

Client experiences of receiving adapted Dialectical Behaviour Therapy (DBT) and its perceived role in the process of change

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Abstract

Research into Dialectical Behaviour Therapy (DBT) has been dominated by the neo positivist paradigm providing clinical practice with a sufficiently robust evidence base for DBT as an intervention, reporting positive outcomes with regards to reducing symptoms of Borderline Personality Disorder (BPD). However, in recent years, DBT has been adapted and replicated to different client groups, offering potential for new research into transdiagnostic applications and adapted versions of DBT to different settings.

Recent literature concludes that there is less practice-based evidence on the process of change in DBT, and which components are useful. The client voice is lacking in the literature, which would provide services with evidence and unique insights into how the therapy works and for whom.

This study aims to address these questions, by asking the clients how they experience DBT and its perceived role in the process of change. Furthermore, the study focusses on client experience in a private hospital setting with a transdiagnostic group of an adapted 12 week DBT programme.

Interpretative Phenomenological Analysis (IPA) was applied as the methodology, incorporating descriptive, linguistic and conceptual elements in analysis of semi-structured interviews. The sample consists of five participants whom had completed a 12 week DBT programme at a private hospital.

Three master themes were identified, namely ‘Pre DBT: Crisis & Desperation’; ‘In-session: Belonging’; and ‘The Real World: Living’. Each master theme was characterised by 4 sub-themes, illustrating the journey of the participants and the perceived process of change. All themes were conceptualised by the overarching theme ‘The private setting: Heterotopia’, giving voice to the role of the context of the private psychiatric setting.

The research findings illustrate that this version of DBT was a helpful and positive experience for participants, where outcomes included being able to build a life worth living, feel hope and joy, build DBT skills into a lifestyle, connect with a sense of spirituality and develop reflective practice. The implications for service delivery and for Counselling Psychology are discussed, along with ideas for future research.

Acknowledgements

I placed a keen emphasis on wishing to contribute to the field of DBT through this piece of research, and therefore attended the annual conference of the ‘Dialectical Behaviour Therapy Society in Britain and Ireland’, in Dublin last year. There I was lucky to meet Dr Christine Dunkley, to whom I should like to thank for putting me in good stead to draw good conclusions from my qualitative study.

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GLOSSARY

Acting Opposite

a DBT skill which teaches clients to act in the opposite way to an emotion's action urge with the aim of reducing the intensity of the emotion. E.g. a person feeling depressed would have the urge to withdraw. Acting opposite would be to reach out in some way to others, such as making a telephone call or being around people.

Behavioural Chain Analysis

a technique designed to help a person understand the function of a particular behaviour. During a chain analysis of a particular problem behaviour (for example, self-harm), a person tries to uncover all the factors that led up to that behaviour in a step by step diagram of events and emotions.

Dialectical

- i. The process or art of reasoning through discussion of conflicting ideas.
- ii. the notion that two opposing ideas can be true at the same time. In DBT, there is always more than one way to think about a situation, and all people have something unique and different to offer. A life worth living has both positive and negative aspects (happiness, sadness, anger) and all of these aspects are necessary and valuable. Dialectics allows for a balance between acceptance and change, both of which are necessary for establishing a fulfilling life.

Distress Tolerance

- i. skills which are used when it is difficult or impossible to change a situation. Their aim is to help individuals cope and survive during a crisis, and tolerate short term or long term pain (physical or emotional).
- ii. the name of one of the 4 core modules of DBT.

Emotion regulation

- i. learning to understand how emotions work, and the skills needed to manage emotions as opposed to being managed by them. Includes how to reduce vulnerability to negative emotions, and to build positive emotional experiences.
- ii. the name of one of the 4 core modules of DBT.

Heterotopia

literally meaning 'other places'. A diverse concept that describes a world misaligned with respect to normal or everyday space, elaborated by philosopher Michel Foucault (1966) to describe places and spaces that function in non-hegemonic conditions.

Interpersonal Effectiveness

- i. refers to the skills which help us to: Attend to relationships. Balance priorities versus demands. Balancing the 'wants' and 'shoulds' to build a sense of mastery and self-respect.
- ii. the name of one of the 4 core modules of DBT.

Mindfulness

- i. based in Eastern Zen philosophy, and includes Western contemplative practices. An awareness of thoughts, feelings, behaviours, and behavioural urges through their constant observation.
- ii. The name of one of the core 4 modules of DBT.

**Non-suicidal self-injury
(NSSI)**

deliberately injuring oneself without suicidal intent. The most common form of **NSSI** is self-cutting, but other forms include burning, scratching, hitting, insertion of objects into the skin.

Radical acceptance	complete acceptance of the things (traumas) that cannot be changed. It is acceptance from the depths of the soul, with heart and mind. It is the decision to stop fighting reality, thereby causing less suffering.
Validation	To confirm, to verify, to authenticate – emotions and experience.
Wise-Mind	wise mind is that place where reasonable mind and emotion mind overlap. It is the integration of emotion mind and reasonable mind. Linehan (1993b) states, "Wise mind is that part of each person that can know and experience truth. It is where the person knows something to be true or valid."

List of figures and abbreviations used

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Abbreviations used

ACT	Acceptance and Commitment Therapy
APA	American Psychiatric Association
BCA	Behavioural Chain Analysis
BPD	Borderline Personality Disorder
BPS	British Psychological Society
CPA	Care Programme Approach
CPD	Continuous Professional Development
DBT	Dialectical Behaviour Therapy
DCOP	Division of Counselling Psychology
DSM	Diagnostic and Statistical Manual of Mental Disorders
HCPC	Health & Care Professions Council
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
NICE	National Institute of Clinical Excellence
OCD	Obsessive Compulsive Disorder
UEL	University of East London

INTRODUCTION

When thinking about undertaking a piece of research into the complex matrix of psychological therapy, I felt that the main aim was to contribute to the field of Counselling Psychology, whilst also doing justice to the voices of the clients we work with. As a fourth year doctoral student, I have spent 5 years working in mental health in a variety of settings and with a variety of client groups. Nothing feels more poignant in this work than the wellbeing of the clients, and the messages they give us constantly about the treatment and care they experience within mental health services. I feel that it is the clients to whom we owe so much – for their insight, their knowledge, their inner experiences – which reveal what really occurs in mental health services, and how we as professionals can learn to improve. This study is a qualitative piece of work, and as such, reflexivity of the researcher runs fluidly throughout.

i. Reflexivity

My interest stems from the time I was employed as a Psychology Assistant prior to my training on the Doctorate for Counselling Psychology. I was working on a low secure inpatient ward in a private hospital, for females diagnosed with Borderline Personality Disorder (BPD). Clients would be admitted having spent years of their lives in hospital, most often on section under the Mental Health Act, with a history of being ferried around psychiatric services from one treatment modality or pharmacological intervention to the next. Typical behaviours would include self-harm or self-mutilation, insertion of objects into the skin, absconding, suicide attempts, substance misuse and comorbid eating disorders. Admissions were of one year or 18 months in duration, with Dialectical Behaviour Therapy (DBT) as the therapeutic intervention. I would work 12 hour shifts on the ward, managing risk by keeping patients¹ safe and dealing with issues around self-harm and other problem behaviours, carrying out daily activities, and delivering some of the DBT groups such as Mindfulness – whilst developing good therapeutic relationships. This work provided me with an invaluable immersive experience to understanding the lifeworlds of those diagnosed with BPD. Working in close proximity to highly distressed individuals did not come without its

¹ The term 'client' is accepted in the field of Counselling Psychology as a term to describe people engaged with mental health services. However, in terms of my reflexive stance, I have worked in inpatient settings where the term 'patient' was commonly used, as well as it being used as a term by clients themselves. This term will therefore be used intermittently in this thesis, with an awareness of the connotations and potential associated stigma of what the term 'patient' may mean as opposed to 'client' (McGuire-Snieckus, 2003; Wing, 1997).

challenges (Perseius, Kaver, Ekdahl, Asberg & Samuelsson, 2007), sparking intrigue and enthusiasm to delve deeper into understanding the lifeworlds of those taking part in DBT. My phenomenological intrigue was in contrast to what appeared in the literature to be a misrepresented group of clients, whose voice was less present and was largely characterised by Randomised Control Trials (RCTs) within the quantitative paradigm as evidence-based practice. As an untrained professional at the time, I was hungry for knowledge as to ‘what to do’ in my role as a healthcare worker, and would have welcomed reading research outcomes on how to adopt and facilitate a therapeutic stance with this client group (Liebenluft, Gardener & Cowdry, 1987). Furthermore, the depth of the clients’ knowledge about their own conditions and engagement with the therapy was impressive to me, but not reflected adequately in the literature. The clients would talk insightfully and at length about their experiences in psychiatric services, with a deep understanding of what worked and did not work for them. Central to my interest was to understand more about DBT as the treatment of choice for BPD clients, who prior to the 1980s, were cast aside as either difficult or impossible to treat. This led to my interest in DBT in general, not only for BPD, but for others diagnosed with different disorders by our medical healthcare system. It seemed that both therapists and clients could benefit from knowledge on what it is like for people to experience DBT in various contexts.

I undertook reflexivity to consider my positioning as a healthcare worker within a medicalised psychiatric system, but with a phenomenological ‘lived experience’ of working closely with patients and trying to understand their lifeworlds through the use of advanced empathy. I realised that I saw the patients as the experts, and that I was an observer to their distress and experiences of psychological therapies, as well as being someone who embodied the nature of what they wished to become. They wished to move from a position of suffering to a position of living and ‘being in the world’, which was projected onto the healthcare workers who were perceived by the patients as being ‘well’ as opposed to ‘ill’. I was keen to delve deep into the lifeworlds of patients, but also concerned with maintaining professional and therapeutic boundaries which felt challenging when undertaking tasks with patients which would assume a stance of a mother or friend, such as taking them shopping, going to the cinema, eating with the patients, dressing them, and watching TV. I realised that the DBT model was key in not only helping the patients recover, but also to protect and look after the staff members. The challenge was to strike a balance between my phenomenological intrigue and my natural tendency to use advanced empathy, and my stance as a mental health professional

interested in DBT and the way in which it was pivotal in the process of change. I realised that a qualitative piece of research should aim to encompass all these positions and tensions which I was attempting to hold and embody. In the methodology chapter of this thesis, I address researcher bracketing and how these tensions and prior experience come to influence the construction of data within a qualitative study.

ii. Introducing DBT as a treatment for BPD

DBT is a model of psychological therapy developed in the 1990s by Marsha Linehan (1993a, 1993b & 2015), an American psychologist with a former diagnosis of BPD. Up to this time, mental health services were having difficulty finding effective treatments for highly suicidal individuals, who would present to services with a pervasive pattern of impulsivity, unstable affect, interpersonal dysfunctioning and identity instability (American Psychiatric Association (APA), 2013) usually with a diagnosis of BPD.

RCTs were launched in the 1990s to investigate the efficacy of DBT for this client group (Linehan, Armstrong, Suarez, Allmon & Heard, 1991; Linehan, Heard & Armstrong, 1993). They indicated positive outcomes, reporting significant reduction in suicidal and non-suicidal self-injury (NSSI; Koerner & Linehan, 2000). Given the long history of finding a treatment model that is effective for treating people at this severe end of the mental health spectrum, this revealed a revolutionary advancement in finding an effective therapeutic intervention for suicidal individuals and helping them build a life worth living.

iii. DBT and its underpinnings

DBT is a complex psychological intervention developed using some of the principles of Cognitive Behavioural Therapy (CBT) in combination with mindfulness-based and systemic strategies. These principles of the therapy are based on the notion of the biosocial theory (Linehan, 1993a & 1993b), whereby it is accepted that people who suffer with severe symptoms have a genetic predisposition to emotion dysregulation, coupled with an invalidating childhood environment to hold or heal any trauma which may occur. This double bind means that those predisposed to emotional dysregulation and suffer early trauma, such as severe neglect or abuse, will most likely develop symptoms of BPD or other mental health issues (Linehan, 1993a & 1993b; Linehan, 2015). From a phenomenological standpoint, this would be characterised by a lifeworld so wrought with the pain of emotions such as sadness, fear and anger, as well as the sense of being completely unwanted and unlovable. The constant embodiment of such emotions and pain would understandably lead

to the wish of an end to suffering, perceived to be achievable only through suicide, or other behaviours aimed at alleviating pain even if for a short period of time.

Initially DBT was a treatment of one year to 18 months in duration, usually in inpatient settings for people who have had a long history of suffering with symptoms that have led to them feeling suicidal for most of their lives. Whilst adaptations of this model now exist, the fundamental principles and teaching of skills will pervade most new replicas. The model is comprised of four modules namely Mindfulness, Emotion Regulation, Interpersonal Effectiveness and Distress Tolerance (Linehan, 1993b & 2015). These core modules aim to equip clients with the skills they need to deal with the pain associated with living with disorganised and painful emotions and those impulsive behaviours aimed at alleviating difficult lifeworlds. DBT takes the seriousness of these presentations in a validating and thorough manner, by offering individuals four modes of intervention – group therapy, individual psychotherapy, phone calls and consultation team meetings (Linehan, 1993b). The principle of ‘acceptance versus change’ is fundamental to DBT, tying in the Eastern Zen approach through mindfulness to the challenging aspects of altering problem behaviours such as NSSI.

DBT has now been widely accepted as the treatment of choice for BPD (Linehan, 1993b & 2015) and has been incorporated into the National Health Service’s (NHS) National Institute for Health and Care Excellence (NICE) guidelines:

‘an intensive psychological treatment that focuses on enhancing a person’s skills in regulating their emotions and behaviour. It aims to address and alter patterns of behaviour by finding a balance or resolving differences (this is what is meant by ‘dialectical’).’ (NICE Guidelines, 2009b).

Following empirical evidence reporting successful outcomes and the introduction of DBT into the NICE guidelines, various adaptations of the standard model came to fruition, with the recognition by clinicians that DBT can be replicated for the benefit of different client groups in various settings (Brazier et al., 2006; Koons, Robins, & Lynch, 2001; Ritschel, Cheavens & Nelson, 2012; Ritschel, Lim & Stewart, 2015; Robins & Chapman, 2004; Swales, Heard, Mark & Williams, 2000). However, the policy around DBT in the UK is rather thin given the body of evidence and literature which now surrounds this psychological therapy and the variety of client groups it offers to help. Thought will be given throughout the thesis with

regards to ideas for policy making and suggestions for improvement with the view that DBT would be better placed at the fore of mental health care provision.

The DBT Society in Britain and Ireland held their annual conference in December 2015, the title of which was 'Journeys - Adapting and Adopting DBT'. This concept is very much at the forefront of questioning the delivery of DBT in current healthcare settings (Swales, Taylor & Hibbs, 2012). In this regard, the importance of continuous research into all such replicas is well documented, to add to the increasing evidence base of what elements of DBT work for whom, how, and in which settings.

iv. The current study

The present study aims to address a gap in the literature by conducting a qualitative inquiry with clients who have attended a 12-week adapted DBT programme in a transdiagnostic group at a private psychiatric hospital. It is hoped that through drawing on experiences of clients who have used DBT as a form of treatment, that the findings would be able to make a contribution to Counselling Psychology by providing clinicians with unique accounts of inner-experiences of clients receiving adapted DBT in a private setting. The findings will build on an existing evidence base for adapted forms of DBT in various settings, and give voice to the process of change which may lead to further research on how to enhance service delivery. Qualitative research has been described as a form of social enquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live (Smith, Flowers & Larkin, 2009). It does not seek to provide unequivocal answers but a range of experiential accounts. Experiential accounts have been considered as essential building blocks in constructing a better understanding of change (Carey, Carey, Stalker, Mullen, Murray & Spratt, 2007) which could potentially lead to increased insight enhancing treatment intervention and paving the way for future research.

CHAPTER ONE

Literature Review

Introduction

The literature review will aim to present and critically evaluate the research that has been undertaken in the field of DBT to date, with a particular focus on the areas which pertain to the research questions. I will attempt also to give the literature a critical realist but phenomenological voice, which is in line with my current stance as a researcher and the positioning of the work and methodology. The research into DBT was largely represented by the quantitative neo-positivist paradigm until more recently. There is therefore some tension regarding research which presents DBT as a form of evidence-based practice as opposed to practice-based evidence, and I aim to illustrate both giving the sense of a rich and varied research base from which to later draw conclusions.

1.1 Search strategy

In order to ensure a search of breadth and depth, the literature search function on the advanced version of EndNote was used, which has the capabilities to search the MedLine, PsycInfo, Ebsco and Cochrane databases, and cross-referenced with the list provided on Marsha Linehan's website (<http://www.linehaninstitute.org>) of RCTs undertaken in DBT, before using specific search terms. The literature search was broken down into the headings of this chapter, to not only give a general overview the research base for DBT, but specifically to explore the research topics which pertain to client experience, the process of change, and the experience an adapted DBT programme for a transdiagnostic group in a private setting.

1.2 Evidence-based practice & the efficacy of DBT

Within the medicalised psychiatric system, DBT currently stands as a treatment of choice for BPD (APA, 2013; NICE, 2009), backed up with considerable empirical evidence for its efficacy. RCTs have therefore focussed predominantly on clients with a diagnosis of BPD, although there is a body of research focussed on other diagnostic groups. Quantitative research has been carried out to test the effectiveness of the standard DBT model (Feigenbaum, Fonagy, Pilling, Jones, Wildgoose & Bebbington, 2012; Koons et al., 2001; Linehan et al., 1991; Linehan et al., 1993; Linehan et al., 2006; Stepp, Epler, Jahng & Trull, 2008). These findings indicate that DBT seems to reduce the severe dysfunctional behaviours that psychiatric services seek to target and 'treat'. These behaviours include suicidal intent, non-suicidal self-injury (NSSI), substance abuse, and binge eating. The

research highlights that if clients are positively engaged, DBT can enhance treatment retention and reduce psychiatric hospitalisation (Koerner & Linehan, 2000). Whilst this evidence and positive view of DBT is interesting and provides services with the evidence they need to apply for funding, it leaves out the client voice and phenomenology which Counselling Psychology and the qualitative researcher seeks to approach. It may suffice to say that the evidence base for DBT is a necessary platform providing empirical evidence, but omits what therapists need to know and do to truly connect with their clients in a humanistic way, thereby increasing retention and recovery, as well as therapist job satisfaction as opposed to burnout.

DBT is not alone in having an evidence base as an intervention for BPD, highlighting the commitment of the mental health profession to help and find appropriate therapy for this client group. Other existing empirically supported treatments include transference-focused therapy (TFP; Kernberg, Yeomans, Clarkin & Levy, 2008), cognitive analytic therapy (Ryle, 2004), cognitive behavioural therapy (Davidson, 2007; Matusiewicz, Hopwood, Banducci, Lejuez, 2010), mentalisation-based treatment (MBT; Bateman, Ryle, Fonagy & Kerr, 2007), schema-focused therapy (SFT; Giesen-Bloo et al., 2006; Young, Klosko, & Weishar, 2003), psychodynamic psychotherapies (Gabbard, 2001), the Unified Protocol (UP) for Transdiagnostic Treatment of Emotional Disorders (Barlow, Allen & Choate, 2004) and general psychiatric management (GPM; McMain, Guimond, Streiner, Cardish & Links, 2012). The more psychotherapeutic approaches claim slightly different mechanisms of action, according to their underlying specific aetiology models. Psychoanalytically-based therapies usually emphasise and use the therapeutic relationship as a model for other relationships, whereas cognitive behaviour therapy-based therapies primarily aim at acquiring new learning experiences and general self-management skills (Chapman, 2006).

