($n = 1$), psychology ($n = 1$), and social work ($n = 3$). Ages ranged from 31 – 60 years (Mean = 48.57, $SD = 10.15$). One team member was trained at the undergraduate level and the remaining members were trained at the graduate level. As a group, the team had an average 19.23 years ($SD = 9.16$) experience working in mental health and an average of 10.79 years ($SD = 8.93$) experience working in the MHDT program. Concerning roles and duties on the MHDT team, there are four Case Coordinators who facilitate groups, provide assessment, and provide individual patient management including individual work and family, employer, and/or community consultation when required. The Program Director, who is also the team psychiatrist, conducts case formulation interviews with each patient, guides the clinical team in individual treatment planning, and provides medication management when necessary. The Program Coordinator oversees the managerial aspects of the program including intra-hospital relations and facilitates groups. The psychologist primarily conducts program evaluation and research.

As research participants, we viewed ourselves as co-investigators and all stages of this project were collaborative, from idea to knowledge transfer. Specific roles and responsibilities for this project were discussed in advance. Everyone participated in the conceptualization and planning of the project, engaged in the discussion-reflection cycles, and provided feedback on any written documents including this manuscript. The psychologist guided the team in terms of methodology, provided analysis of data to further the discussions, and drafted written materials. The Program Director provided leadership within the discussion sessions.

Action-Reflection Cycles: Study Phase

We decided upon a methodology that was *practical, efficient, and replicable* so that other teams may engage in a similar process in the future. This method consisted of iterations of discussion and thematic analysis, the results of which furthered the next discussion. We met as a team 15 times over a five month period. Meetings were approximately 30 minutes in duration, the time and length being chosen to accommodate busy clinical schedules. During the 14th meeting, we noted that we had reached redundancy in terms of new material being uncovered. We decided to conclude with a final meeting wherein the time could be open and flexible in order to ensure that saturation of the data had been

reached to our satisfaction (i.e., no new ideas were emerging; Polit, Beck, & Hungler 2001). Accordingly, the final meeting was two hours in duration.

The first session began with a general discussion about the overall strategy for articulating the theoretical basis of the program. We agreed to focus on a set of guiding queries about theory along with a discussion of each component of the program and illustrative cases (See Table 1). This approach was thought to allow for an understanding of the theory as well as how the program components and treatment of patients fit within the theory. We discussed each group comprising the MHDT program as well as overarching factors such as the therapeutic milieu and therapeutic alliance. Following our initial session, subsequent discussions began with a written summary of the primary themes from the previous session. These themes then served as a catalyst for ongoing discussions.

Table 1: Format for Discussion Sessions Regarding Theoretical Basis of Multiple Component Group-Based Therapy

Guiding Queries about Theory*
<ul style="list-style-type: none"> - How and why do people develop maladaptive patterns of relating to the self and others? (personality pathology) - How and why do people develop distressing symptoms characteristic of Axis I disorders? - How is the system of dysfunction maintained? When is a person with underlying personality pathology at particular high risk for experiencing symptoms and distress? - What constitutes mental health? - How can patients achieve symptom reduction and/or mental health? Is there a difference? - How can patients maintain the gains that they make during active therapy?
Queries about Groups and Other Program Elements (e.g., individual case coordination, case formulation, therapeutic milieu, unstructured time)*
<ul style="list-style-type: none"> - What are the goals of the group or program element? - What tasks are used in achieving these goals? - For groups, what is the relative focus/orientation of the group (e.g., cognitive, behavioural, health-based, emotion-focused)? - How does this component fit with the other program components and relate to the queries about theory?

*In all instances, try to incorporate illustrative case examples into discussion

Analysis

During the sessions, extensive and detailed field notes were kept, which served as the basis for analysis. Analysis proceeded very rapidly, with approximately one week elapsing between discussion sessions. Thematic analysis was chosen to examine the data which focuses on identifying themes and patterns evident within a qualitative data set (Aronson, 1994; Braun & Clarke, 2004). It is primarily descriptive, providing rich detail about the specificities of the data although some researchers may further provide interpretations about aspects of the research topic based on the analysis (Boyatzis, 1998). In essence, thematic analysis involves coding small units of text into patterns (i.e., themes) that are evident within the data set. These patterns can be sub-divided more thoroughly and/or discussed more broadly in order to develop a comprehensive view of the phenomenon as a whole (Aronson, 1994; Tuckett, 2005). Each week, one team member (i.e., the first author) initially examined the field notes, coding text, ideas, and concepts into themes and subthemes (based initially on our guiding queries about theory and program elements), which were then brought back in written summary to the team for clarification and discussion. Thereby, each discussion session also served as member checking or “recycling interpretation” in order to substantiate the analysis (Crabtree & Miller, 1999). The overall thematic structure was expanded upon as the sessions progressed.