The fact that so many other modalities exist is interesting to the phenomenological researcher, seeking to understand more about the phenomena of the helpful elements of therapy and the lived experience of clients. It lends to questions about what therapies are working and for whom, regardless of diagnosis, pathology, and medicalised terms. Perhaps there are other elements which are influencing what is perceived to be ‘effective’ therapy, such as the context the therapy is delivered in, what kind of person is engaging in the therapy in terms of their character and what feels comfortable for them, socio-economic status, and the length of time clients have been in and through the ‘psychiatric mill’ or revolving door of psychiatric services.

For DBT, the most influential of all studies is in the form of a two-year RCT and follow up of DBT versus therapy by experts for suicidal behaviours and BPD in the USA (Linehan et al., 2006). This RCT replicated previous empirical findings of the effectiveness of the model (Koerner & Linehan, 2000; Koons et al., 2001; Linehan, et al., 1991; Linehan et al., 1993) and concluded that DBT appears to be uniquely effective in reducing suicide attempts. Suggestions for further research included finding ways to keep more suicidal clients enrolled, perhaps by breaking down the components of DBT and client experience to discover what elements of DBT work and why, lending to the need for a practice-based evidence approach in new research.

A real-world study of the effectiveness of DBT in the UK National Health Service (NHS) was carried out to build on existing empirical evidence and to critically evaluate the perceived effectiveness of the model (Feigenbaum et al., 2012). Despite the popularity of and governmental support for DBT, concerns have been raised as to whether the growth of DBT in clinical settings has preceded the establishment of a sufficiently robust evidence base dominated by RCTs (Scheel, 2000). On this basis, the aim of Feigenbaum et al.'s (2012) study was to consider the effectiveness of DBT provided by mental health professionals with the level of training and supervision anticipated in a standard outpatient specialist service. The study found that there were no differences between DBT and the control group, which is in accordance with Burckell & McMain (2011) who found no differences between DBT and general psychiatric management for BPD in an outpatient clinic in Canada. The conclusive remarks went on to say that whilst the efficacy of DBT has been established, the evidence base for the effectiveness of DBT in standard clinical settings remains under researched. This brings in the need for a more qualitative inquiry into the phenomena of DBT and how these are described by clients as either helpful or unhelpful, taking into account contexts and lived experience.

A further interesting slant to the empirical evidence is the effect of the therapeutic alliance, which especially in Counselling Psychology, is considered to be one of the most important factors in client recovery (Ardito & Rabellino, 2011; Horvath, 2001; Horvath & Symonds, 1991). Feigenbaum et al., (2012) suggest that the dropout rates in their study were due to a therapist leaving the programme, and the subsequent effect this had on clients, which for borderline personality would feed into the trait in the diagnosis of fearing abandonment (APA, 2013). The paper went on to say that it was difficult to ascertain if 'DBT' was in fact delivered at all, and perhaps it was clients that attached to the supportive therapeutic

environment that facilitated client recovery. This throws up an interesting area of tension between this and other RCT studies which advocate ‘effectiveness of DBT’. It may be that in fact it is the therapeutic alliance, and not the model of therapy which is the overarching factor in client recovery (Martin, Garske & Davis, 2000), and thereby highlights the need for adherence to the DBT model in order to test its effectiveness. Since the common factors model of therapy is now the more dominant paradigm, (Hofmann & Barlow, 2014) it would seem appropriate to focus more on the therapeutic relationship, client lived experience of change, and the contexts of the services in which DBT is delivered.

Scheel’s (2000) critical review of DBT studies concluded that although results to date are promising, there remain methodological difficulties in the limited research base that supports this ‘eagerly received clinical approach to borderline personality disorder’ i.e. DBT has demonstrable effectiveness, but why or how is not known. Chapman’s (2006) review highlighted five functions of delivering DBT which need to be met to ensure effectiveness, and gave considerable emphasis to therapist training and knowledge of emotions and emotion regulation. The individual components and modules of DBT, client experience of the intervention, and *how* change occurs remains largely under researched, as concluded in several studies (Brazier et al., 2006; Feigenbaum, 2007; Hodgetts, Wright & Gough, 2007; Linehan & Wilks, 2015; McSherry, O’Connor, Hevey & Gibbons, 2012; Perseus, Ojehagen, Ekdahl, Asberg & Samuelsson, 2003; Robins & Chapman 2004). It would seem that the people the system seeks to treat in medicalised clinical terms, are left out of the evidence in terms of what they may have to offer in terms of what is helpful and unhelpful about the therapy as well as ideas for enhancing the delivery of the model.

The evidence base for DBT was pulled together comprehensively in 2012 (Stoffers, Vollm, Rucker, Timmer, Huband & Lieb, 2012) whereby 28 studies of 1804 participants regarding the effectiveness of the intervention was evaluated. The study concluded and thereby officially recognised DBT by The Cochrane Review (2012) as the treatment of choice for characteristics associated with BPD in the USA, including impulsivity, interpersonal problems, emotional dysregulation, self-harm, and suicidal behaviours. These same characteristics distinguish the clients labelled as most ‘difficult to treat’ in the mental health system. This is a promising review within this paradigm, and emphasises the need for similar studies in the UK and Europe so that policy, such as NICE, is able to advocate the use of DBT more widely. However, it is also clear that the client voice and practice-based evidence

is pivotal in shaping policy, in terms of how clients are assessed for such an intervention, taking into consideration how DBT works and for whom.

Drop-out rates have been reported as an issue in DBT, which according to the literature has been largely due to the impulsivity of the client group and difficulty in retaining in any form of treatment (Feigenbaum et al., 2012; Koerner & Linehan, 2000; Linehan et al., 2006; Kroger, Roepke & Kliem, 2014; Rusch et al., 2008). Whilst there is empirical evidence to suggest that those that stay in DBT treatment recover and have an enhanced quality of life, Stoffers et al. (2012) found no statistical superiority of DBT in terms of keeping participants in treatment. The process of change and motivation of the clients to stay in treatment have been reported as poignant factors for future research (Robins & Chapman, 2004; Hodgetts et al., 2007) as little is known about what change is fundamentally comprised of and what therapists need to know and do to enhance outcomes (Koerner, 2013). However, these remarks indicate a deficit in the client as opposed to shifting the gaze towards services and how they could improve to help engage clients. It would seem that there is a need for qualitative research into client experience so that delivery of the therapy can be enhanced, paving the way for future RCTs which together, could aid in informing policy around the dissemination of and recommendations for DBT.

From the phenomenological stance, it is interesting to think about the lived experience of clients engaging in DBT, potentially feeling stigmatised or pathologised through assessments for a programme advocated in clinical terms. Gaglia (2013) found that clients who came to DBT from the Care Programme Approach (CPA) often dropped out, due to the emphasis on change in DBT. The CPA is known for keeping patients safe and managing risk, but with less challenge presented in terms of asking individuals to change. The lived experience of DBT could perhaps be frightening for clients who are fearful of what it means to change and give up behaviours that keep their painful lifeworlds at bay. It also presents the client as one with perceived deficits in character, whereas in practice, it takes a skilful and well trained team of therapists to present the ‘acceptance versus change’ philosophy of DBT in a validating and non-threatening way.

Following RCTs and reviews focussing on efficacy and effectiveness, more recent quantitative literature has sought to discover which elements of DBT work, and for which diagnostic groups. For example, individuals with BPD and symptoms PTSD were investigated (Harned, Jackson, Comtois & Linehan, 2010), individuals diagnosed with an

eating disorder such as Bulimia Nervosa or Binge Eating Disorder (Chen, Matthews, Allen, Kuo & Linehan, 2008; Kroger et al., 2010; Safer, Telch & Agras, 2001) and skills-only training (Wolf, Ebner-Priemer, Schramm, Domsalla, Hautzinger & Bohus, 2011) which published positive results in terms of reducing negative symptoms. In terms of researching which specific skills are effective, studies have looked at homing in on either one module, such as Mindfulness (Soler et al., 2012), or creating mobile apps providing access to an online DBT coach (Rizvi, Dimeff, Skutch, Carroll & Linehan, 2011). Research has also focussed on specific diagnostic categories which will be discussed later when looking at DBT's application to transdiagnostic groups.

Overall, the effectiveness and efficacy of DBT has been proven by a firm and robust evidence base, for those who engage in DBT and are retained in the programme. However the dropout rate, currently standing at 27% (Gaglia et al., 2013), is indicative of DBT not working for some clients. This perhaps advocates the need for a more phenomenological and practice-based approach to research in the field of DBT. This would place clients as the experts in enhancing clinician knowledge of the delivery of the therapy, as opposed to reliance on statistical outcomes deeming it 'effective'. There is also a very lively and current debate as to how the model can be effectively adapted and adopted to different client groups, and to which settings, as well as understanding which elements of DBT work and why. This throwsup dilemmas around the usage of other treatment models as opposed to DBT as standard, which will be discussed further on in this chapter.

1.3 Practice based-evidence and the client voice

Quantitative research and the adaptations of DBT have paved the way for more intricate qualitative research in recent years, aiming to elicit client voice to gain a better understanding regarding the delivery of the model and how it works. Furthermore, practice-based evidence has been advocated as a promising paradigm for Counselling Psychology (Henton, 2012).

Published qualitative studies have explored the contribution clients can offer about their experiences of DBT. Perseus et al. (2003) interviewed 4 therapists and 10 clients, analysed with qualitative content analysis. The study reported DBT as life changing in reducing suicidal behaviour and giving clients a bearable life situation. It was suggested that a challenge for further qualitative DBT research would be to understand in more detail why and what components that work, so that the model and its adapted forms can be used more widely in psychiatric services.

Cunningham, Wolbert & Lillie (2004) undertook a study into a 15 month programme of DBT and interviewed 14 clients about their opinions of the programme and treatment impact. Interpretative analysis of the interviews revealed both positive and negative aspects of the therapy, indicating that clients found positive benefits of being in a group where there was reduced stigma around their illness, and they could learn from others. They also highlighted that the delivery of DBT can be overly intricate, and that appropriate levels of therapist awareness and training is essential. Cunningham et al. (2004) concluded that the level of hope was paramount to recovery and led to clients being able to develop a 'life worth living'.

Closely linked to the current study is research carried out by Hodgetts et al. (2007) who undertook a qualitative piece using Interpretative Phenomenological Analysis (IPA) to interview 5 participants diagnosed with BPD on their experience of DBT in the NHS. The study reported results under three main themes – joining a DBT programme, the experience of DBT and evaluation of DBT. Research implications from the study included the potential for theory development in relation to treatment completion by incorporating user experiences. This feeds in nicely to the current study which aims to build on this evidence base of user experiences to pave the way for theory regarding dropout rates, thus enhancing service delivery. The current study of the private healthcare system can sit alongside the findings of Hodgetts et al. (2007) with the aim of providing a basis for future research to develop theory and enhance retention rates in a variety of mental health settings (Marra, 2005).

McSherry et al. (2012), conducted semi-structured interviews and focus groups to examine clients' perspective on the effectiveness of an adapted DBT programme in a community mental health setting, and its impact on their daily lives. The study found that BPD's classification as a psychiatric disorder detracted from the traumatic histories of the clients and pathologised their psychological distress as being symptomatic of illness. McSherry et al. (2012) concluded that DBT may be an effective treatment delivered by community services for individuals with a personality disorder, but that further studies are needed to consider the impact of experience and adherence to DBT in improving outcome. This links back to the research on dropout rates which is only possible to truly understand through qualitative work by interviewing clients who have disengaged with the therapy and their reasons. Further to Gaglia et al. (2013) identifying the CPA as a barrier to retention, Barnicot, Couldrey, Sandu and Priebe (2015) went on to undertake thematic analysis on the perceived barriers to skills training specifically. They concluded that clients who experienced high anxiety as part of the

skills training groups were most likely to dropout of the treatment, thereby highlighting the importance of the role of the therapists in managing client emotion.

The qualitative research has aimed to elicit the client voice, missing from quantitative studies and therefore limiting knowledge on how clients perceive the therapy, and which elements work for them and why. If clinicians are to improve service delivery, and academics are keen to know which elements of DBT are helpful, then qualitative research is essential to understand more about these facets at the level of the clients, as well as the client-therapist interactions (Koerner, 2013). My piece of work will hopefully build on research to date, by attempting to understand from a phenomenological viewpoint, how clients experience the therapy including what elements of DBT were helpful and unhelpful. Although clients in this study will all have been positively engaged in DBT and not dropped out, it will pave the way for future research on client dropout specifically, so that we can begin to obtain a fuller picture of what people are saying is helpful and unhelpful, whether they have remained engaged in a DBT programme or not.

1.4 Adaptations and Settings

There is a body of research in the field which pertains specifically to how to adopt and adapt DBT, and to which settings. There is a concern that adapting DBT outside the standard model presented by Linehan's group (1993a & 2015) would compromise on the therapeutic elements of the model. It is advocated that implementing DBT with fidelity to specific evaluated protocols is considered the best way to maximise client outcomes (Dimeff, Koerner & Swenson, 2007). Others (Marra, 2005; Pederson, 2015; Ritschel et al., 2015) argue for a less prescriptive delivery of the model, where fidelity is kept but with flexibility, claiming that there is no evidence to support that high fidelity and adherence to specific ingredients are needed for successful outcomes. This would allow for DBT to be adapted, adopted and replicated into different settings and for different diagnostic categories, as long as the client and therapist assumptions of the model are honoured (Marra, 2005; Pederson, 2015; Swales et al., 2012). In phenomenological research therefore, the researcher would be interested in client experience with regards to the context within which the therapy is being delivered. This would add to previous studies and reviews and help to pacify a debate around which context may be 'better' or lead to positive engagement as opposed to dropout. My study will seek to address this, by forming research questions around the context within which the

therapy is delivered, to understand more from the client's perspective, how DBT is experienced within a particular context – in this case the private psychiatric hospital setting.

There is a split between the research groups and the context in which DBT is currently delivered. In the USA, Linehan's group in Seattle works on RCTs and delivery of DBT into state hospital settings. Meanwhile other groups, such as Pederson (2015) and Marra (2005) have published on the dissemination of DBT into private practice. In the UK, Feigenbaum et al. (2012) amongst others have largely conducted research in the NHS, whilst qualitative papers have addressed samples in the community. The qualitative research into the private setting remains under represented, especially from a qualitative standpoint. Undertaking this research from a phenomenological viewpoint would aid in addressing important questions such as how clients experience DBT in a private context and offering a platform for future research to compare this with other settings. It would help the DBT community ascertain what it specifically is about contexts that clients would deem important in retention and recovery.

In terms of adapting and replicating DBT to variety of diagnostic groups, empirical evidence now exists. Adaptations of DBT include DBT for PTSD (Bohus et al., 2013), DBT for the eating disorders (Wisniewski & Porath, 2015), Radically Open DBT (Lynch, Hempel & Dunkley, 2015) DBT for forensic inpatients (Nee & Farman, 2007), DBT for individuals who meet BPD criteria but are also drug-addicted (Dimeff, Rizvi, Brown, & Linehan, 2000) as well as adaptations for adolescents (Fasulo, Ball, Jurkovic & Miller, 2015; Miller, Rathaus & Linehan, 2007; Rathaus & Miller, 2015) and short-term programmes (van den Bosch, Sinnaeve & Nijs, 2013). The concern here is how the model is replicated, and to what degree there is variation from the standardised model to achieve good outcomes and for it to be called 'DBT'. However, all studies show positive effects on suicidal and NSSI behaviours, as well as studies reporting bespoke benefits with regards to the various diagnoses.

Current NICE guidelines (2009a) advocate DBT as a treatment of choice for women with a diagnosis of BPD, or for the management of self-harm, and for certain cases of eating disorders. This is a comparatively small group for such a widely recognised treatment model, and advocates the need for research into delivery of DBT to wider groups. My study would aim to do this, by placing client experience at the fore within a certain context and transdiagnostic group. Ritschel et al. (2015) present research describing transdiagnostic applications of DBT to show it can be effective for substance use disorders (Linehan,

Schmidt, Dimeff, Craft Kanter & Comtois, 1999), bi-polar (Goldstein, Axelson, Birmaher & Brent, 2007), as well as adolescents (Wasser, Tyler, McLlhaney, Taplin & Henderson, 2008). Many papers exist on specific groups such as DBT for binge eating (Klein, Skinner & Hawley, 2013), gambling (Christensen et al., 2013) and stalkers (Rosenfeld et al., 2007). The current study, with a range of diagnoses in the same DBT programme, can add to this body of literature by highlighting the helpful and unhelpful elements of the therapy for people diagnosed with a variety of symptoms.

Swales et al. (2000) keenly assert that DBT does not ‘believe in’ a diagnosis per se but utilises it because it has been demonstrated to be effective. This more humanistic stance reflects the philosophy of Counselling Psychology whereby the diagnosis functions to predict the prognosis of various types of treatments with a given population and allows the therapist to develop a treatment plan accordingly, but with flexibility. Swales et al. (2012) raised the concern of sustainability of DBT programmes and that continuous staff training and development is key. This is in accordance with Koerner, Swenson & Torrey (2002) who identify a number of barriers to the implementation of an effective DBT programme including high staff turnover, limited funding for services, and lack of adherence to the treatment programme. They highlight that modifications to the treatment programme and extensions to populations not previously included in efficacy studies can result in failures of DBT programmes to achieve expected results.

The debate around standard DBT, and the application of adapted and replicated programmes to transdiagnostic groups is likely to continue. It is testament to the DBT model itself that it is one that offers the possibility of being adapted to different client groups in various settings (Linehan & Wilks, 2015; Pederson, 2015). However, there are calls for services to be careful when naming their programmes as ‘DBT’, and that the term ‘DBT-informed’ therapy could be a more authentic form of terminology (Dimeff et al., 2007). The present study will take place in a service where DBT has been adopted and adapted to suit the needs of the clients and the service. This therefore will aid in ascertaining positive outcomes of ‘DBT-informed’ therapy at the level of the client. Whilst it is clear within the DBT field that clinicians are concerned with adaptability of DBT and the settings in which it is delivered, it is interesting to understand more about the way these adaptations are experienced by the clients themselves, to inform service delivery and future research. Literature goes on to say that understanding the process of change at the level of the client is paramount in achieving good

outcomes (Carey et al., 2007), which paves the way for qualitative research to begin addressing these important questions.

1.5 The process of change

Rizvi & Linehan (2001) clarified that DBT likely involves a number of principles of change, but there is no empirical basis for determining exactly which ones are critical or if there is a particular combination of factors that produces change. Rosen & Davison (2003) advocated that psychology should list empirically supported principles of change and not trademarked therapies or other treatment packages. This is a positive move away from the pathologising (and possibly stigmatising) system of mental health services served by the DSM signposting clients to allocated models of treatment. This more humanistic approach is underscored by Counselling Psychology's non-reductionist philosophy (Division of Counselling Psychology (DCoP), British Psychological Society (BPS)). This principle has been taken forwards by the APA (2006) whereby the policy states that "*the treating psychologist determines the applicability of research conclusions to a particular patient*" as "*individual patients may require decisions and interventions not directly addressed by the available research*" (p. 280). Given this approach, it would seem important that principles and processes of change in DBT are researched, to add to the body of evidence available to psychologists treating their clients. A system focussed on principles of change would list the multiple change principles thought to be operative in DBT whilst noting that dismantling studies aimed at elucidating process mechanisms are yet to be conducted (Rosen & Davison, 2003). Koerner (2013) concludes that this is a current aim of the DBT community, to enhance practice-based evidence by creating online communities of practitioners who can systematically collect consented data from the clients they treat, thus adding to the body of evidence of what components of DBT work under what conditions.

In a preliminary study (Soler et al., 2008), the transtheoretical model (TTM; Prochaska & Diclemente, 1983; Prochaska & Norcross, 2001) was used to define stages of change in DBT. The transtheoretical model proposes that there are 6 stages of change, including pre-contemplation, contemplation, action with ambivalence and maintenance. This quantitative study was able to conclude that conceptualising motivation for patient readiness to change in terms of TTM can enrich and further our understanding of the process of change in people engaging in DBT. It was suggested that further research is necessary to understand more about how these stages are experienced by clients, with a focus on specific behaviours related

to BPD, such as self-injurious tendencies. This would lend towards qualitative inquiry, whereby a phenomenological approach could help give voice to the perceived process of change, at the level of client experience.

In a study conducted by Clarkin, Levy, Lenzenweger & Kernberg (2007), three treatment models were examined over a course of three years. It was found that whilst clients with BPD respond to structured treatment in an outpatient setting, it was highlighted that TFP was associated with change in multiple constructs across six domains, whilst DBT was associated with fewer changes. The study concluded by suggesting that further research is needed to examine the process of change in these treatments beyond common structures. Despite the support for the effectiveness and efficacy of existing treatments, researchers are still confronted with a high degree of uncertainty about the underlying processes of change (Clarkin & Levy, 2006).

Koerner and Linehan's review of research on DBT (2000) stated that the therapist's knowledge of change and stages of motivation in clients is paramount to ensuring a style of delivery of DBT which will enhance treatment and raise enrolment numbers. Lynch, Chapman, Rosenthal, Kuo and Linehan (2006) went on to propose that change is associated with mindfulness, validation, targeting and chain analysis, and dialectics. This article aimed to provide guidance for theoretically grounded research to be undertaken on the mechanisms of change in DBT. Koerner (2013) went on to research what therapists specifically need to know and do to get good outcomes in DBT. The paper lists 6 principles which need to be adopted to achieve good results in DBT and concludes they provide a practice-based research approach that could help a move towards evidence-based answers about what therapists must know and do to positively impact the client change processes related to pervasive emotion dysregulation.

Although more dated, historical studies into psychotherapeutic approaches provide a good insight into the underlying process of change from a person-centred perspective, which may also be applicable to DBT. Duncan and Miller (2000) view the client's theory of change as holding the keys to success regardless of the model used by the therapist, and especially with cases of multiple treatment failures. Similarly, Frank (1995) concludes, *"I'm inclined to entertain the notion that the relative efficacy of most psychotherapeutic methods depends almost exclusively on how successfully the therapist is able to make the methods fit the patient's expectations"* (p. 91). This humanistic stance lends well to seeing the therapist

skills as central to client experience, which would form an interesting focus in the current study in terms of how the clients perceive the role of the therapists delivering DBT.

Higginson & Mansell (2008) determined that in order to identify the process of change in clients, semi-structured interviews should include details of the journey of the problem. This study identified theory of change in terms of hopelessness and locus of control, experiential avoidance, acceptance and mindfulness, insight, and adversarial growth. The findings were also discussed in relation to a theory of self-regulation known as perceptual control theory (PCT - Powers, 2005). It is proposed that this theory may provide a valid account of the process of psychological change which highlights reorganisation of neural networks. Studies have proven that DBT alters neural networks in a similar way to other psychotherapies (Schnell & Herpertz, 2007) and therefore the PCT may provide an explanation as to how change occurs in DBT. PCT states that in the reorganisation, aspects of the neural network are altered by a random, trial-and-error process until error in the network is reduced and the ability to function as desired is restored (Powers, 2005).

The assimilation model (Stiles, 2001) is in some ways similar to the process of reorganisation described in PCT. The principle components of the assimilation model include schema, problematic experience, and the complementary processes of assimilation and accommodation. However, it differs from PCT by giving a 'stages-of-change' model as opposed to a reorganisational one. Carey et al. (2007) undertook a qualitative study of client experience of change and concluded that both these models – a stage model versus an organisational one – feature in client experience of change. The research suggested that future studies should look at the phenomena of change at the level of client experience, to ascertain if and when these change models are experienced and in which client groups. The study advocated the perceived experience of change as an important outcome to pursue, so that treatments can become more consistent with facilitating the change process. In order to do this, the study advocates future research which essentially listens to those who are undergoing change in order to understand the process more accurately (Carey et al., 2007). This paves the way nicely for qualitative inquiry of client experience of the perceived role of therapy in the process of change, which takes a central focus in the current study.

1.6 Summary and rationale for current study

The literature is clear in proving the efficacy of DBT through quantitative RCTs and research. However, several studies conclude that the process of change, how the clients experience the therapy, and what therapists must know and do to deliver good outcomes, is under researched. Qualitative inquiry to date has looked at client experience in the NHS and community settings, which has begun to provide the DBT community with a richer picture of how clients perceive the therapy delivered to them (Perseius et al., 2003; Cunningham et al., 2004; Hodgetts et al., 2007; McSherry et al., 2012). The present study builds on this literature by exploring client experience of receiving adapted or ‘DBT-informed’ therapy in the context of the private healthcare system thereby implying findings to a wider group. The study will contribute to the field of Counselling Psychology by offering a unique illustration of client experience to inform practitioners involved in delivering DBT groups, managing wards and services, or using DBT as part of individual therapy. Moreover, this study draws on DBT as an intervention for treating transdiagnostic client groups, so that the components can be more widely and effectively used in psychiatric services (Burckell & McMain, 2011; Feigenbaum 2007; Feigenbaum et al., 2012; Marra, 2005; Perseius et al., 2003; Ritschel et al., 2015). Ultimately the study aims to address gaps in the literature through qualitative inquiry, thereby raising the profile of the client voice to gain a rich account of the experience of the treatment.

1.7. Research Questions

1. How do clients experience and perceive receiving adapted DBT in a private setting?
2. How do clients experience and view their progression through the 12-week programme?
3. What is the perceived role of adapted DBT in any changes clients may identify, if any?

CHAPTER TWO

Methodology

2.1 Introduction

The present study is concerned with answering research questions within a qualitative paradigm. This chapter aims to bring to the fore the chosen methodology to address the research questions alongside philosophical underpinnings. It is accepted that the researcher is central to a qualitative study, whereby methodology informs epistemology and vice versa. The process of considering a 'best fit' in terms of my standpoint as a researcher and the philosophies of various methods and paradigms will be made explicit. Thoughts around the epistemologies of the study, the methodology and researcher reflexivity are examined to give an in-depth account of how this was achieved. The section will then move on to how the study was itself conducted, with thought given to the ethical procedures and approvals, culminating in a detailed account of the analytic strategy employed whilst maintaining expected standards of trustworthiness and validity.

2.2 Nature of the study

2.2.1 Rationale for qualitative study

Reicher (2000) suggests that it is not advised to merely distinguish whether studies are qualitative or quantitative, without investigating their theoretical and philosophical differences. According to Smith et al. (2009) qualitative research seeks to uncover and give rise to complex situations, whereas the quantitative approach seeks to quantify or precisely measure the extent and existence of a given phenomenon in society. Where the quantitative researcher typically assumes a positivist stance, more recently credited as being permeable with the quantitative-qualitative boundary (Madill & Gough, 2008), the qualitative researcher challenges this approach to knowledge development generally to include phenomenological, pragmatic, hermeneutic and critical traditions (Elliott, Fischer & Rennie, 1999).

Qualitative methodology has come under scrutiny and judgement in recent years from its positivist quantitative counterpart, as well as qualitative researchers themselves being concerned with lack of 'excellence' in published research (Elliott et al., 1999), rendering these psychologists to 'marginal scientists' (Reicher, 2000). However, Carter & Little (2007) argue for a pluralistic approach to qualitative research, which does not call for one true 'logic' to govern it but opens the researcher up to reflection across paradigms, whilst

adhering to guidelines with regards to validity, rigour and reliability (Morrow, 2005; Morse, 2015). Numerous strategies now exist to ensure these criteria are met, and a researcher should evaluate these strategies with a critical eye ensuring that they are fitting with the study in question as opposed to blindly following pre-existing structures which may either not be effective, or worse, unreliable (Morse, 2015).

The present study is concerned with the inner-life worlds of participants of a hard-to-reach group, whose experiences may give rise to new and complex phenomena. The focus of the research questions on ‘experience’ and the clients’ own perceptions of their processes, leans towards a qualitative inquiry where phenomena can be considered as ‘latent’ and waiting to be uncovered. Phenomena in the context of this study could perhaps be the elements of the therapy which were helpful or unhelpful, previous unknown emotions about the therapy, and ‘change’ as a phenomena in itself. Where the quantitative method would seek to measure the existence of phenomena, my study is seeking to uncover and ‘make sense’ of what may previously not have been seen or discovered (Larkin, Watts & Clifton, 2006). The aim is not to quantify this phenomena, but rather to explore it and give voice to previously unheard experiences and processes. This deep understanding of client experience would offer insight into what is important to clients in the delivery of DBT, offering audiences a unique insight into how to adapt and adopt the therapy to best effect. In order to achieve this, research would need to engage in a highly reflexive process of interpretation, ensuring that data is not overly influenced by the researcher but aims to keep the client experience at the fore. A qualitative approach which can engage in phenomenology, hermeneutics and constant reflexivity and reflection was thereby deemed appropriate for this study.

2.2.2 Interpretative Phenomenological Analysis

The methodology chosen for the thesis is Interpretative Phenomenological Analysis (IPA, Smith et al., 2009), with the aim of giving voice to the inner experiences of people, and helping them make sense of their world (Larkin et al., 2006). The method was chosen for its multi-layered approach which includes phenomenology as well as its emphasis on hermeneutics and ideography. Engagement with phenomenology means that the claims and concerns of participants are elicited with the aim of getting as close as possible to the complexity of ‘experience’. This is carried out with immediate recognition that ‘experience’ as it is heard and expressed is partial, and co-constructed by the participant and researcher.

The subjectivity of the descriptive account is acknowledged as being as close as possible to the participant's lifeworld, whilst providing a unique and in-depth account of a person in a particular context (Larkin et al., 2006; Pietkiewicz & Smith, 2014; Pringle, Drummond, McLafferty & Hendry, 2011; Smith & Osborn, 2008). This leads to the engagement in hermeneutics, or theory of interpretation. The researcher attempts to understand what it is like to stand in the shoes of the participant, and to make meaning by translating it, thereby helping the participant make sense of their world. This 'double hermeneutic' or dual interpretation process enables the researcher to understand what an experience is like from the participant's perspective, whilst also formulating critical questions with regards to process (Pietkiewicz & Smith, 2014). IPA is also committed to the ideographic particular, whereby each case is analysed in a detailed line by line exploration of the text before moving to the next case. This is in contrast to other qualitative methodologies which may use many participant accounts to generate themes or theory. Collecting data therefore is less focused on sample size and more on the concern of eliciting rich, detailed, first-person accounts of experiences and phenomena under investigation using semi-structured in depth interviews (Pietkiewicz & Smith, 2014; Smith et al., 2009).

In analysis, levels of interpretation can start from the descriptive and move to the linguistic and conceptual (Smith et al., 2009; Smith & Osborn, 2008). The researcher is committed to moving between the *emic* (unique) and *etic* (universal) perspectives, by looking at data through a psychological lens as well as the participant's account. It is this multi-layered approach in analysis which is unique to IPA, and allows for a non-reductionist development of higher level theories and insight (Pietkiewicz & Smith, 2014). It has been noted that novice researchers in IPA, such as myself, can be too cautious in allowing conceptual and deeper levels of interpretation to arise (Smith, 2011). Adopting a less cautious stance meant the need for a strong triangulation process to ensure validity, rigour, reliability and trustworthiness further illustrated in section 2.5.1.1 (Morrow, 2005; Morse, 2015; Rodham, Fox & Doran, 2015).

Alternative methodologies were considered such as Grounded Theory (Glasser & Strauss, 1967). However, the present study is less concerned with generating theory and rather seeks to do the opposite, by allowing the client voice to speak for itself, in an area where the medical model and theory have dominated through controversial diagnoses and empirically evidenced theoretical frameworks pertaining to efficacy and effectiveness (Feigenbaum et al., 2012; Koerner & Linehan, 2000; Koons et al., 2001; Stepp et al., 2008). Emphasis on

phenomena and experience could get lost and would not offer the unique insight into the world of this misrepresented client group.

Narrative and discourse analysis (DA) were also considered. Both approaches could take a phenomenological viewpoint to answer the research questions, but would not offer the richness of the hermeneutic circle with emphasis on phenomena as the focus would invariably shift to either life histories or to discourse (Hammersley, 2008). Life stories of participants from a client group who typically present with history of severe (sexual) trauma (APA, 2013), could give rise to serious distress during semi-structured interviews, presenting an ethical dilemma. DA has been presented as a 'superior paradigm' and more than a methodology in its own right (Willig, 2012), but one which leaves out much of the person and the 'person-in-context' that we may think is important, through prioritising the action-orientated aspects of talk (Langdridge, 2008). IPA explores how people ascribe meaning to their experiences in their interactions with the environment (Biggerstaff & Thompson, 2008). This is especially fitting for the present study concerned with the 'private setting' i.e. the context in which the participants experienced the therapy.

2.3 Epistemological Considerations

The reflective researcher actively adopts a theory of knowledge thereby influencing implementation of method, relationship between researcher and participant, and the way in which quality of methods is demonstrated (Carter & Little, 2007; Finlay, 2008; Morrow, 2005; Rodham et al., 2015).

Historically, epistemology is rooted within the academic discipline of philosophy, creating a debate across disciplines with regards to the use that the study of epistemology can bring to this branch of social science. These long and laboured debates have led to questions and divisions between 'opposing forces', such as those amongst positivists and radical social constructionists (Becker, 1996; Ponterotto, 2005). It has been posited that qualitative researchers examine the similarities, as opposed to the differences of epistemological and methodological positions, since high quality qualitative research accepts and understands a researcher's tension between paradigms (Hammersley, 2008). This is in accordance with recent thoughts of not neatly fitting research into epistemological boxes but allowing for creativity in line with publishable guidelines (Elliott et al., 1999; Morse, 2015). Of primary importance is the focus on appropriate research questions and the role of the researcher, making labelling an epistemological foundation an explicit process (Duggleby & Williams,

2016; Willig, 2012). In the context of the current study, this meant undertaking a reflexive approach from inception to dissemination, whereby I actively engaged and questioned the positioning of my theoretical stance, my work as a clinician, and the questions I was seeking to address in the research process - explored further in sections on reflexivity.

2.3.1 Phenomenology and IPA

A phenomenological approach primarily takes the stance that we can access the worlds of others, and is heavily influenced by philosophers such as Husserl and Heidegger. Husserl's radical phenomenological philosophy of the 1900s stemmed from his belief that "*there is but one world constituted as the true world*" (Husserl, 1970, p. 73), which is accessible through a process of phenomenological reduction (Husserl, 1970). He was interested in the *activities* of consciousness as a medium between the person and the world. Descriptive phenomenology, as it has become known, has found its place in psychological research concerned with studying the whole person, as opposed to fragmented psychological processes (Giorgi, 2012). The descriptive method stays close to Husserlerian philosophy, whereby the researcher adopts the attitude of phenomenological reduction, that is, to resist from becoming part of whatever object is being presented, through 'bracketing' past knowledge (Giorgi, 2012; Husserl, 1970).

Heidegger (1962) argued that it is impossible to ignore subjective influences of 'persons-in-context'. This is meaningful for the IPA researcher who is also part of the construction of the data set with his/her own subjective influences. Heidegger went on to argue that the 'bracketing' that Husserl posited as essential to the discovery of new phenomena, is, in practise, impossible to achieve. The IPA researcher accepts their limitations here, and thereby engages in reflexivity of their own process, bringing awareness to the potential for influence of the data by *adjusting our ideas* in response to subject matter (Larkin et al., 2006). More will be discussed here later, in terms of the researcher's engagement in the interpretative elements of the methodology.

IPA is also influenced by the phenomenological and existential perspectives of Merleau-Ponty and Sartre, which consider the person as embodied and embedded in the world, in a particular historical, social and cultural context (Larkin et al., 2006; Smith, 2004; Smith et al., 2009). Our bodies, as sense-like objects, experience sensations which can tell us something of 'experience'. This is meaningful for the IPA researcher who wishes to understand more about the embodied experience of others, and therefore would touch on how the participant

experiences things ‘in the body’, as sensations, and/or emotions. In terms of the current study, this is meaningful to enable a richer layer of understanding in analysis, to fully encapsulate what it is like for clients to experience DBT.

2.3.2 Interpretative phenomenology and IPA

IPA allows for multiple possibilities of interpretation, ranging from providing an insight into the participant’s lifeworld (phenomenological), offering an interpretation provided by the participant (ideographic), giving an example of the cultural resources used by the participant (hermeneutics), and even eliciting an expression of the participants’ unconscious conflicts and desires (Shinebourne, 2011).

Ricoeur & Kearny (1996) distinguish two interpretative positions, a hermeneutic of empathy and a hermeneutic of suspicion – the first being an approach to reconstruct original experience, whilst the second can use theoretical perspectives. For IPA, good interpretation is achieved from reading within the terms of the text, and therefore differs slightly to Ricoeur’s hermeneutics of suspicion by adopting a hermeneutic of questioning through puzzling, and to question what people are saying (Smith et al., 2009).

IPA methodology can go further with its theoretical underpinnings of phenomenology, hermeneutics and ideography. Smith et al. (2009) explain that:

“phenomenological research systematically and attentively reflects on everyday lived experience... (which) can be either first-order activity or second-order mental and affective responses to that activity - remembering, regretting, desiring, and so forth... IPA requires a combination of phenomenological and hermeneutic insights... Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen” (p. 37).

This means that ‘experience’ can be described and interpreted at various levels, namely descriptive, linguistic and conceptual (Smith et al., 2009). The descriptive layer complements the descriptive phenomenological method, whereby it is acknowledged that describing things ‘as they are’ is of central importance and often lost in other methodologies. The linguistic component looks at how people are ascribing meaning to their experience and can attempt to ‘flesh out’ the nature of stammering, faltering, or the use of particular words. The conceptual layer takes it one step further by allowing the researcher to engage with what is interesting in the participant’s account, and prompt further questions. This often brings in the researcher’s personal reflection and/or professional knowledge, offering an added layer of

depth to the findings. IPA has been posited as especially suited to studies that aim to relate findings to bio-psycho-social theories that dominate current thinking in healthcare professions (Biggerstaff & Thompson, 2008). With DBT qualified as being based on the biosocial theory of emotion dysregulation (Linehan, 1993a), IPA was deemed a good fit for the present study.

2.3.3 Epistemological standpoint

There is a varied argument with regards to the ontological assumptions of IPA. Braun & Clarke (2013) argue that IPA is underpinned by a critical-realist ontology, where it is accepted that language reflects a *perception of experience* requiring a critical approach to interpretation. Others would argue for an existential-phenomenological position (Shinebourne, 2011) focussing on accessing the inner lifeworld of a participant. Larkin et al. (2006) posit that IPA can be socio-constructionist if one is to argue about the nature of reality and the impossibility of refuting active intellectual construction. This eclectic approach to the ontology should credit the stance of IPA – that it is able to offer a researcher a unique process of engagement with the philosophical assumptions of the methodology (Smith, 2011).