Results

The theoretical basis of the MHDTP program is drawn from both clinical experience and established psychotherapeutic practices. The program utilizes many aspects from different orientations and there has been a conscious effort to understand the relationships among these components. The themes which emerged from the discussion sessions reflect a comprehensive perspective about the development of psychopathology (Figure 1) and process of psychotherapeutic change. It is not our intent in this manuscript to provide a comprehensive discussion of this theory, but rather to highlight the core themes. A comprehensive program manual outlining the theory in detail was written following this project and is available from the authors on request.

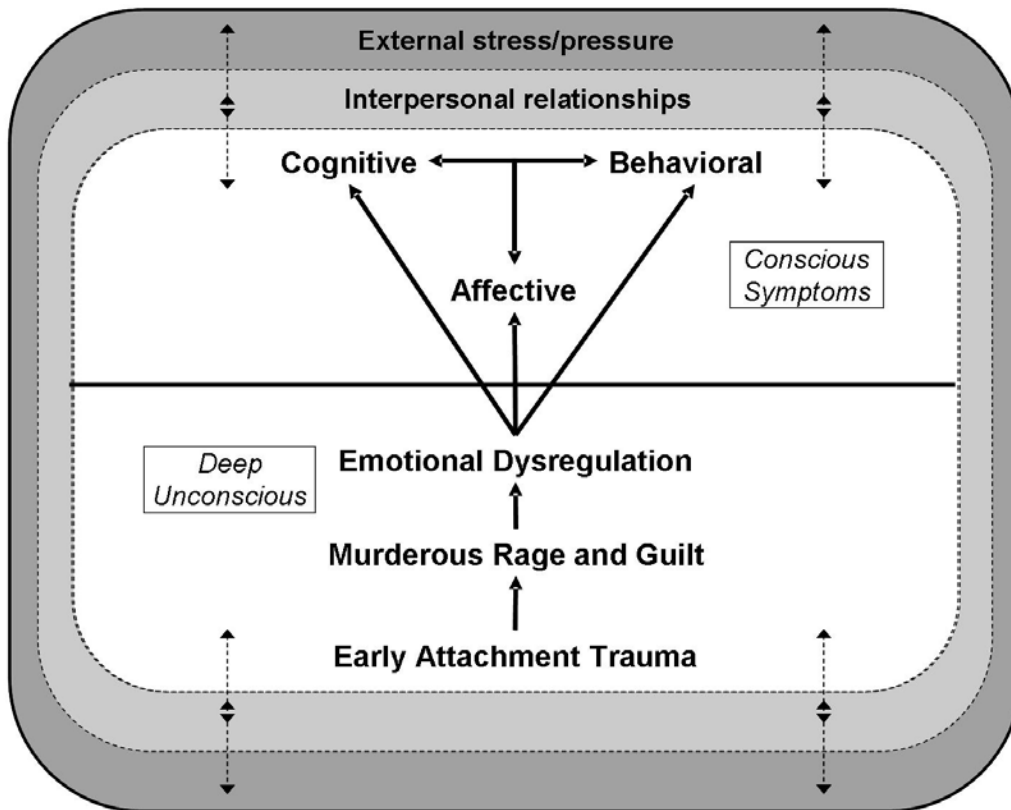


Figure 1. Mental Health Day Treatment Theoretical Model of the Development of Psychopathology

Theory of Dysfunction

Our discussions elucidated a theory of dysfunction that is grounded in a psychodynamic framework, but also flexible enough to encompass ideas related to cognitive-behavioural and interpersonal conceptualizations. Dysfunction is embedded within the dynamic unconscious wherein feelings from early childhood continue to affect the patient's current relationship and functioning. Four core themes emerged: Early attachment trauma; Early feelings of rage, guilt, hurt, and anger; Emotional dys-integration and dys-regulation and; environmental pressures contributing to the development of conscious symptoms.

Early attachment relationships form the basis of healthy emotional development. Neglect or violation of attachment needs gives rise to psychological distress and dysfunction. Normal feelings of hurt and anger (that accompany attachment trauma) are avoided because children feel conflicted about having these feelings towards caregivers and not adequately worked through and integrated. In response to attachment trauma children also make causal attributions and maladaptive assumptions about their worth and capacity

and the worth and capacity of others. They cope by avoiding negative emotions through projecting anger and blame on to others (“fight”), escaping and turning feelings inwards (“flight”), or detaching through dissociative processes (“freeze”). However, because emotions contain information foundational to the construction of healthy self, unresolved feelings result in a compromised ability to process current thoughts and emotions and further difficulty with emotional integration and regulation. The patient’s preferred way of dealing with uncomfortable emotions, (i.e., “fight”, “flight”, or “freeze”) remains relatively stable over time and is generally not marked by acute symptoms (although denotes deeper character issues). When stress overpowers the system, a collapse into symptoms occurs, providing signals of the overwhelmed state.