I would like to demonstrate how taking a critical-realist approach in an IPA study can add an extra layer of interpretation in analysis. Shinebourne (2011) has argued that unconscious desires can be touched upon in IPA as long as they are rooted in experience. Merleau-Ponty (1962) said “*the significance of psychoanalysis is less to make psychology biological than to discover a dialectical process in functions thought of as ‘purely bodily’*” (p. 158), indicating an overlap in the concerns of phenomenology and psychoanalysis. Taking this epistemological position would add to this study the layer of depth missing from other qualitative studies such as McSherry et al. (2012). It also credits the critical-realist ontology, whereby I am recognising that participants can tell me something about their experiences, but that in order to discover the meaning of that experience, I needed to take a critical approach in interpretation without compromising on validity. This included drawing on psychodynamic theory to conceptualise interpretation, as opposed to looking to psychodynamic theory in the first instance and making the data ‘fit’ around it.

2.4 Reflexivity

2.4.1 Epistemological reflexivity

IPA's engagement with hermeneutics, and its concern with the ideographic particular meant that researcher reflexivity was key to ensure parity across data sets. Husserl articulated that 'bracketing' though a process of phenomenological reduction is necessary to *see* the pure phenomena as an absolute given (Husserl, 1970). He distinguishes the science of phenomenology from the psychology of perception, and only by removing the ego from the process is one "*'seeing' pure phenomenon in the phenomenological sense*" (Husserl, 1970, p. 35). Heidegger's claims challenged those of his mentor by asserting that "*whenever something is interpreted as something, the interpretation will be founded essentially upon having fore-sight, and fore-conception...understanding always pertains to the whole of Being-in-the-world*" (1962, p. 191-192). The notion of 'fore-sight' became part of the language of other philosophers, with Merleau-Ponty (1962) describing the concept as '*implicit understanding*', which resonates with the language used in an IPA study when referring to the influence of the researcher on the research process. He went on to acknowledge that one must try to break familiar acceptance of the world, by taking a step back to be able to *notice* what our understandings are and bring them into consciousness: "*reduction does not withdraw from the world....it steps back to watch the forms of transcendence fly up like sparks from a fire...it reveals the world as strange and paradoxical*" (Merleau-Ponty, 1962, p. xii).

It is, therefore, accepted that the researcher is by nature the embodiment of their experience, and that the task of removing this implicit understanding is impossible. The researcher's engagement in reflexivity has been posited as one way of recognising, at some depth, the researchers influence on the project from inception through to analysis (Shaw, 2010). Finlay (2008) highlights novice researcher's tendency of mistaking the bracketing process as a straightforward method of setting aside assumptions and acknowledging subjective bias towards establishing rigour and validity. Instead, the recognition is that bracketing is an immediate self-aware evaluation of the intersubjective dynamics between the researcher and the researched (Finlay & Gough, 2008).

From a philosophical standpoint, I share a critical-realist approach, with a focus on phenomenology. This mirrors my humanistic stance as a Counselling Psychologist and clinician, whereby my therapeutic practice is concerned with the lived experience of clients and using advanced empathy. My longstanding interest in psychodynamics means that I will

always lean as a clinician to the works of Freud and other psychoanalytic authors, but only if this is rooted in the experience of the client. Imposing beliefs and theory on clients is in my view unhelpful and I therefore have experience of bracketing knowledge in clinical work.

Bracketing in this sense is carried out as a scientific phenomenological reduction (Giorgi & Giorgi, 2003) in the awareness that my past experience, knowledge, and how I am experienced/perceived by the participant, will influence the data. Creating space in the interview between myself and the participant was key in bringing my implicit understandings into consciousness, and reflecting on the complex co-constructed mesh. Listening in awareness and holding the empathetic interviewer stance facilitated this, creating an active space for insight and reflexivity - an intricate process of moving forwards and backwards to grasp, as much as is feasibly possible, the lifeworlds of the participants.

My epistemological considerations have also been influenced in my work with long-term inpatients diagnosed with BPD. This environment was prone to dealing with self-mutilation, suicidal intent and absconding on a daily basis, as well as high levels of projective identification (Klein, 1946). In this role I also had experience of delivering DBT groups such as Mindfulness and Distress Tolerance. Patients on the ward would frequently say that DBT was not worthwhile, and many hated the therapy and had little time for it. However, the patients would slowly recover, all the time attacking the DBT programme. I learnt here therefore, that whilst I was interested from a phenomenological standpoint in the inner lifeworld of the clients and their experience, that it was also helpful to adopt a critical-realist stance to understand more about their recovery.

Psychoanalytic theories such as object relations and the notions of transference/countertransference helped me to understand more about the ability of this client group to use projective identification and splitting (Klein, 1946) as a means to connect and cope with their highly emotive and painful internal states, as well as their fragmented internal worlds (Thompson, 1990). The effective use of countertransference (Freud, 1912) was an invaluable tool utilised to highlight what may be going on for the client, where the therapist uses their own feelings about the client to make sense of the client's emotional world. Furthermore, the client group is represented as one which evokes 'enactments' (Bateman, 1998), whereby both client and therapist jointly overstep a boundary. This was important to recognise and hold in terms of the current study, where I could be pulled into enactments by participants and thereby overly influence the data.

2.4.2 Personal reflexivity

My reflexive process in terms of this study has therefore been central, with an awareness that I am working with a different group of clients – outpatients not inpatients – and of different diagnostic categories, in a different department of the hospital. Whilst my interest in DBT began on an inpatient ward, it is clear through my research path that DBT extends to many, and my gaze shifted to the inner lifeworlds of others who had experienced DBT and how they experienced any changes. I attended the Society for DBT's Conference in Dublin in December 2015, where I met leading researchers asking questions about the different methods of delivery of the therapy – how to adapt, adopt and implement DBT effectively.

Although my reflexive process has allowed me to bracket my understandings so as not to overly influence the data, it is accepted that I cannot refute this prior knowledge. In some ways it could be seen to help, where I was able from past experience to manage any signs of potential distress during interviews or use some DBT terminology as common ground, as well as being aware of possible 'enactments'. I have also been aware of the nature of my dual role in the hospital, and that of therapist-interviewer. Whilst I had not worked previously on the Therapies Department where the research took place, the staff team were known to me. The therapists there provided a gateway to the recruitment sample, and held me in mind not only as a Counselling Psychology doctoral researcher but also as a Psychology Assistant having worked with inpatients at the more extreme end of the spectrum.

In order to manage concerns over the dual role at the hospital, I spoke regularly to a Counselling Psychology trainee at the hospital, who aided in coaching me through my concerns and ideas of moving the project forwards. This helped in thinking about how to approach the therapists and how to advertise the research in a sensitive and timely fashion. I used group peer supervision with my Counselling Psychology colleagues to talk about the interview process, the notion of 'therapist-interviewer', and to share data sets. I made good use of supervision to think about my process and my emotions around interviewing the client group and how to adopt an IPA stance as opposed to a therapeutic one. I made use of the London IPA group to talk about the notion of reflexivity and the importance of keeping a reflective journal. I wrote in the journal after each interview as well as at other times during the research process when pressing issues came to the fore. This enabled emotions and cognitions to be processed or highlighted, thereby embodying a more insightful stance with space and capacity to reflect.

2.5 Procedures

2.5.1 Context

Clients were recruited from a 12-week DBT group programme currently run in a private psychiatric hospital. The hospital is a psychiatric facility housing five wards for people suffering with mental health issues. The hospital houses inpatient and outpatient facilities, as well as a Therapies Department. The Therapies Department runs therapeutic groups for inpatients and outpatients, as well as 1:1 therapy, including a 12-week adapted DBT programme. The setting is a holistic one, in that the group therapies on offer pertain to all models of therapy such as CBT, DBT, Mindfulness, psychodynamic support groups, dance & movement, yoga therapy, Acceptance and Commitment Therapy (ACT), and groups tailored for specific clinical diagnoses such as a bi-polar support group.

The hospital is a 'private' setting, in that patients need to be covered by health insurance, which offers psychiatric treatment for a month to three months in duration, depending on the severity of the illness. Individuals sectioned under the Mental Health Act are able to apply for additional coverage for the length of their stay. The hospital also has a contract with some local NHS hospitals, to cover an overflow of beds. These patients are referred to the private hospital but would be referred back to the NHS once beds become available again. Self-referral to the hospital is possible, but costs approximately £900 for a consultation with a psychiatrist and then a daily rate. The implications for patients are financial, political and time constraining, for example if they are engaged in therapy as part of a 3 month insurance plan, they would need and want to get as much out of the experience as possible, to feel ready to go back into their communities and employment once funding had run out. This has been seen in some cases to be an incentive to 'get well quick' leading to higher motivation to engage in therapy, whilst others feel fearful of not having had enough support and are prone to relapse when they are discharged. The implications of this are discussed later.

In terms of the physical setting, the hospital is set in calm grounds with a large lawn and gardens away from the main road. The hospital is a historic whitewashed building very pleasing to the eye. Upon arrival, visitors and patients enter a carpeted reception area with a gift shop, and a waiting room housing a tropical fish tank and a machine for complimentary tea and coffee. The hospital is carpeted throughout and the inpatient rooms are either single or double ensembles, not dissimilar to a luxury hotel chain. There is a notable difference in feel and experience compared to an NHS setting. The research questions and methodology were

thereby chosen to ascertain how this private psychiatric setting may have impacted the experience of clients engaged in DBT.

2.5.2 Sampling and participants

The sample recruited for this study were clients who had completed the 12-week (3 month) DBT programme on the Therapies Department for both inpatients and outpatients (see appendix D). The DBT group is facilitated by trained DBT therapists, and is a transdiagnostic group programme. Clients who have been diagnosed with BPD (APA, 2013) or personality ‘traits’ by their psychiatrist, are referred for assessment with a DBT therapist in the Therapies Department. This assessment screens the suitability of the client to join the 12-week DBT therapy programme. The assessment includes inclusion and exclusion criteria pertaining to the client’s diagnosis, history of the presenting problem, engagement in problem behaviours such as substance use or disordered eating, and readiness for change. The sample for this study therefore includes participants with a diagnosis of BPD or personality ‘traits’. Those with ‘traits’ only had other diagnoses such as depression. There were no inclusion or exclusion criteria based on age, gender, religion, sexual orientation or ethnicity.

It was considered that these inclusion criteria are essentially based on a medicalised model of mental health, in contrast to the philosophy of Counselling Psychology which seeks a non-pathologising approach to treatment (DCoP, BPS). A pathologising and thereby reductionist approach to mental health takes away much of the person the system seeks to treat, especially from a phenomenological stance. My personal clinical ethos is to ‘meet the person’ as opposed to the label, whilst acknowledging that a diagnosis can be helpful in prescribing appropriate medication, if at all necessary. It is acknowledged however, that Western society’s approach to mental health is largely medicalised, and in order to achieve a homogenous sample, that these labels are helpful in developing inclusion criteria. This also gives the study a sound basis in being able to respond to other research which has focussed on diagnostic criteria, with the aim of being able to implicate the findings to a wider group. Furthermore, common to all the investigations of change and recovery is the focus on highly homogeneous populations with specific difficulties/illnesses (Higginson & Mansell, 2008). It is therefore considered that the sample for this study contained homogenous and heterogeneous elements all of which were taken into consideration in analysis and when drawing discursive conclusions.

Some participants would have started as inpatients at the hospital and tried the DBT programme, only to be discharged following lapse of insurance cover and then come back to re-engage with the programme as an outpatient at a later date. There is no limit as to the number of times a client is allowed to engage and complete a DBT programme at the hospital, as long as they meet the criteria in the assessment, and have the funding approved by their insurance companies. To that end, the sample recruited for this study comprises three participants whom had completed DBT twice, and two participants whom had completed the programme only once.

Within this rather bespoke hard-to-reach group, the heterogeneity of the sample here is a strength as opposed to a limitation. It allows the research to give voice to a group of people who have undertaken DBT at various times in the last few years, but within the same context, having undergone the same assessment procedures, and with very little variance on the delivery of the model. Many of the participants engaged with the same therapists and mentioned them by name in the interviews. The study would therefore be able to ascertain what it means to participants to go through the programme more than once, the experience of the private setting, and the implications of these elements on the perceived role of DBT in the process of change.

At professional doctorate level, it is suggested that 4-10 participants is a reasonable sample size for a project using IPA (Smith et al., 2009). This study's sample consisted of 5 participants, 4 females and one male. Three of the participants were diagnosed with BPD, one with clinical depression and a comorbid eating disorder, and one with bi-polar affective disorder (see appendix D). The first participant had a history of being treated for addiction through a 12-step programme and other therapy, now with a diagnosis of BPD. The second participant had a long history of engagement with mental health services, having undertaken multiple rounds of CBT for intrusive thoughts throughout teenage years. The third participant had a 4 year history of issues with over-eating and more recently clinical depression. The fourth participant had a diagnosis of bi-polar affective disorder where she had experienced two severe episodes in her early adult life. The fifth participant had a long history of pharmacological intervention for 'depression' only to find this ineffective and being given a diagnosis of BPD following a crisis, thereby being signposted to DBT (see appendix D).

In IPA, a homogenous sample is often what the researcher would be aiming for, but here, the heterogeneity of the sample should be celebrated. The literature is keen to understand more about whom DBT works for, and whether transdiagnostic applications have positive outcomes. Rather than thinking about whether DBT works for particular clinical diagnoses, this study advocates that diagnosis per se holds less importance, reflecting the non-reductionist perspective of Counselling Psychology. The aim is to understand client experiences of DBT at a particular time, in a particular context, with a focus on how the therapy was perceived to work for them. The experience of individuals with a variety of diagnoses within the same group programme would pave the way for further research into the replication of transdiagnostic applications. It would open DBT up to a wider scope of individuals, whereby they would be recruited onto programmes based on their characters, readiness for change, emotion dysregulation, and basic life needs at the time. In this way, the application of DBT would aim to become a lot less dictated by the DSM and psychiatric movement, and towards a more holistic approach to recruitment and retention.

2.5.3 The adapted DBT programme

Standard DBT is usually one year in duration, comprising of the 4 modules – Mindfulness, Distress Tolerance, Emotion Regulation and Distress Tolerance. This is delivered within a therapeutic framework which contains group skills training, 1:1 therapy, telephone consultations and team consultations. The frequency of the skills groups are dependent on the setting, for example an inpatient setting may deliver a daily skills group, whereas an outpatient setting may run the same group on a weekly basis.

The DBT programme in the current study comprises all the elements above, but is shorter, concentrated over 12 weeks. The patients attend a weekly 3 hour skills group, weekly 1:1 therapy with a member of the DBT team, and are supported by telephone consultations/coaching on an as needed basis. That is, should they feel distressed such as experiencing suicidal intent or impulses pertaining to NSSI, they are able to call the hospital to speak with a member of the DBT team. The telephone consultation option is therefore only available during working hours. In this way, the programme is an ‘adapted’ form of DBT or a ‘DBT-informed’ programme, in that it is a variation on the standard model disseminated by Linehan’s group (Linehan, 2015), whereby telephone consultation can be made available on a 24 hour basis. To this end, the current study would be said have recruited from an ‘adapted DBT’ or ‘DBT-informed’ programme. As mentioned in previous

chapters, there is a need for ongoing research into the delivery and experiences of adapted versions of the therapy (Ritschel et al., 2015; Swales et al., 2012).

2.5.4 Recruitment

Participant information sheets (PIS), participant consent forms (see appendix A & B) and a recruitment poster were constructed according to ethical guidelines and professional standards (BPS, 2009; HCPC, 2015). Full details were given about the nature of the study in line with ethics of not coercing participants, and to diminish power imbalances by providing potential participants with as much information as possible (West & Byrne, 2009).

Recruitment took place by meeting with the DBT team of therapists at the hospital, who invited me to attend the DBT group 6 times over the course of 14 months, from December 2014 to February 2016 where I gave out the PIS to clients. I was contacted by email by one participant in December 2014, and others in the summer of 2015.

A dilemma presented itself with regards to recruitment in December 2015, when it had been 4 months since I had received contact from a participant. I spoke to the therapists at the hospital regarding this, and also deliberated over the sample size. In qualitative research, the data should be rich, showing enough divergence and convergence, as opposed to focussing on bigger sample sizes. Furthermore, IPA is ideographic in nature where depth in analysis and interpretation is brought to the fore (Smith et al., 2009). It became clear as I began analysis in March 2016, that the data was giving rise to complex phenomena and 5 participants was sufficient to bring depth to the study of a hard to reach group. Ethical amendments are discussed in section 2.5.8.

2.5.5 Pilot work

The interview schedule was devised (see appendix A) on the basis of literature and with support of the supervisor, whose expertise in IPA and editorial position of the Counselling Psychology Review ensured reliability and trustworthiness. I triangulated this process by attending the London IPA group on a bi-monthly basis at the Tavistock Clinic, whose facilitators approved the interview schedule and proposed further reading to ensure rigour. The questions were structured in line with Smith et al.'s (2009) suggestions of eliciting first and second order responses, in an open and expansive way. The descriptive questions came first, with probes to elicit further response if necessary, with the aim of building rapport with the participant through an 'easier' descriptive response which they would feel comfortable speaking about. The remaining questions were in line with Higginson & Mansell's (2008)

suggestions of the type of questions required to research psychological change. These included details of the problem they faced, how the problem affected their lives, and how they felt about their problem looking back.

I interviewed two friends regarding their experience of their own therapy, using the interview schedule. I found that the interview questions were constructed in the right order, as first order responses came in the first part of the interviews, and the final questions elicited second order responses about how they experienced change (Higginson & Mansell, 2008). Feedback was that the interview had been an enjoyable reflective experience where they had felt heard. I was aware therefore that the challenge may arise in not delivering the interview itself, but building rapport with participants previously unknown to me, or I to them.

2.5.6 Interview procedure

Participants were invited to the interview room and asked to read the copy of the PIS, and to read and sign the consent form and any demographics they wished to disclose. Once the audiotape was running I used the semi-structured interview technique in line with IPA (Smith et al., 2009). Interviews varied in length from 50 minutes to 1.5 hours, depending on how much the participant wished to disclose, how much they felt they had to contribute and how rapidly they spoke. Once the device had been switched off, I held a debrief and provided participants with numbers of supportive agencies. I kept a reflexive journal to detail my account of the interview process, which was especially important given the tendency of the client group to use projective identification – which could bias the data if not adequately worked through prior to analysis.

2.5.7 Ethical considerations

Ethical approval was sought from the University of East London's (UEL) ethics committee (see appendix E) and the Clinical Governance Committee at the private psychiatric hospital (see appendix F).

Confidentiality and anonymity of participants was assured as outlined in the participant invitation letter and the consent form. In order to obtain fully informed consent, the participant information sheet was distributed to clients who attend the 12-week DBT programme. The invitation letter was followed up with a consent form for participants to sign before interview. Participants were advised of their right to withdraw from the research study at any time without disadvantage to them and without being obliged to give any reason. Should a participant withdraw, they reserved the right for all data collected on them to be

destroyed and not used as part of the study.