A Theory of Therapeutic Change

Our participatory discussion sessions elucidated the following themes related to therapeutic change: 1) belonging and trust; 2) a focus on emotion; 3) concrete tools and skills for change; 4) insight and awareness for consolidation of changes into the patient’s life; and 5) the timing and weighing of interventions to individualize the treatment.

It is by way of a strong alliance and therapeutic relationship that a patient is able to create the internal sense of belonging and trust (safety and support) necessary for program success. The alliance is conceptualized multiple levels, including the working alliance, the unconscious therapeutic alliance (i.e., the healing force within the patient which opposes and offsets resistance; Davanloo, 1990; 2000), and the therapeutic milieu, which relies on the alliance among the patients. The milieu (operating within the treatment groups in addition to more informal aspects of the program), in particular, is essential in providing a safe, strong, and contained setting in which therapy can occur. This structure and support allows the patients to access deep, painful emotions and learn to apply and practice new cognitive, behavioral, and interpersonal skills. The team is active in setting the culture of the program through: adherence to group guidelines; prioritizing the integrity of the group prior to engaging in individual work; and having an expectation of patient capacity to do the work.

Emotion-based work centered on coming to terms with core unresolved feelings is a key aspect of the program. The patient is actively encouraged to experience emotions and associated impulses and sensations directly, rather than employ characteristic maladaptive defenses. Through different program elements, the patient is helped to differentiate specific emotions and become aware of his/her characteristic patterns of avoidance. In conjunction with emotion-based work, the program provides concrete tools and skills for change that address characteristic patterns of thinking, feeling, and behaving that have developed in response to original traumas. These patterns are addressed in situ to their real-world contexts thereby providing a realistic and reasonable path to wellness. Further, patient awareness, insight and self-understanding are pivotal

in establishing autonomy, regaining a sense of empowerment, improving resilience, enabling self-management of difficulties, and ensuring emotional health. Ongoing insights into emotions, thoughts, and behavioral patterns allow the patient to further internalize knowledge and continue their work in their daily lives.

Although a group-based program, individual case formulation and case-coordination allows the team to accurately time and weigh aspects of the program in a sequence that meets an individual's needs. The treatment is individualized so that patients with a variety of immediate psychological needs can be serviced. Depending on the patient's needs, work is focused on initial safety, containment, and grounding (first phase of treatment), emotional work (second phase) and/or consolidation (final phase of treatment).

The Connection of Theory with Program Components

As evidenced through the discussion session in this project, the groups and program components within the MHDTP are linked with one another and anchored to the Theories of Dysfunction and Therapeutic Change described above. The program is aimed at the patient acquiring a holistic view of his/her unique developmental history, current difficulties, and a trajectory towards recovery from both a theoretical and pragmatic perspective. For example, Relaxation group and individual case-coordination work help to ground the patient, providing a secure base from which the patient can explore deeper issues. Some groups and components involve the examination of unconscious, emotional material and others provide exploration of conscious material/symptoms and provide concrete tools and skills for change. The complement of groups and components and their detailed relationship to the Theories of Dysfunction and Therapeutic Change are discussed in detail in our program manual (available on request).

Knowledge into Action

We sought to integrate the knowledge gained from this project into the daily clinical practice of the MHDTP program and reflect on the effectiveness and implications of doing so to further another level of understanding (Israel et al., 1998). As a team, we thought this research process was very helpful for clinical practice, *changing* the way we interact with patients on an ongoing basis. Although our knowledge about theory had been operating implicitly, making it explicit and furthering the process of theoretical integration was of immediate clinical relevance. The results of this process were compiled into a comprehensive program manual which fully details the Theories and Dysfunction and Therapeutic Change and describes how every program component relates to these theories. This manual is highly relevant for the training of learners with the MHDTP as well as the team's ongoing reflections about programming, especially when considering format changes.

Three primary areas of change can be described resulting from this research process. First, there is now greater appreciation for the need to differentiate feeling states which impact on the facilitation of groups and patient assessment. The discussions furthered understanding about conscious affective symptoms and unconscious unresolved emotions, as well as the distinction between conscious and unconscious anxiety. Second, there is an increased emphasis on establishing the appropriate pace for individual patients. We recognized that it is appropriate to slow the pace of work based for some patients (especially for fragile patients) and focus more on grounding and containment strategies. Finally, there is a greater understanding and clarity in relation to how the different components of the program theoretically relate to one another, which increases program fidelity and allowed for clearer transmission of this understanding to the patients (i.e., a holistic and multifaceted understanding of symptoms and presenting problem).