I sought advice from the Data Team at UEL by asking to meet with the data officer, to ensure full protection of confidentiality and data storage methods. It was advised that as a lone researcher, data could be stored securely during the data collection phase in the researcher's home, on an external hard drive, backed up on a USB. This was carried out until data collection and transcription were completed. Data was stored under the reverse initials of the participant, with no real names. Once transcribed, all identifying data was omitted e.g. real names, addresses and dates. Following the viva, original data on the USB and hard drive will be destroyed. The anonymised transcripts will be saved on an external hard drive and backed up on USB in the researcher's home, for up to one year for publication purposes.

It is known that due to qualitative research's focus on in depth interviewing, the process can be painful for participants (West & Byrne, 2009). The risk of harm presented a specific ethical concern surrounding the trait of self-harm in clients diagnosed with BPD (APA, 2013). The 12-week DBT programme consisted of clients suffering with BPD (or personality disorder 'traits'). This means that those attending the interviews were potentially at a higher risk of emotional harm due to unstable affects, leading to risk of harm through NSSI.

It was therefore ensured to keep the focus of the interviews on the clients' experience of the group and their treatment, as opposed to traumatic memories which may negatively impact on the unstable emotion regulation system symptomatic of BPD (APA, 2013). Studies reveal that the DBT model helps the therapist (and interviewer) to focus on the here and now, by engaging participants in 'wise-mind' or mindfulness skills (Linehan, 1993b) as opposed to bringing up the past and possible memories of abuse common in BPD (Liebenluft et al., 1989; Thompson, 1990).

This ethical concern presented a tension in the study, whereby I was positioned as 'interviewer', with professional knowledge and experience of working with the BPD client group, as well as a therapist. In line with IPA methodology, I was aware to attempt to bracket previous understanding so as not act in the dual role of 'therapist-interviewer' (Smith et al., 2009), whilst understanding that previous experience of working with this client group was an additional resource.

The interviews took place on the hospital site, familiar to the participants, with adequate support available to manage risk as necessary. Furthermore, telephone numbers for supportive agencies were offered at the end of the interviews, including Samaritans and the

hospital Therapies Department, and the participants were offered a full debrief following their interviews.

2.5.8 Ethical Amendments

Two ethical amendments were submitted and approved over the course of the study (see appendix G & H). The first was to hold interviews at the University of East London, at the request of a participant. The second was to apply to recruit from an affiliate hospital of the same company who deliver the same 12-week DBT group, to increase the sample. However, no participants came forwards from this affiliate.

2.5.9 Transcription & Analytic strategy

Data was transcribed verbatim in the researcher's home and saved as described and all identifying information was anonymised.

In accordance with the analytic strategy for IPA (Smith et al., 2009), steps for analysis were considered. As a novice IPA researcher, I felt it important to stay close to the steps outlined by Smith et al. (2009), whilst also understanding that IPA is a creative process and that the steps are not prescriptive. Step 6 involved looking for patterns across themes, and here I firstly grouped the themes in accordance with Cooper & McLeod's (2016) guidelines of analysing client perceptions of change from interviews (see appendix K). This enabled a richer engagement with step 6 of the analysis to a novice researcher struggling for the first time with the notions of abstraction and function in the interpretative coding phase of analysis (Smith et al., 2009). Through this process, the principles of abstraction and function became clearer, and I was able to focus on looking for patterns across themes, and take into consideration the function and notion of context. The emerging results grouped themes under master themes, all the time rooted in the context.

2.5.1.1 Trustworthiness, Reliability, Validity and Rigour

Qualitative research has advanced considerably in the last 25 years, reflected in the impact of journals such as the Journal for Qualitative Health Research and the foundation of the International Institute for Qualitative Methodology (Morse, 2014). The centrality of validity of qualitative research, and whether it can be posited as an empirically evidenced 'science' has given rise to criteria which must be followed to produce quality work for publication (Elliott, et al., 1999; Morse, 2015). 'Quality' in this sense means validity, credibility, rigor and trustworthiness (Morrow, 2005). Whilst adherence to criteria could be seen to restrict the

process of conducting creative qualitative research which does not compromise any of these facets, these are now common standards serving as a guide rather than absolute methodological prescriptions (Morse, 2015; Reicher, 2000).

The rich nature of the data meant that a small sample size was sufficient, to ensure depth in analysis (Rodham et al., 2015) with no need to ‘cherry pick’ (Morse, 2010). Of the strategies described by Morse (2015), triangulation, researcher bias and peer reviewing were used to ensure a trustworthy study, as well as the importance of reflexive notes and working collaboratively if possible (Rodham et al., 2015).

Triangulation occurred by meeting with the supervisor of the project and sharing analysed data sets, quotes, and the analytic strategy/analysis. Peer reviewing took place by attending research groups with trainee Counselling Psychologists, and sharing themes with the London IPA group, and coffee groups. As previously mentioned, the reflexive journal aided in ensuring the validity of analysis and reducing researcher bias.

2.6 Summary

The chapter has aimed to give voice to the epistemological and methodological assumptions which underpin the current study, with IPA being seen as not only fit for purpose, but in line with my personal philosophies of how to make a study as interesting and useful as possible. The main reflexive question for me will always be ‘so what’? If something is interesting, then the chosen methodology and analytic strategy should be one that is able to provide a pathway for contributions to Counselling Psychology and therapeutic practice more generally. This should hopefully mean positive implications for clients, therapists and wider groups, with a view to generate findings that might make a difference.

CHAPTER THREE

Analysis

3.1 Introduction

Analysis of interviews began by creating analysis transcripts (see appendix I) of each participant account, and applying steps 1-6 in IPA methodology as described in the previous chapter (Smith et al., 2009). The data was perceived as rich and in depth, which meant that focus on research questions during analysis was key, to ensure correct and useful abstraction of themes from the participants' accounts.

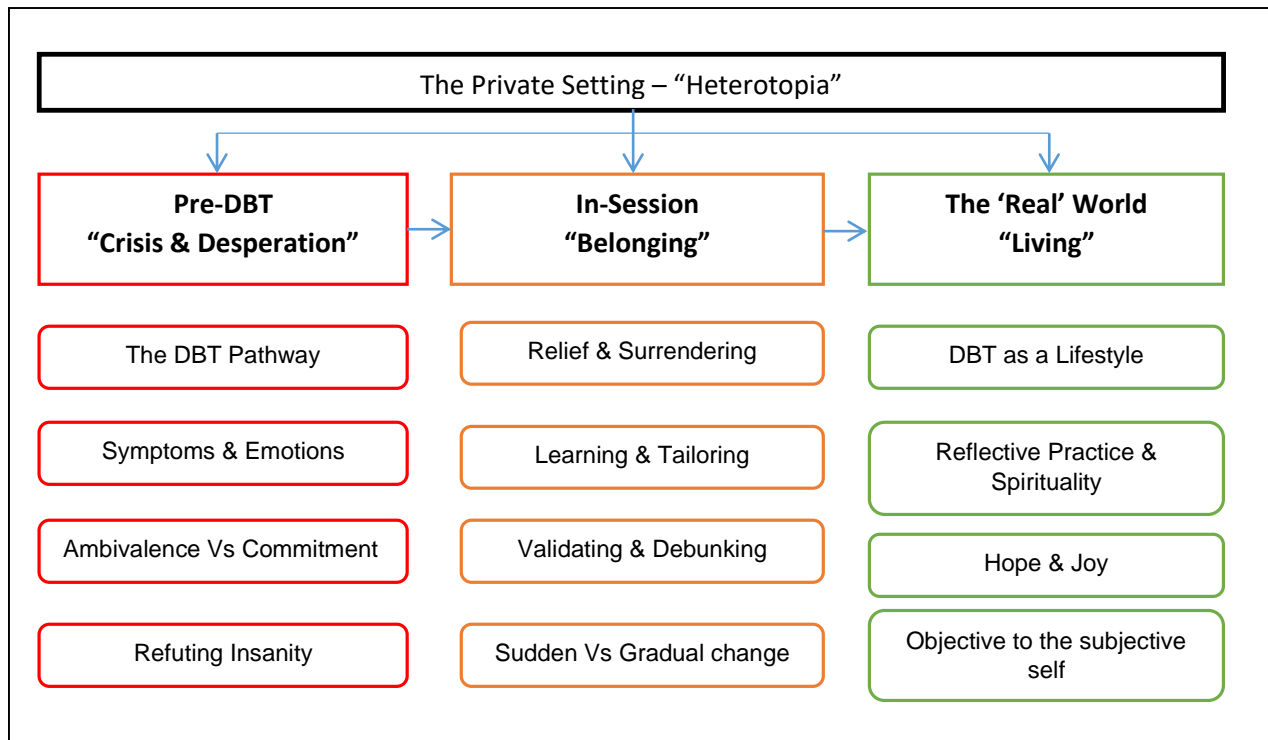
As previously stated, in order to understand more about the process of change as a phenomena, the journey of the problem and the participants' journey through the programme was important (Higginson & Mansell, 2008). The analysis was therefore grouped under the three master themes of 'Pre-DBT – "*Crisis & Desperation*"', 'In-Session – "*Belonging*"', and 'The 'Real' World – "*Living*"'. Each master theme was defined by 4 sub-themes, therefore 12 in total (see Figure 1.0 below). The first master theme groups together the experience of clients' journeys before embarking on the DBT programme. There is a sense of desperation and crisis in the lives of the participants, depicted by severe mental distress. The second master theme was formed on the basis that the next step on the journey is being part of the DBT programme which includes group sessions creating a sense of belonging. The third part of the journey is the end of the therapy and returning to the outside world where participants are able to live as opposed to leading lives of crisis and desperation.

It was noted throughout analysis, that the participants' accounts were grounded in the context in which they experienced the therapy. This also pertained to the research question interested in uncovering how participants experience the therapy in a private setting. This phenomenological aspect was captured in allowing the themes to reside under the overarching theme of 'The Private Setting – "*Heterotopia*"', giving voice and importance to the context of experience (Larkin et al., 2006). There was a sense that the context was experienced as a 'place of otherness' or *heterotopia*, allowing for different things to be experienced and to occur.

The themes are not meant to be viewed as linear or mutually exclusive, but as overlapping and fluid. Some themes reside very closely to each other, with others displaying a sense of progression through a journey of change. However, to fully encapsulate and give life to the

data, themes were formed so that the audience can gain the best picture possible of what it was like for these participants to go through a 12 week DBT programme in a private hospital setting.

Figure 1.0



3.2 Master Theme 1 – Pre-DBT: ‘Crisis & Desperation’

The first master theme relates to the part of the journey experienced prior to engagement in the DBT programme. There are many examples of clients having hit a major crisis and feeling desperate to find something to help them. This theme also pertains to the notion of clients having been through the ‘psychiatric mill’ or the ‘revolving door’ of mental health services for a large proportion of their lives. By the time they reach their assessment for DBT, they are often wrought with a sense of frustration about previous ineffective therapies, shame about their ‘diagnosis’ and medicalised stigmatising labels, leading sometimes to a sense of apathy. This theme will attempt to flesh out the lived experience of the participants prior to engagement with DBT, aiming to understand more about how clinical settings and professionals can improve.

3.2.1 Sub-theme one: ‘The DBT Pathway’

This sub-theme will incorporate the experiences of the participants to date, from previous ineffective therapies, right up to their assessment for DBT. There is a sense that the journey into DBT is a long one, whereby many participants have tried many and various therapies, and come to DBT as a last resort or ‘last ditch attempt’, sometimes following a crisis. DBT is usually characterised by clients who have a long standing history with mental health services and have been through the ‘psychiatric mill’ or revolving door of psychological services. This stance can sometimes be dominated by apathy in the client, or conscious and unconscious anger towards the mental health service provision which has failed as yet to ‘work’ for them. Emma explains her experience:

“To be honest by that time I had been having so many assessments for various things, that it kind of became a bit wroth to me... I’ve had self-harming behaviours since I was7 or 8, so... I’d been through multiple rounds of CBT since the age of 12, which had never really stuck”. (Emma, p.1, lines 15-18).

This is in accordance with literature that advocates DBT as a treatment of choice for BPD as opposed to CBT (Koerner & Linehan, 2000; Linehan & Wilks, 2015). Whilst some principles of CBT are used in DBT, the downfall is CBT’s nature of constantly challenging thoughts and emotions making it hard for individuals to accept their beliefs as real and reasonable. As such, they could perceive that others view their emotional pain as not real and an attempt to get attention, when in fact, they are truly suffering and experiencing emotional pain (Bass, van Nevel & Swart, 2014). The notion of CBT not ‘sticking’ gives the sense that despite efforts to engage in multiple rounds, the process had been somewhat futile as the therapy had not accessed Emma and her issues in a helpful sense paving the way for less psychic conflict. Indeed, it would seem that she continued to try, to her testament, but that she simply was in the wrong form of therapy for her, leading understandably to the ‘wroth’ that she voices. Another participant goes on to talk about the reasons why CBT is not as effective:

“CBT I didn’t really click with it, I didn’t really understand it, and I just felt what they were saying in CBT wasn’t really going with what I was going through... (DBT) wasn’t like any of the other therapies things that I’ve done before. I’ve done all of them. And then I did this.” (Charlotte, p. 1, lines 3-5).

There is a sense that whilst CBT has something to offer clients, mirrored in the fact that Emma went through ‘various rounds’, that it does not access the clients in the most effective ways in order for them to feel validated and to provide a platform for recovery. This is in accordance with DBT’s commitment to ‘acceptance versus change’ (Linehan, 1993a & 1993b), whereby the idea of validation is key in order for clients to be able to then challenge their thoughts or behaviours. As Rose comments:

“I found it very practical...as opposed to challenging thoughts, challenging this and that. I just found there are actually solutions, things you can actually take away and do”. (Rose, p. 1, 26-27).

Rose’s account helps us to understand more about the nature of what it is like to be challenged and how it can feel a somewhat laborious process, almost hinting at deficits within the client, as opposed to offering tangible solutions for them to experiment with. DBT in this sense is perceived as a ‘giving therapy’ as opposed to a merely challenging one, also sustained in sub-theme 6, Leaning & Tailoring. Emma further encapsulates her CBT experience:

“I think a lot of the stuff I learnt in CBT, rightly or wrongly, was to try and challenge these thoughts, to try to understand them, to try to change them. But to be honest that quite often led me down an obsessive spiral of just policing my own thoughts and arguing with myself and just getting more and more distressed.” (Emma, p. 2, 50-53).

The linguistic component to this quote is powerful, with the use of words such as ‘obsessive’, ‘spiral’ and ‘policing’. It gives the sense of the mind as a perilous place where criminal-like activity could take place, requiring a strong jurisdiction to control it. It transforms a part of Emma into a policewoman, scrambling desperately to train herself against the darkness of potential harmful activity. There is a noticeable split in herself, where she argues with the different parts of her mind, creating a lifeworld that would understandably feel confusing and distressing.

The sense of crisis and desperation is evident from many accounts, and often carries the added burden of anger towards the mental health system which up to the point of finding DBT, had failed them. As Rose comments:

“I was an inpatient here for about month, and then did a bit of daycare until my insurance ran out, and then I continued paying for it myself and... I was sort of up and down...then I

got shingles ...and so erm, that got me really down. I have been off work, it's been more than 18 months now. I got chronic pain labelled as post-active myalgia... then as a result of that I came back to daycare... I was seeing through the NHS, having CBT...for my eating disorders..." (Rose, p. 1, 4-13).

This highlights the severity and nature of one such journey into DBT, and the internal battle that Rose had to suffer in order to progress on her journey, especially in the wake of a misdiagnosis. This would understandably create anger or ambivalence towards future treatments as well as contributing to underlying shame about her own condition (Willie, 2014). Rachel goes on to describe her journey:

"There was a CBT session here that I found really useful...about being present. So in the now. And I thought it's fine, I am going to be absolutely fine. I am going to go to India, I am going to learn yoga, and I am going to be in the now, and I am going to go surfing... And actually catalysed a total breakdown". (Rachel, p. 30, 629-635).

For Rachel, attending CBT could be construed as potentially damaging to her at that time. She was new to therapies in general, having spent most of her life on medication to treat symptoms of self-harm and emotional dysregulation. Her experience could highlight the importance enhancing good signposting to effective treatments. This could lie in developing proper and thorough assessments carried by healthcare professionals at the individual level, regardless of diagnosis, from Primary Care through to inpatient settings.

It would appear that the assessment for DBT is rather like a gateway to a new and improved treatment for clients, but that this assessment carries with it the weight of an 'exam' or 'test' for some participants who either felt pressured to be accepted onto the programme or had to convince the assessors that they were right for the therapy. As Charlotte comments:

"They were asking me things...questions such as do you self-harm, or do you use substances, and you kind of have to go through all of these questions to see if you can be accepted onto the course." (Charlotte, p. 1, 6-8).

Charlotte's lived experience seems to be one of being perceived as 'not good enough' in an attempt to prove that she is acceptable for the DBT programme. From an empathetic stance, I felt a sense of warmth and care towards Charlotte who seemed to perceive DBT as out of her reach and that she had to pass a certain set of criteria to be part of. There is a sense that the

assessment process denigrates her, and may well add to the underlying feeling of shame she may carry about her pathologised self.

However, in terms of the treatment on offer and what is trying to be achieved by clinicians, the picture is a very different one. The clinicians are trying hard to seek to do the opposite of using diagnosis as a premise for ‘acceptance’ onto the course, and to find out if the person is suited to DBT through patterns of behaviour and emotion regulation. It highlights the notion that DBT is not a ‘fit for all’ model, and that strict adherence to assessments forms part of the structure in this setting. Whilst the lived experience of participants may have been slightly negative in that they felt they were being ‘tested’, the stringent and thorough assessment measures enable the sense of group belonging illustrated in the sub-themes of Master Theme 2, and adherence to treatment protocols for DBT as advocated in the literature for forms of adapted DBT (Pederson, 2015). It also may have implications on the level of motivation generated in clients, by setting DBT up as a treatment individuals need to ‘qualify’ for. The fact that Charlotte calls DBT a ‘course’ lends to a sense of respect of what was on offer, for which she would need to show some motivation in an almost professional capacity, a bit like CPD.

Rose goes on to describe the assessment process:

“When I was assessed I was asked ‘why are you here’, because initially I was told that it is mostly for people with personality disorders and I don’t have a personality disorder, and then, sort of, when I got into it a bit more and they found out more about my background, they said, oh we can see why your consultant has got you to come and do this.” (Rose, p. 3, 35-39).

Rose’s account highlights the positive adaptation of DBT to a transdiagnostic group. Whilst the assessment for DBT was firmly boundaried, it was open to different diagnostic categories, suggestive of a more flexible assessment approach being useful. Whilst both Charlotte and Rose did not have a diagnosis of BPD, they were accepted onto the programme based on questions around emotion regulation skills, impulsivity and substance use. This would advocate for a more widely adapted version of DBT, irrespective of diagnosis and honouring a less pathologising approach to psychological therapy.

3.2.1.1. Summary of sub-theme one

This sub-theme of the DBT pathway has included all participant experience prior to DBT, whether that was their experiences of crisis and desperation, or those of previous ineffective therapeutic interventions. Common to all participants is the sense of having experienced the darker elements of their psyches coupled with the futility of their attempts to reconcile - be that in ineffective treatments, trips around the world, or the desperate search within the mental health system to find an effective intervention. In order to answer the research questions, it is important to reflect on the nature of how the participants experienced primary symptoms and emotions, to give voice to the perceived process of change.

3.2.3 Sub-theme two: Symptoms & Emotions

The symptomology of all participants was reported to be more prominent at the beginning of the therapeutic process than at the end. At the beginning it is clear that they were all suffering with high levels of mental distress. These ranged from suicidality, alcoholism, major depression, self-harm, anxiety, and intense experience of emotions such as fear and anger. Emma describes intrusive thoughts as being the most distressing of her symptoms:

“I’ve had some compulsive behaviours like skin-picking...but...the intrusive thoughts...was very very distressing. And that would be completely paralysing because there wasn’t enough room in my head for any other thoughts when all the intrusive thoughts were going on so I found it really hard to do, or feel anything apart from dread and horror of what was happening inside my head.” (Emma, p. 1, 27-31).

The experience of paralysis encapsulates the detrimental nature of her mental distress, that she is fully immersed in a world of horror, with no tools to dig herself out. It is understandable that this would take over the entire being, so that she, in effect, becomes the embodied nature of ‘horror’ in a world of policing thoughts coupled with the inertia of paralysis. She goes on to explain how her anxiety held no logic, it was non-sensical to her:

“anxiety is something I’ve had all my life really...it’s like feeling threatened but you can’t actually find the threat. It would make it easier if there were a solid threat around you could go ‘ok there is a bear that is about to attack me, that is why I am having this feeling, ok, so it’s appropriate’. It’s just that inappropriate feeling of being keyed up and full of dread the entire time”. (Emma, p. 1, 32-37).

Whilst there is something almost accepting in her account about the nature of what she has had to live with from a very young age, there is also the sense that this has been a struggle, dealing with a non-sensical world inside her own mind and body. The fact that she is able to clearly articulate this at this point in time would give the impression that she has managed in her own way to ‘make sense’ of her experience, or rather to *accept it* as experience. Rachel also describes what sense-making meant to her:

“I started to feel that I made a bit more sense to myself, and I might not like a lot of the things about myself, but that, I am alright... the reason DBT has helped, started me getting on the way to feeling that I am ok...is because, it sort of says well that’s ok, you know, you are not faking it! I felt extremely ashamed about how I instinctively feel about things, I feel like I over feel, like I over react. I don’t want people to think I am a drama queen, that I am melodramatic, or attention seeking... It also teaches you that they (emotions) are useful. You know, if you have an emotional response, if you can listen to it, I don’t mean act upon it but listen to it, it is telling you something.” (Rachel, pp. 9-10, 301-308)

This sense-making leading to feeling accepting of the self feels important in terms of an internal psychic shift as well as a deeper connection with the emotive self. Both Emma and Rachel’s accounts suggest shifts from the objective to the subjective, fleshed out in sub-theme 12 in how participants change their perceptions towards the self.

Anxiety is described as being experienced by all participants, before and after the therapy. The emotions experienced by participants included loneliness and isolation, shame and fear. Three participants mention ‘love’ or intimate relationships as a trigger for emotion dysregulation or isolation. James describes splitting up with his partner as a trigger and deterioration in mental state:

“just before I started (DBT), I was erm.. It’s difficult looking back to that time, because I was in such turmoil, erm. But at my worst, I was yeah. Feeling suicidal, I had self-harmed on a number of occasions. I had sort of started doing new things like, self-harm...hitting, hitting myself. That was usually in front of other people, so my parents or my ex-girlfriend. Destroying objects. Erm. So sort of angry rages.” (James, p. 19, 661-665).

On reflection, James appears fearsome of his previous mental state, describing painful memories of a previous suffering self. The use of the past tense however - present here and in other parts of the interview - would advocate change and recovery, and that going forwards he is more aware of potential triggers for emotional distress:

“I do feel a bit anxious at times about history repeating itself. Because erm...yeah I think, the two sort of periods in my life when I have gotten really unwell have been in connection with serious relationships. So. Yeah. I think part of my improvement at the moment is cos that is not something I am currently involved in.” (James, p. 20, 711-714).

There is an indication of shift in emotions coupled with a fear of potential triggers, especially in the form of relationships with others. This would indicate a preventative buffer having been created through insight into triggers and past emotional dysregulation. Whilst there is a fear of relational triggers, James has created a space in his life to work on his acquisition of new skills thereby building strength and *mastery* over his emotions. Whilst relationships may always be a potential trigger for distress, his ongoing awareness of the self and how to deal with emotions would provide him with a stronger foothold in which to engage with others in the future.

3.2.3.1 Summary of sub-theme two

This sub-theme has attempted to illustrate the experience of participants in terms of emotions which feature a prominent place in their lifeworlds. Their insightful reflections aid in understanding the role of DBT in the process of change, to be considered in later themes.

3.2.5 Sub-theme three: Ambivalence versus Commitment to therapy

Having participated in a wide variety of therapies and experiencing varied journeys in the mental health system, it is not surprising perhaps to find that participants were managing ambivalence towards the DBT programme prior to embarking on the course. Literature highlights that clients enrolled in DBT are often difficult to engage, and dropout rates are high. Engagement is therefore key, and the ambivalence is a firm barrier to treatment outcome. As James describes:

“I was feeling suicidal...if certain scenarios were to happen then I would plan to sort of, end my life, rather than going through DBT...” (James, p. 2, 45-47).

He goes on to explain:

“I sort of thought that it would be too difficult and I would have to go through a lot of pain...not necessarily as a result of the therapy as such, but just the...yeah...I guess addressing my issues, yeah...the suicide, at certain points, seemed preferable to that.” (James, p. 2, 55-61).

On a descriptive level it would seem that James perceived DBT as frightening in some way, and that the fear of suicide is lesser in his mind than that he could face in DBT. A linguistic interpretation notices James' use of the past tense, providing us with implicit proof that the therapy worked for him. There is a sense that he feared what lay beneath, and his perception was that the therapy would put him in a situation where he would be forced to face painful emotions.

This is helpful to DBT therapists who know that DBT does not advocate that clients talk about their past traumas. DBT actually seeks to work in the opposite way, and to build on the acquisition of new skills as opposed to talking about traumatic events. Perhaps it is important to inform clients that it is not a 'no pain no gain' form of therapy, in order to increase intake numbers and reduce dropouts. Rachel helpfully articulates this:

"If it can be sold at the beginning this is not namby pampy therapy, talk to me about your you know, 3 months as a baby, stuff. This is really practical, like, practical, tangible, you know, rather than necking half a bottle of whiskey a night, because that is not working out so well for you at the moment." (Rachel, p. 24, 811-814).

Rachel's reflections are based on the notion of her own initial ambivalence:

"What is BPD? I didn't even know what a personality disorder was, I still don't really understand... [the therapist] spoke to me about it and said yes, DBT would definitely be suitable for you

Interviewer: And how did you feel about that?

Rachel: whatever works.

Interviewer: And what makes you say that?

Rachel: Desperation." (Rachel, p. 3, 89-100).

Here Rachel articulates her desperation in having tried many things to help herself over the course of her life and recent crisis, to no avail. Her laconic responses are not typical of the rest of the interview, resulting in a perception of this *part* being embossed upon the *whole*. It could be reflective of a lifeworld overarched with continuous and utter desperation, which she has attempted her whole life to cast to one side, to no avail. The 'whatever works' response has an air of anger or perhaps shame, of what it means to be suitable for a DBT programme. The BPD label can hold negative connotations to those not previously

diagnosed with the condition, and that they misattribute themselves with deficits in character, as opposed to people who need to learn new skills to cope with emotion dysregulation.

Rachel goes on to highlight through the benefit of hindsight, the importance of clients being fully explained to them at this stage what DBT is, to ensure that they are prepared to commit to the programme. She talks about the experience of DBT as a ‘rolling group’ programme, in that new clients will join at various points in the 12 weeks:

“you get a mixture of people...(some) are quite sort of comfortable and know each other, and sort of know what’s going on. And some people that are sort of rabbits in the headlights, this is all new, what is DBT? ... There was one person who I found very disruptive in our DBT group, who subsequently I understand left DBT. Because she, didn’t – I don’t think it had been explained to her what it was at the beginning. And she would constantly make comments, you know, why do we have to check in, why do we have to identify our emotions, why is it helpful to talk about our emotions, why can’t we just think positive, why can’t we be here talking about happy activities and happy things. And that I found really frustrating.”
(Rachel, p. 17, 565-574).

The take home message for therapists here would be to offer clients all the appropriate information about DBT prior to them starting the programme, as well as having to manage the distress and ambivalence of some clients through the course itself. Clients are often engaged in conversations with therapists prior to starting DBT, providing therapists an opportunity to perhaps ask clients about their thoughts and perceptions of DBT at the outset, holding in awareness this ambivalence and confusion around diagnosis and what it takes to commit to a 12 week programme. It would not be the job of the therapist at this stage to challenge or shift the ambivalence, but to hold it for the clients and offer them all the appropriate information about DBT and what it has to offer them in terms of acquiring new skills (Linehan, 2015), as opposed to a deficit model for the ‘sick’. It is quite possible that this is already being carried out in services, however, Rachel’s lived experience of frustration tells us something about how professionals can begin to understand the experience of those committed to the programme versus those who dropout. It alludes perhaps to the need of thorough dissemination of information at the outset, possibly leading to better retention rates, and less of a ‘rabbits in the headlights’ experience.

DBT is a demanding programme with 4 core modules to be learnt over 12 weeks (in its current adapted version) including a day of skills group training, and weekly 1:1 therapy.

Additionally there are homework tasks and telephone consultations. This is highlighted in Charlotte's account:

"it's such an intense course...and I don't think anyone can just sort of be thrown onto it. I think...you've really got to have like... I'd say, not problems, but you have to be like not in a good state, or you have to be...it's quite traumatic basically. The stuff they go through and how to deal with it. Not just anyone can go onto that course" (Charlotte, p. 1, 11-14).

Charlotte's account gives an idea of the intensity of experience and that clients would need to have some resilience to undertake DBT. The 'trauma' she mentions may pertain to notions of suicidality and NSSI and how to cope with these emotional states. In that sense, DBT is more 'intense' than for example, CBT, due to the problems experienced by this client group. However, to be able to offer guidance to clients like James, it should be emphasised that DBT does not look to dwell on the past traumas of clients, unless they wish to bring this subject matter themselves to a 1:1 therapy session.

Participants have shown that DBT requires clients to negotiate their life commitments to be able to attend the therapy, and throws up the tension around associated stigma. Through this negotiation of home life, professional life, or both, clients are admittedly going 'in for treatment', which is subject to the perceptions of relatives and work colleagues. This stigma is described by Rachel:

"I was told by the managing partner of the firm that I was doing my reputation more harm by being there rather than not being there..." (Rachel, p. 8, 264-266).

"(DBT) was a huge time commitment, I was at the time negotiating to get a day off work...which is a 20% pay cut as well as the work difficulties it creates in terms of my reputation, my image, and practically what work I am able to take on." (Rachel, p. 12, 408-411).

Rachel describes here the implications on career, salary and potential stigma. Alongside the fear of stigma from others in her professional life, there is also a sense that she is objectively looking at herself in terms of her professional identity, and perhaps stigmatising herself as well. More will come to the fore here in sub-theme 4 when the notion of 'insanity' is considered. James also describes having to negotiate life commitments:

“in order to attend the DBT erm, I got some special permission from my work to erm, to take Thursdays off and work every Saturday. So I guess effectively I was getting one day off a week.” (James, p. 14, 506-508).

This commitment to rearranging professional life stands in contrast to the ambivalence mentioned above. It is suggestive of a lot of effort and organisation, as well as experiencing unease in terms of potential stigma. This is an interesting tension within this theme, where ambivalence may actually refer to a deeper conflict related to the desperate need to commit to something which may help, requiring high motivation. Rachel explains:

“I felt enormously invested in it. Enormously. I was like right, we take this seriously... I had already looked through it before the first session, because I like to know, you know, what’s this about and how does this work and I had Googled it and...it was a 12 week programme, and it was a huge time commitment”. (Rachel, pp. 12-13, 402-408).

The 3 other participants revealed less concern regarding stigmatising responses outside of the hospital or issues with negotiating commitments, as they were not in employment at the time. For these participants, the idea and concern of stigma came towards the end of the therapy, when they were about to be reconnected with the outside world. More will be discussed in the overarching theme: The Private Setting – “Heterotopia”.

3.2.3.1 Summary of sub-theme three

This sub-theme has aimed to encapsulate the tensions experienced by clients due to requirements of embarking on a DBT programme. This could be viewed as a spectrum, with ambivalence on the one hand, and commitment (and motivation) on the other. The developmental process of what it takes to move from one to the other is illustrated in other themes, resulting in shifts in perception of the self, others, the therapy, and the world (context) in which they inhabit.

3.2.4. Sub-theme four: Refuting Insanity

Throughout the data set there is a sense that identification with the term ‘mad’ or ‘insane’ or ‘sick’ was difficult for most participants. Four participants appeared to have difficulty accepting their own ‘madness’ at the beginning of the treatment, and often would refute their illnesses or problems as less severe than those typically thought of in society as ‘mad’. James explains:

“I think I was expecting to be in there with er...I don’t want to be politically incorrect, but people who are evidently ‘mad’!...and what I found out was that...on the face of things they were sort of, normal everyday people”. (James, p. 3, 81-85).

For Rose, refuting the seriousness of her major depressive symptoms resided in recruiting the non-clinical population into DBT:

“I’ve always had issues... I just think anyone should do it (DBT). It doesn’t matter even if you are not suffering with a mental illness, because I just think it’s so practical. Because everyone gets down...” (Rose, p. 2, 47-51).

Rachel also feels similarly:

“One of the concerns I have about DBT is why am I on it? Is that, I mean, I think everyone should have DBT, I think it’s absolutely brilliant for helping you to be more sympathetic to yourself, and to stop trying to squish yourself into, myself into, the person I think I should be.” (Rachel, p. 18, 608-612).

Rose and Rachel notice that the people around them in their lives also suffer with the everyday difficulties in interpersonal relationships and bouts of depression or anxiety. There is a sense that DBT has provided them with insight into the detrimental behaviour that other ‘normal’ people also engage in. There is also a need to push their own issues away somewhat, and their severity, in an attempt to normalise and destigmatise themselves and DBT. Whilst the majority of the population could well do with better DBT skills, they may not be suffering to the same extent as Rose and Rachel whose symptoms have brought them into hospital.

In a similar vein, Emma describes her symptoms as less serious than others on the DBT programme:

“most symptoms or expressions of Borderline Personality Disorder didn’t really apply to me. So I didn’t have problems with addictions or abandonment or anything like that. But I think the questions were mostly about the entrenched nature of my self-harming behaviours” (Emma, p. 1, 20-22).

We know from her previous account of ‘paralysis’ the severity of symptoms, but here there is something which refutes the gravity of suffering in her lifeworld. It could mean that symptoms are deeply rooted and resistant to change, as they may be serving a protective

function. The use of the word ‘entrenched’ throws up an almost war-like, soldiering on that she has had to undergo. It is suggestive of a huge and courageous battle on her part, where survival is dependent on refuting the seriousness of the danger she felt she was in. In the same way that true soldiers on a battle field need to protect their minds from the horror of life-threatening situations by not allowing thoughts of the dangers and perils to control them, she has managed to find her way through her internal battle of the perilous mind.

For Rachel, the process of refuting her own insanity is very explicit:

“the reason I resisted all kinds of treatment for a very long time was because I could not, I did not accept, I did not accept until about a month ago that I have been ill. I certainly did not accept the word ‘ill’ when I was an outpatient or inpatient, I was very angry, because I felt like I was... I felt that as it was something in my head...I couldn’t understand why I couldn’t control it... so basically, so I am faking it. So I am, at some level, making it up, faking it” (Rachel, p. 4, 113-120).

This feeling of fakery could allude to a process of pushing away notions of an ‘insane’ self and the implications of identifying with that part of herself. Having previously discussed her work achievements and life commitments, it would be extremely difficult to then integrate another aspect of the self which completely negates her lifestyle and professional commitments. This again illustrates the action of ‘refuting insanity’ as protective, in order to put on a ‘brave face’ to the world in an attempt to fit into it and its societal constructs.

Therapists would hopefully aim to hold this underlying sense of shame or fear, and allow clients to find their own ways to come to terms with different aspects of the self. In the DBT model, this occurs through use of validation techniques and the balance between acceptance versus change (Linehan, 2015). The outcomes of this are described under the third master theme in sub-theme 12 ‘From the objective to the subjective self’.

The divergence of this stance resides with Charlotte, whose diagnosis of bi-polar affective disorder (APA, 2013) at a young age and having been through the mental health system for some time meant that she was perhaps more *au-fait* with viewing herself as ‘ill’. She describes herself and other people’s illness as a bonding factor enhancing capacity for mutual understanding:

“the nice thing was that you go round and most people have the same illness. Either bi-polar or personality disorder. And that’s really nice, because you all have the same illness so you can all talk about it.

Interviewer:there are a few diagnoses in the group, but they all felt the same?

Charlotte: they are all very close... Like you can be misdiagnosed with something... If you have a personality disorder you are more than likely to have bi-polar...and (they share) all of the same feelings

Interviewer: So what was that like, how did that feel?

Charlotte: It was just nice to talk to people who have the same thing as you really. ”
(Charlotte, p. 2, 54-64).

There is the sense that Charlotte takes ownership of her ‘illness’ whilst at the same time highlighting the futility of the diagnostic system. She identifies herself and others as having an ‘illness’ but that the diagnostic category is fairly inane, and she seems less inclined to have faith in what these labels mean. She narrows it down to people who ‘*have the same thing*’. The ‘*thing*’ here could pertain to a number of diagnoses but she is really talking about people’s emotions, reactions, and lifeworlds which resonate with her own. This is in tandem with the assessment criteria for a transdiagnostic DBT group, which looks at the emotion regulation skills and impulsive behaviours of clients, as opposed to their diagnosis per se.

3.2.4.1 Summary of sub-theme four

This sub-theme has attempted to highlight ‘refuting insanity’ as part of the process of engaging with a DBT programme. It is perhaps in essence a behaviour, or what psychoanalytic schools of thought would term a ‘defence’. However, this sounds critical and negates to illustrate this behaviour as a fundamental survival strategy, serving as a protective factor enabling *being in the world* as they know it. Perhaps it is in the trust and faith placed in the DBT framework that enabled participants to feel safe enough to relinquish this behaviour and reaction towards the self, creating space for something new in their lifeworlds to occur.

3.3 Master Theme 2 – In-Session: ‘Belonging’

The second master theme was termed ‘In-Session’ following the description that the DBT programme felt like ‘school’ or being on a course as opposed to ‘therapy’. DBT imposes structure, rules, obligations and firm boundaries, together with groups that can feel like school classes. Participants speak of compliance with the DBT regimen, which demands a high degree of commitment and faith in the process. The nature of how participants

experienced DBT is broken down into 4 sub-themes, highlighting their lived experience as well as what they felt was helpful and unhelpful about the therapy.

3.3.1 Sub-theme five: Relief & Surrendering

All participants commented on a sense of belonging, togetherness, mutual support and empathy. The significance of this cannot be underplayed, in terms of the 'DBT Pathway' which they have all had to endure to come to this point in their journeys, finally finding a place of belonging. The group and setting provided the opportunity to make friends thereby offering a space for intimacy and connection. This is accompanied by feelings of relief, whereby they are able to let go of a previous ambivalent stance and surrender to the process of the therapy. Rachel says:

"I think that sitting around and thinking happy thoughts hasn't worked for me so far. And the relief about DBT is that it seems to be saying, you don't have to sit around thinking happy thoughts, it's ok that you are feeling a bit shit, actually." (Rachel, p. 17, 583-585).