Discussion

This project related to the exploration of a multi-disciplinary MHDTP team's operating Theories of Dysfunction and Therapeutic Change using a CBPR framework. We sought a research process that was derived through the participation of all team members, directly relevant to clinical practice, and potentially informative to other groups wishing to engage in a similar pursuit. Overall, the methodology we developed was useful including differentiating roles and responsibilities of team members, the format of discussions, the iterations of discussion with thematic analysis, clarification of the results with further discussion, and incorporation of the results into clinical practice.

It was evident through the discussion sessions that our team was at ease with considering strategizes about how and why techniques may, or may not, be unified to reflect a more holistic view of the clients' difficulties and how these related back to their previously implicit theoretical models. The process was active, careful, reflective and responsive to new information clinically and empirically. Although it is possible that *foreclosure* on a theoretical perspective may be limiting for a clinician, an active and flexible position, with ongoing reflection on clinical process and implicit operating assumptions, was discovered to be helpful for this team in unifying components of a multifaceted program and deepening clinical reasoning. We acknowledge that the theoretical perspective has been developed primarily through clinical observation; however, the collective team has extensive knowledge about the peer-reviewed literature and empirical evidence regarding the use of technique. Both clinical and empirical evidence comprise the Theories of Dysfunction and Therapeutic Change described herein. We contend that an active reflective process allows for flexibility and further development of theory, thus allowing for recognition of falsification and subsequent modification.

In general, the theory described herein is a *comprehensive* theory encompassing both how patients develop psychopathology (Theory of

Dysfunction) and how they can be treated (Theory of Therapeutic Change). It is a theory that is *emergent*, arising from the interactions among the team, between the team and the patients, and among the patients themselves (the therapeutic milieu). The theory is reflective of a process of ongoing discussion that is *dynamic, thoughtful, and responsive* to the day to day workings of the program and clinical population. Finally, the theory reflects a *clinical/empirical* process that incorporates both case information as well as empirical literature. It is possible that these characteristics are common to other MHDT program theories, as well. In order to begin to understand the components of MHDT, as called for by numerous researchers (Karterud & Urnes, 2004; Karterud & Wilberg, 2007; Mortl & Von Wietersheim, 2008; Orgradniczuk & Piper, 2001) it would be advantageous to begin to dialogue about the role of theory across different programs.

In consideration of the research process and our findings, two caveats must be mentioned. First, we elected not to audiotape and transcribe our discussion sessions. This may have led to inaccuracies in the thematic analysis. However, we contend that this risk was mitigated to an extent by the presentation of themes in writing back to the team and ongoing discussion of the analysis each week. We further contend that the ease and speed of using field notes was beneficial in allowing the discussion session to occur in close succession (on a weekly basis) and may aid in providing a realistic method that bridges the clinical utility/research gap. Second, in this investigation, we decided to utilize only the perspective of the team, rather than include the patients attending the treatment program. Although we certainly recognize the importance of knowing the patients' understanding of the program, we considered it advantageous as a first step to elucidate the operators' understanding of Theories of Dysfunction and Therapeutic Change and their intention in communicating these views to the patient. We are now in the process of extending our knowledge about theory and the program's operation to include patient perspectives. We contend that the unique opinions of individual patients concerning illness and wellness will do much to further our knowledge and enrich our theory.

Conclusions and Recommendations

This project provided an opportunity for our team to have an ongoing, dynamic discussion about the theoretical basis of the MHDTP. Local theory was functioning implicitly in the program and this project explicated and integrated the specifics. We found the experience very helpful, noting changes that ensued in daily clinical interactions. We underscore the relative simplicity of the research methodology, inviting other teams to undergo a similar process in order to better understand the theoretical grounding of their programs and how this is reflective in patient interactions in order to improve clinical care.

Specific recommendations for the exploration of local theory are as follows:

- Develop and formalize a forum for the discussion of local theory.

- Consider both Theories of Dysfunction and Therapeutic Change with an emphasis on their relationship to programmatic elements.
- Discuss and consider roles and responsibilities of each team member in the research process including a point person to summarize in writing the themes derived from discussions.
- Contextualize theory within the broader empirical literature.
- Clarify terms so that every team member has a shared understanding.
- Discuss continuing education participation in order to advance knowledge and incorporate new elements into the existing theoretical framework.
- Plan, execute, and evaluate active ways of incorporating knowledge about theory into daily practice.

Authors:

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