Rachel's use of 'sit around' indicates the futility and inertia that accompanies 'thinking happy thoughts' giving rise to non-acceptance of the self. Relief is found in the acceptance of painful emotions, which may also be accompanied with action as opposed to incapacitation through the forcing of 'happy thoughts', fundamentally detrimental to the self in need of validation.

Charlotte goes on to explain her experience:

"I just always get nervous, about meeting new people...and then, I suppose once I get to know people I am more open with this stuff. And I think actually, I think once you become 'well', because I think in the group, you obviously do become...because you can see people becoming well, and opening up more. And then it becomes more like, you share more and more, and you are like ok! What are you doing later? And stuff like that". (Charlotte, p. 2, 67-71).

Charlotte highlights how one of the main components of starting group therapy is the impact of others in the group. She describes the visible process of recovery that she felt in herself, and saw in others. Over time, this cohesive experience created an appropriate psychic place for friendships and connections in the hospital and outside. Emma describes her experience:

“I remember things for example like the strict regulations around time, not being late and not coming back later from breaks, and I quite liked that, having the structure of it, having someone to report to.” (Emma, p. 3, 118-120).

The reporting structure is an interesting inference, perhaps implying the therapists as ‘teachers’ or ‘leaders’. This coincides with earlier language she used around war, and that here she has found an army-boot-camp like experience which suits her endeavour to soldier on in the face of battle – that is – the battle with her own mind. She continues:

“I think because there were smoking breaks, and I don’t smoke! But I would just sit there whilst everyone else smoked and we’d all just have a chat about what was going on. So it felt very supportive. Because I think a lot of the people there were struggling with similar issues or had you know, similar ways of viewing said issues... So it sort of felt like a safe place... I felt there was a lot of room to question what was going on and ask for clarification. Because I was constantly saying, ‘but what about this and what about that?’ And I wasn’t feeling like I was about to be told to shut up and sit down.” (Emma, p. 3, 123-131).

The sense of belonging is clear in being involved in breaks and forming new connections. There is an ease in the way she speaks about the experience, inferring fluid social connection in contrast to perhaps previously difficult or stifled ones where her ‘said issues’ had no place to reside. The freedom to question and not infantilised was important to her – and there is a sense that she provided the group with food for thought and was an attribute to her peers and to the therapists who validated her inquisitive nature. James resonates with this:

“It’s difficult to describe but there was something in the group dynamic that...I guess you could get other people’s feedback and you could...well I gained a lot from hearing other people’s sort of views on things...I guess also, compared to 1:1 therapy, in a way I think I sort of felt less pressured because it wasn’t all about me.” (James, p. 3, 94-98).

He goes on to describe:

“In terms of the way it was conducted, I felt, I felt very comfortable in the environment, um, because the leaders, the therapists, I thought they were very good in creating this sort of, validating environment... I didn’t feel as though I was under pressure to perform in any way.” (James, p. 3, 103-106).

That ‘something’ in the group dynamic could pertain to the ease and fluidity that Emma describes in being able to form connections based on common and mutual understanding of each other’s lifeworlds, together in an environment that felt validating and encouraging.

It is surmised that the process of engagement with DBT begins with ambivalence and moves on to this feeling of relief of being in the right place, heard and accepted. This then seems to enable a surrendering to the process of the therapy, where participants can engage in a more real way, with less barriers to learning. The ‘surrendering’ was so named due to the implications of participants engaging with their spiritual selves throughout the programme, through mindfulness. Mindfulness is a concept and practice which is often met with high degrees of ambivalence, and yet unconsciously engages people in the spiritual aspect of the self. It is through this process of engaging with mindfulness as well as other skills that the sense of surrendering to the process comes in. Participants find that the skills they are learning actually work and speak to them, enabling a deeper sense of belonging and commitment to the programme. Rachel describes her experience:

“I had tried mindfulness before...I had tried it, I’ve tried it, I tried the app, and failed. Because I didn’t really understand what I was meant to be doing and I didn’t understand why I was meant to be doing it. I remember having the first week of mindfulness and thinking... Oh why am I doing this. Like you know.” (Rachel, p. 8, 249-254).

She goes on to explain the shift through a real-life example:

“around the third week, early on, very early on...and I had found myself in (the city) at rush hour... It was really hot, I was wearing really uncomfortable clothes, I felt fat, and I didn’t have a phone, I didn’t know where I was going... I just wanted to cry, and you know. And I found this hedge! And I thought ok. And I did some breathing exercises. I was near a bus stop, so it looked like I was waiting for a bus... so I was like, I did some mindfulness looking at the leaves. So I did breathe, breathe, breathe, breathing, and mindfulness looking at the leaves. Erm... And that’s when the mindfulness stuff started to make sense.” (Rachel, pp. 10-11, 337-349).

On probing Rachel about how this changed things for her she said:

“I just thought, I can’t keep...doing...I can’t...I don’t want to carry on living the way I am at the moment [tearful], because it’s rubbish. So I just thought I will look at a hedge.” (Rachel, pp. 11-12, 371-373).

This is a good example of how engaging in mindfulness, perhaps as a last resort following a long journey of pain and internal torture, marks a shift from ambivalence towards the therapy to an internal commitment to change. This commitment has more of a surrendering feel to it, in that it is markedly different from the commitment referred to in sub-theme 3, where a conscious and negotiating commitment took place to be able to practically embark on the programme. Here, through finding an escape from previous torment, there is a sense that she can surrender to the process of the therapy in the lived-belief that it has value to her. Other participants reveal a similar process, as Charlotte explains:

“I remember things clicking, like, mindfulness... I was just like what... this is so shit, what is this. And then actually, I remember doing this once, coming out of the session and having a fag, and just actually being mindful. And I was just like, oh my god, this actually works! And I was like, oh my god, this is so cool!”

Interviewer: What was that like? To go from ‘what’s the point of this’ to ‘oh my god this is so cool’?

Charlotte: It’s pretty amazing like, I still like...there will be days where I am like, oh my god I am being mindful. And it’s a really good key to have.” (Charlotte, pp. 4-5, 139-145).

There is a sense that finding that mindfulness ‘works’ enables a different kind of commitment to the programme, and an inner faith in the process. To describe something as ‘shit’ is fairly revealing and deploring of the techniques she was being taught, and it is the experiential learning that enables a surrender to the process and an even deeper sense of belonging. Furthermore, this surrendering enables the skills to be more long lasting, in that she is still practising or able to observe her mindful moments post-therapy.

Another marked shift in the surrendering process was when participants could begin to accept their powerlessness over their emotions, in a way of relinquishing control. Rachel explains:

“It’s about sort of acknowledging that I feel sad, and that, I don’t have to like feeling sad, of course I don’t like feeling sad, but that I can’t make that feeling go away. You know, sometimes I can distract from it, by seeing a friend, or a film, or whatever it is. But, I can’t actually change it. I just have to accept that it is there. And it’s the same with anger... I can’t magically not be angry. So it’s not... I would say DBT is not about being passive at all, but it is about saying so long as you have to just accept that stuff is there, you don’t have to

like it, but that it is just, and it is just there. And not in a negative way at all. Not in a pessimistic way.” (Rachel, p. 14, 442-450).

Rachel is keen to see the therapy positively despite her internal struggle with difficult emotions that she must ‘sit’ with. This is testament to her character perhaps, that she is able to take this new way of approaching her emotions with a sense of acceptance despite associated internal pain, indicating the effort and resilience required to sit with unpleasant feelings. She is letting go of past attempts to control or ‘magically’ make feelings go away.

3.3.1.1 Summary of sub-theme five

The sense of belonging is illustrated in this sub-theme as being facilitated by a sense of relief and surrender to the therapeutic process. It is here that participants seem to place trust in the parameters of the programme, so that they can begin to engage more authentically as they commence the learning and acquisition of new skills. The surrendering has a spiritual aspect to it, highlighted further in sub-theme 10, ‘Reflective Practice and Spirituality’.

3.3.2 Sub-theme six: Learning & ‘Tailoring’

All participants comment on DBT feeling uniquely different to other forms of therapy, and the analogy of it being like ‘school’ or course was referred to:

“Interviewer: You mentioned it was like school, can you tell me a bit more about that?”

Charlotte: Well I hated school, I thought it was really shit, but... I think it was like... you were all friends and you were all like...and I remember like, whoever I was sat next to I remember asking ‘oh what are you highlighting!’. And like, it’s that taking part, and not so much the information they are giving to you, it’s the taking part.” (Charlotte, p. 8, 280-284).

She goes on to describe:

“I liked having a folder. I thought that was pretty cool. Making your own folder, having all these little dividers, actually going into my room...and I felt really cool having a folder” (Charlotte, p. 4, 131-134).

This is mirrored in Rachel’s experience:

“It’s that kind of school, I really liked school.

Interviewer: You said it was like a class?

Rachel: Yes. I sometimes refer to it as class. I mean, it's not class. Because... well it's just not is it? It's different...

Interviewer: Well here you are sitting with a ring binder...

Rachel: I've got a ring binder, oh I bought the ring binder myself! [laughs]. And I really like, that sort of, gives me a sense of gumption! Like it's not just, I am not just going to sit around and talk about being sad, I am sad, what can I do about it, right! Let's go!" (Rachel, pp. 22-23, 754-761).

The linguistic use of 'gumption' strongly emphasises motivation, assertiveness, energy, and creativity - in finding out how to get well. It is interesting that something as simple as allowing participants to have folders led to such a dramatic sense of personal responsibility, with emphasis on being treated as adult learners. Emma explains how the setup of it being like a 'course' enabled a unique learning experience for skills to be embedded over time:

"if you didn't fill out your DBT diary or your, or whatever your homework was for that week, that would be 'non-compliant' with the DBT course. And so because you had that external framework in place, it made one less likely to forget the lessons of the previous week, because you had to bring them with you, and you had to be considering them the whole week through." (Emma, p. 11, 449-453).

This highlights the secondary gain of setting the therapy up like 'school' or a 'course'. School is a model familiar to people, providing an interactive learning environment whereby the therapists become teachers or facilitators delivering 'lessons'.

In Charlotte's case this provided her with a corrective experience, where she could engage and feel comfortable and 'cool'. Rather than infantilising the clients, the school-like analogy seems to give them a sense of enabled purpose and status as human beings, as opposed to stigmatised 'mentally ill' patients receiving treatment in a psychiatric hospital.

The learning of skills was central to the group learning experience, some of which were perceived as helpful and others not so helpful. DBT is experienced as a 'giving' therapy, whereby an interactive learning environment provided enabling tools to manage distress. For Rose, and others, it was the practical nature of this learning experience which was so refreshing:

“It’s a therapy that is very practical, so it actually gives you...it says ‘right you have a thought or a feeling’, it doesn’t challenge it...it sort of says fine, you sit with it...but in order to prevent anything else from happening you sort of stop at that point by doing various things. So like, Distress Tolerance, if you are feeling really down, in order to prevent it getting to a stage where you might self-harm for example, you would sort of stop it...by using various things...like smells, touch, or whatever works for various people”. (Rose, p. 3, 97-103).

Unique to DBT is the implicit process of clients actually ‘tailoring’ their own therapy. DBT provides clients with a familiar and holding framework in which to learn, whilst being taught an abundance of skills. Understandably, some skills will speak, to a greater or lesser extent, to some clients than others. They are able to take in and take away, the skills that work for them. Distress Tolerance skills were named by all participants, including taking cold showers, putting the head into a sink of cold water, or holding an ice-cube. Charlotte describes the excitement of learning new Distress Tolerance skills:

“It’s like an elastic band to do the ‘tinging’ thing. I used to wear an elastic band. Sour sweets, incredible. And...I mean they say like listen to music and stuff like that, but for instance when someone has that instant (to self-harm), I don’t think people can turn on a CD player, that doesn’t work, that’s not real life. So I think it’s the instant things actually really caught people’s attention. Cos you could say just do a painting, but that’s not real life, that’s not how it works.

Interviewer: When you say it’s not real life, how do you know?

Charlotte: Because it’s like, when someone is in that ‘right I am going to self-harm’, you don’t think, oh right, what did someone say? Oh right, let me find my paintbrush that is under my bed.

Interviewer: So how did it feel to be told something like that, put on a CD or something?

Charlotte: Well you do listen to it, but I don’t really, I’m just like....you know what works for you and what doesn’t.” (Charlotte, p. 11, 382-393).

Charlotte’s reflections on Distress Tolerance skills neatly encapsulates her engagement with ‘instant’ skills providing relief, as opposed to others which she could dismiss as not being part of real life. She infers that others felt similarly, as resonated in Emma’s account:

“DBT is a lot more about grounding yourself in the physical world sometimes. Especially with the self-harm treatments, such as biting into a hot chilli or holding an ice-cube, they are the sort of things that really snap you back to reality.” (Emma, p. 12, 477-479).

Rachel talks about her use of Wise-Mind skill:

“State of mind: wise-mind. I found really helpful. Again, this is one...my mum...she’s always on about ‘What would a wise-man do?’ Previously this has made me want to scream, and stamp and kill people. Not actually... Because it sounded so...middle aged? So impractical. Well yes, if I were sitting on a rock, and I had you know, lots of time to stroke my beard and think about these things, then yes, I would act wisely, but I don’t! I don’t... So actually the discussion of wise-mind, acting in wise mind, and using...this is where the mindfulness came in”. (Rachel, p. 10, 328-336).

Rachel gives a good account of how previous experience can affect the way in which she engaged with this particular skill. She shows that despite preconceptions, that if delivered in the right way in the right context, with good explanation, that engagement with the concept in a new and enabling way is possible.

Other skills voiced by the participants as useful included Acting Opposite, distraction techniques, radical acceptance and self-soothing. The Behavioural Chain Analyses (BCAs) were often mentioned in tandem with self-soothing, as Emma describes:

“I think doing the BCAs was quite a big thing, because I hated hated hated doing them! But then, the entire time it was about ‘what could you have done differently, what could you have done instead?’ And suddenly you get those voices in your head when you have the urge to self-harm saying ‘what could you have done differently, what’s a self-soothing behaviour you could go and do?’ You know, do you need to go and hold an ice-cube or paint your nails or have a hot bath...” (Emma, p. 7, 283-287).

Emma’s experience resonates with her previous accounts of feeling that there is a reporting structure in DBT, and that there would be negative repercussions if she did not remain compliant. There is a sense that she respected the process of the therapy and therapists, in that she did not want to displease others by taking a step backwards and engaging in problem behaviours. She seems invested in the ‘voices’ in her head telling her to do something differently. From this and other participant accounts, it would appear that faith in the therapy is essential to client change, probably possible only in the context of core conditions where

clients feel trusting enough to surrender to the process, and can engage in interactive learning and tailoring.

Conversely, participants also revealed what did not work so well for them. Some felt that skills could be overly complicated, and confusion over the term ‘dialectical’ came up. Rachel explains how she dealt with her confusion here:

“I don’t really understand the dialect-dialectical part, but I have tried, the way I have tried to think about it is about radical acceptance, which is the hardest thing.” (Rachel, pp. 13-14, 439-441).

There is a sense that DBT does come with difficult terminology and perhaps needs a lot of explanation and time from the therapists to ensure group members understand. As Rachel suggests:

“perhaps (the therapists) going around the room, you know, what do you understand, you know, what do you understand?” (Rachel, p. 6, 181-183).

There is a sense that this would be an added piece of work for therapists in an already time-constrained therapy, but that the benefit for clients could be high, through the checking-out of acquired knowledge to ensure correct understanding of complex terms. For Charlotte, it was the length of the sessions which was draining:

“you were in that room for long hours. It was bloody long. I remember sitting like going, when will this end? It was like so long.” (Charlotte, p. 10, 328-329).

3.3.2.1 Summary of sub-theme six

This sub-theme begins to flesh out the core of DBT – how clients learn skills, and how they are able to tailor the therapy through a ‘pick-and-choose’ flexible modality. This leads on to capturing the deeper psychological effects of the therapy, highlighted in the next sub-theme.

3.3.3 Sub-theme seven: Validating & Debunking

Validation was mentioned by all participants and featured prominently in most accounts.

There is a sense that the notion was difficult to understand and experience, albeit essential to the success and client progression through the therapy. There was a need to debunk many of the ideas and cognitions in the lifeworlds of the participants, with the support of the therapists.

Rachel describes feeling annoyed for not understanding validation in the first few weeks of the therapy, but that the process of understanding was key in providing her with the capacity to move forwards:

“...and I remember in the first couple of weeks hating the word validate. Someone said you have to validate your emotions what does that mean? Some kind of therapy talk? Erm, and I sort of thought it sounded like rubbish. But that has made the biggest difference.” (Rachel, p. 4-5, 133-136).

She explains what she understood in the first instance:

“what I understood by the word validate, was, by being, you know, advised that I should validate my emotions, was that I... should agree with them, like them, condone them in some way? Or, and/or, that I should act upon them.” (Rachel, p. 5, 152-154).

Through a process of debunking her beliefs about what validation meant to her, with the support of her therapists, she came to a metaphorical understanding of the term:

“so the opposite of validation I thought, was sort of, metaphorically, hitting myself with a stick. So if I feel sad, that can be...I mean that can be an awful feeling. And then if I then get angry with myself for feeling sad, well then, me being angry with myself is me hitting myself a stick... well that's, that's not going to actually make me feel any better. Because then I am just sad and I have been hit with a stick. Whereas if I can not do the hitting myself with a stick part, then, I am still sad and I am still rubbish, but it's less rubbish than sad and hit with a stick, does that make sense?” (Rachel, p. 7, 221-227)

There is a sense in Rachel's account of being able to let go of previous reactions towards her emotions, paving the way for a new capacity for understanding, and the space to do something differently. There is a sense that being hit with a stick reduces her to a shameful sub-human level. To be able to let go of that position would raise her status to that of human consciousness, where she is part of a world of intense 'rubbish' emotions, but as a human-being – *being in the world*. There is an energy here, as if the understanding was a catalyst to meaning-making giving rise to space for the creation of something new, despite the notion of having to sit with her deep seated sadness.

James explains how validation enabled a more compassionate response to the self:

“previously if I was feeling say, anxiety or anger, my attitude to that would make it worse, because for whatever reason, I would think that it was wrong to feel anxious or angry. So sort of, learning how to sort of self-validate was massive...erm...

Interviewer: So are you saying that you still have those emotions...

James: Yeah

Interviewer: but that your reaction to them is different?

James: Yeah, it's a bit more....self-loving really or self-accepting...” (James, p. 8, 277-283).

Debunking previous assumptions around self-harm amongst other things provided a platform for validation and the capacity to view the self in a more compassionate way. Other forms of debunking were the previous messages retained from CBT of needing to challenge thoughts as opposed to sitting with them, validating, and employing skills to change using wise-mind. The phrase ‘black and white’ thinking comes into play, where previous patterns of thought are replaced with a dialectic of having a conversation with the different parts of the self:

“When I feel, ‘bad’, that’s an inadequate word, but ‘bad’, I instinctively think, ok check in. What’s going on here.” (Rachel, p. 14, 471-472).

The fact that Rachel can identify ‘bad’ as insufficient to properly encapsulate the full range of human emotion and experience is progress, thereby evidencing a shift in how she may previously have attributed blanket terms to describe her experience. She now employs a skill to question the self, in a more compassionate way.

It’s here, in this theme of both validating and debunking, that the skills of the therapists come to the fore, as the participants explain how they experienced the therapists. They mention a ‘family’ being created where they felt comfortable in being both accepted and motivated to change. The participants were given the freedom to question themselves, the therapy, and the skills taught. As James explains:

“they were very skilled... It was all sort of drummed into us really actually, that, whatever, whatever we say is, and however we were feeling, that is ok... They were... when they kind of sensed that I might be feeling uncomfortable, they would kind of say...you know...it’s ok your feelings are valid. And then in a group situation, if they saw someone else was struggling a bit, they would get that same reinforcement... And I could sort of tell that the way the

therapists went about it, was. I felt they actually meant it, like they weren't just reading off a script kind of thing.” (James, p. 4, 118-124).

Being ‘drummed’ into reveals a repetitive and relentless enforcing of the skills, possible only perhaps in conjunction with a validating and respected therapeutic environment. The genuine nature of the therapists is deemed important here, that they were connecting with each client’s lifeworld, experiences and emotions. This is experienced as reinforcing, that is, giving a sense of stabilisation in a previously unstable emotional world. The stance of non-judgemental empathy and care comes through and is further reflected in James’ thoughts around self-harm:

“I can’t remember exactly what the therapist said, but it was the way, the way she was listening to me was important, and... the way she responded sort of conveyed the message to me that... It’s very difficult to describe. Because obviously I don’t want to be engaged in that behaviour, and the therapists don’t want me to, but at the same time... That it’s ok... That I was... That that was the behaviour I was engaging in.” (James, p.10, 353-358).

There is something implicit in the stance of the therapists which is deemed important in the validation and debunking necessary around self-harm. Interesting is the fact that what the therapists say, the actual words, are perceived as less important as what they embody and reflect. James’ reflective pauses here are suggestive of a considered, warm, genuine understanding from the therapists, which sounds mindful and caring. What the therapists can embody as role models feels pivotal to the success of the experiences of the participants that engaged in this experience of DBT.

For Rose, self-disclosure of the therapists was important as well as giving feedback:

“the therapists would get involved as well, so they would give feedback. And that is really helpful... Because you think, you know all the theory, you know everything, and then when they give their stories, and, they are human after all, you think, well they can do it, why can’t we?” (Rose, p. 14, 490-493).

Rose goes on to explain how the therapist’s persistence and using the ‘why’ question helped her to debunk beliefs around previous unhelpful behaviours:

“if someone (a friend) invites me, I won’t say no initially, I will say yes and then cancel last minute because I don’t want them to forget about me. So they (the therapists) use that, why

why, why do you think that is the case, what are you wanting. So I think it is more the challenge (by the therapists).” (Rose, p. 9, 313-316).

It is striking that Rose’s lived experience of being challenged in such a way does not appear to be experienced by her in a negative or punitive way, but rather harnesses a will to delve into a deeper understanding of her lifeworld. This is testament to trained therapists who probably have excelled in validating Rose’s emotions, to bring her towards an impasse (Carey et al., 2007) where she is able to be challenged in a holding and therapeutic way, and then to think about ways of changing.

As well as the therapists providing explanations and new rationale to debunk various understandings, Emma describes how seeing the issues of other group members helped her change the view towards herself:

“when you are able to see those processes in someone else, it’s sort of easier to identify when your thoughts inside yourself are being counterproductive or destructive...” (Emma, p. 6, 253-255).

“when you are seeing someone else and they are they are saying ‘I think X-Y-Z’ and you are thinking ‘that’s ridiculous, you don’t need to worry about that, that’s not even an issue’, then makes you feel a bit hypocritical if you are thinking the same thing. So you have that direct experience of seeing somebody else having similar thoughts and rationally being able to think, well they have got nothing to worry about.” (Emma, p. 7, 265-269).

This shared group learning feels pivotal in allowing clients to view and experience themselves in different ways, like a mirror of their own processes in others. It is almost as if others provide a screen for them to watch a film of their own personalities, with the parts of the film they like and can have fun with, in contrast to the darker elements which they would prefer to edit out. This seems to provide a rapid but profound shift, with a sense of startle and surprise at the ways in which the previous self had been watched, conveyed and reacted to.

3.3.3.1 Summary of sub-theme seven

Emphasis is given here to the importance placed by the participants on the concepts of validation, and debunking previous assumptions detrimental to the self and recovery. It leads to how participants experienced change, possible now that the barrier is lifted on the parts of themselves that had previously been refuted.

3.3.4. Sub-theme eight: Experiencing (Gradual versus Sudden) change

The perceived process of change was experienced by participants as subtle and gradual, or in ‘Eureka’ like moments. Rachel expresses a euphoric moment in finally understanding what it meant to her to apply validation to her experiences and emotions:

“(I felt) euphoric... cos I thought, and I remember texting, I’ve done it! I have worked out how to make myself better!”

Interviewer: Ok

Rachel: I don’t mean I didn’t feel... I didn’t feel I had made myself better, but I felt like hang on, now, now I kind of understand how I might do this.” (Rachel, p. 8, 238-244).

My response here appears to be perceived by the participant as a hermeneutic of suspicion (Ricoeur & Kearney, 1996), which appears to quickly propel the client into downplaying her euphoria in the fear that I may have misattributed this to an extreme notion of having been ‘cured’. She quickly goes on to explain that whilst she felt euphoric at the time, that it was coupled with a rational wise-mind, indicating that the euphoria was about an internal shift in the process of change, as opposed to pertaining a full recovery.

Rose comments on how the skills are like simple ‘*common sense*’ ideas that she had not thought of, and that hearing about new ideas led her to a sense of gradual change:

“you are learning little little things, that can change erm, like I can’t remember which module it falls in, but you know, just reading a book, or just doing little changes that they are suggesting can actually change your mood, and thinking god, that is so simple.” (Rose, p. 6, 209-211).

There is a sense that there is beauty in simplicity – in that small practical ideas can give rise to a shift in a debilitating mood. She goes on to say how this worked for her:

“maybe not reading a book, but looking outside, or doing whatever, and you can change your mood, and then you can think oh, there seems hope. So, at the beginning you think there is nothing and then as you gradually go through the course you think, oh there is hope, because there are things you can do...” (Rose, p. 6, 211-214).

“I mean I have had therapy for years, since I suffered with depression, and I had psychodynamic in the NHS which was a complete waste of time, all I did was just talk...” (Rose, p. 7, 219-221).

“(DBT) gave you life examples that you could actually use and take, and when we were going through them in class with homework, you would go back and people would be talking about what they had done, and you would think oh I actually, I didn’t think of that, I could do that as well. So it was the practicality that was there...and you pick and choose which ones were suitable to you. I think that was what was really important.” (Rose, p. 7, 225-230).

Rose seems to emphasise that DBT has a lot *to offer* in order for her to change – that she can learn and accept new ways of coping, as opposed to being offered nothing in the form of her experience of (individual) psychodynamic therapy. The change process is perceived as not merely coming from the suggestions of the therapists but group members, homework tasks and lastly, herself. It is this impetus on the self as the agent of change which seems difficult here, and that outside help and support in the form of ideas generates hope for change, which perhaps has an even greater implicit therapeutic benefit than the skills themselves. It is revealing of a lonely journey to date through the ‘DBT Pathway’ and that the DBT group provided a buffer against the unsupported loneliness paving the way for gradual change through hope. More will be fleshed out in sub-theme 11 ‘Hope & Joy’.

James describes a significant moment for him in relation to seeing all the different explanations offered to him on a handout for self-harming behaviour:

“Hearing that explanation, and seeing that there are potentially different ways, healthy ways to manage those emotions, that, that was quite a significant moment...it was a bit sort of an ‘ahh-ha!’. Ok, so that’s maybe why I was... (self-harming)... I think there was some sadness about... Erm. You know... looking at these sorts of issues. I did feel sad that, or maybe shame, that I... I had engaged in those sorts of behaviours...” (James, pp. 11-12, 391-410).

He goes on to reframe this:

“I think it’s more sadness and regret, than shame

Interviewer: Right

James: So there was that, and erm...that was positive... and I think that was another moment actually. Was that learning, that, you can feel these things at the same time.” (James, p. 12, 421-426).

What was interesting here is James’ ability to reframe a potentially difficult and toxic emotion (shame) into a more manageable and tolerable framework. He is displaying here

how things changed for him – that receiving an explanation brought insight and clarity, even though it also threw up difficult emotions. Armed with DBT skills he was able to push this feeling away, and reframe it, giving rise to a different conversation with the self and the emotions he identifies with.

The participants all recount having experienced some kind of change, be it a sudden or more gradual process. In focussing on what and how this occurs, Charlotte explains her experience:

“I think any sort of therapy helps someone. Whether it be DBT or whatever. I think it just has to suit you, do you know what I mean... I think every therapy, I think it is an outlet for someone. It did help me, because I was actually, maybe it gave me confidence skills to talk in a group, maybe it made me more sociable, maybe it gave me little things which maybe it's not meant to, maybe it's given me other things which erm, has helped me in my life.” (Charlotte, p. 14, 468-473).

Charlotte alludes to the therapy providing her with implicit skills or ‘things’ which have helped. It could be surmised that the experience in itself offers clients something which is less tangible, but enables a different experience of themselves and of *being in the world*. Charlotte is able to recognise what has been offered to her, and that it has worked for her, because of her character fitting the DBT model and delivery. This is interesting in thinking about character styles ‘fitting’ with models of therapies, rather than using only diagnoses and NICE guidelines to ascertain which therapy would work for whom. Charlotte benefitted from the confidence building and acceptance of the group programme above all, and acknowledges that this may not be a fit for all.

All participant accounts speak of change, be it subtle, gradual and/or in sudden moments of clarity and insight. Overarching this is a change process that participants speak of as so subtle that it is ‘difficult to describe’. This phrase came up many times in participant accounts, indicative of something out of reach of consciousness, but residing within them, as part of them and their current experience of themselves. James attempts to put this subtle change into words:

“the mindfulness, yeah, it's sort of difficult to describe, but... (pauses) it sort of permeates the whole thing, so. Developing mindfulness techniques, skills, is helpful in the other modules, I guess because it improves your... self-awareness, and erm. Yeah! I am not sure if I explained that very well!” (James, p. 5, 152-155).

Emma describes this in terms of her experience:

“Cos I don’t think there was an out and out change. I think it was something more subtle.

Interviewer: What makes you say it was more subtle?

Emma: Because I didn’t have any sort of grand epiphany! And like, I was still self-harming for a fair while after the DBT group it just sort of kept lessening in frequency and intensity until it got to the point where I could just ignore the impulses.” (Emma, p. 7, 276-281).

This subtle process is difficult to describe for participants, indicating that something has become part of the self, perhaps through embedding of skills over time. James’ use of the term ‘permeate’ gives voice to an almost constant permeating umbrella of mindfulness across the whole programme, which perhaps continues post-therapy. As Emma describes, some problem behaviours were still apparent post therapy, but she had learnt the skills to continue with and embed the subtle process of change. She encapsulates change as something that is possibly unconscious to the individual:

“It’s hard to detect change in oneself whereas I think other people can see it a bit more.” (Emma, p. 10, 386-387).

3.3.4.1 Summary of sub-theme eight

Change as a process, a phenomena, and as a concept, is experienced in various ways by the participants, and the accounts draw out both subtle and more poignant features. More will be discussed on this process post-therapy in the next master theme.

3.4 Master Theme 3 - The ‘Real’ World: “Living”

This theme encapsulates the lived experience of participants who had undertaken a 12-week programme and were finally ‘released’ back into the ‘real-world’. The context comes into play here but will also be analysed more closely in the overarching theme: The Private Setting: “Heterotopia”. There is a sense that this has been a huge journey for the participants, some of whom have completed the DBT programme more than once, or are likely to come back to try again.

3.4.1 Sub-theme nine: DBT as a Lifestyle

This sub-theme aims to encapsulate the notion throughout all participant accounts that the process of DBT – in learning, tailoring, embedding, reacting – continues post-therapy. There

is an indication that participants allow DBT to become part of themselves, part of their lifestyles, albeit in a conscious or unconscious way. James describes how practising skills is backed up in his knowledge of neuroplasticity:

“It is more like blind faith really. Yeah. Yeah, I am really putting my faith into what has been told to me... that the brain can be rewired. Yeah. There is evidence to sort of suggest that it can. So. Yeah. That does give me some motivation to sort of, practise these skills as much as I can.” (James, p. 17, 614-617).

For Rose, the process of embedding skills is explicit in terms of what the therapy had offered her, in the hope that it could become more habitual:

“In sessions we would just do one minute of something, and you think god, you can just simply do that... And you think, and that’s something that I would like to do, put it in your daily routine on a regular basis as opposed to thinking, oh god, I need to do this. So be it a bit more, because it comes unconsciously in your mind, that is what I would like to do.” (Rose, p. 13, 467-471).

Self-disclosure of the therapists was important to Rose in this process:

“even when the therapists, you know, they make out they are human as well, and then they say, they have given their own example, for example, one said they were stuck in a traffic jam, and they were getting late to go somewhere, we could have gone oh my god, and gotten herself stressed and everything, and one just said, I just put on some music... I guess that just becomes second nature that they know, oh my god, in order to prevent that happening, we can simply do something...so that makes me think about it becoming second nature.” (Rose, p. 14, 477-485).

Interesting here is Rose’s use of the therapists ‘making out’ like they are human, prior to self-disclosure. It is almost as if her idea of what it takes to ‘be human’ needs debunking as a term. She gives the sense that the therapists become one of the sub-human group members suffering with a mental illness, as opposed to the reality that all people suffer with their own forms of anxiety in some way. There is a process of change here, from the ‘refuting insanity’ sub-theme, to this stage where through therapist self-disclosure, the true essence of what it takes to be human, is revealed. Seeing her own ‘madness’ reflected in the ‘all-knowing human’ therapists enables her to experience herself in a new way, and feels enabled to change and incorporate DBT skills into a lifestyle, as they instinctively do.

Rachel goes on to say how this instinctive practice of skills occurred for her:

“It is absolutely part of my life.

Interviewer: Can you say a bit more about that, how it has...integrated into your life?

Rachel: This is part of... I mean. This is part of everything. So I have...from basic self-soothe stuff...will...often help me in a situation. So little stuff like er, I bought myself the posh body lotion I really like...it's really expensive ...and that is something like, I kind of reach for it and I sort of...whether that's putting something on my scars in a way of saying, that's ok. Work – so when things happen at work, trying to, I actively think, actually ok, right, this is what has happened, what do I feel? Ok, I feel anxious, afraid, angry. Ok. Are those feelings valid, well yes. Ok we understand why they are valid, yes, ok. What's a rational response, and then trying to use a wise mind response. And that's something that I do, that's a process that I try to do with everything. It doesn't always work. But, that is something, I would never, I wouldn't have even thought of that before.” (Rachel, p. 15, 482-493).

Rachel has clearly embedded skills into her lifestyle, apparent in the example she give of working on her level of self-worth. She now gifts herself with ‘expensive’ body lotion, giving rise to the notion of a deserving self, one in need of care and nurturance. This presents a shift in the process of change, where previous lifestyle issues would have resulted in very different and detrimental problem behaviours. This is resonated in accounts of all participants in their own ways. Charlotte goes further to explain in more detail the complexity of this:

“If I sat here and said that just doing a course helps someone's life. And going through what they go through, it doesn't. I think you gotta have a lot more than that to get better... You can probably learn as much as you can but...with an illness all of a sudden triggered and you get ill, and in that moment, nothing that anyone would've taught you would be able to help you.” (Charlotte, p. 12, 400-402).

Charlotte's diagnosis of bi-polar may have something to do with the way she views ‘being triggered’ and ‘getting ill’, in the sense that manic episodes can be completely consuming and uncontrollable. There is a sense that her lifeworld houses a complex mesh of fearing illness, and learning to embed and integrate new skills into her life. However, she is also alluding to

testaments of character and readiness for change in order to take on board what is taught on a DBT course and integrate it into a lifestyle. She goes on to say:

“the second time I did DBT it really helped, the first time I was so ill, I didn’t really understand what I was doing... a second time, you are like, oh ok, you really like, it sinks in more. And you really take it in...”

Interviewer: And in terms of your day-day life, how might DBT have changed things for you?

Charlotte: I think it did, it probably does help, day-day... But I think it’s not just that. It’s my lifestyle, and maybe it helped me how I see things now, my outlook and things.

Interviewer: such as?

Charlotte: I dunno. I actually look at whether the weather is sunny today or, do you know... Whereas I would be so in my head and not even give a shit about what the weather was. I would be thinking, oh my god, like, what’s everyone looking at me, why is everyone... Whereas I wouldn’t even take in things, like, oh the weather is really nice, oh this smells different. So I think it has helped me on that level.” (Charlotte, p. 13, 434-446).

It feels important that Charlotte is able to see things in a simplistic way reaping benefits by being grounded in the world around her, as opposed to an idealistic view of what it may have meant to incorporate DBT into her lifestyle and outlook. Her use of ‘take it in’ is indicative of DBT as a giving therapy, where in the presence of active clients ready for change, they are able to receive what the therapy is offering and allow it to ‘sink in’ and take it into their lifestyles. There is a sense throughout all accounts of an onward struggle, but one that is full of life, of ‘living’ and *being in the world*.

3.4.1.1 Summary of sub-theme nine

The notion of DBT as a phenomena in itself is brought to the fore in this sub-theme, indicating that the skills, the philosophy, and developmental process can be integrated unconsciously into the self. This leads on to the next sub-theme which considers some additional processes which are occurring throughout the therapy for each individual.

3.4.2 Sub-theme ten: Reflective Practice & Spirituality

Participants talk of being more insightful, non-judgemental and reflective - thereby more in control of their lives and their lifeworlds. Key throughout this theme is the participants’ spiritual observation of themselves and others, that is, a considered and observed approach to

the emotive world. The use of mindfulness through the course and the continuation of this post-treatment offers a gateway to the spiritual aspect of the self. As James reflects:

“It’s introduced me to mindfulness, that I found...very helpful. Not that I practice loads, but I try...it has given me something to investigate further...you can find mindfulness groups. And erm, day-day life... I wasn’t working, and I was just spending all day... I barely left the house...now I am sort of going out and about everyday, going to work, and doing something I really enjoy... And I think I feel more...it has changed my perception on things like, if someone is feeling upset or depressed, I think I am able to deal with that in a more sort of a, loving way, really.” (James, p. 19, 684-695).

This compassion James talks of is quite moving, and the internal shift is apparent. He has learnt to observe and react differently towards the self, and this skill is also applied to others, giving the sense of a more connected world for him, with possibilities for intimacy and love.

The spiritual aspect is one that is questioned frequently by participants in the delivery of mindfulness during the course, and also the notion of finding a ‘higher power’, similar to that found in the 12 step programme (APA, 2007) and incorporated into DBT (Linehan, 1993b; Linehan, 2015). Whilst some are able to overcome their preconceptions easily, Emma talks about how this resided with her:

“it was kind of like this ‘everything happens for a reason’ ideology, and I think it was also mentioning a higher power, which as an atheist, doesn’t mean much to me...” (Emma, p. 4, 134-135).

“I can’t remember what it was that was about spirituality, I remember there were a few bits where I ended up rolling my eyes, and there was a bit of higher power stuff as well, which again, rolling my eyes at, because just not applicable to me at all.” (Emma, p. 10, 422-425).

However, following the course, she is more in touch with her spiritual side whilst still verbally refuting it:

“I have since started doing yoga as well, which I find useful as there is a lot of that meditation and much of that non-judgemental observation of thoughts, which all sounds like complete spiritual guff when I say it out loud, but it works for me!” (Emma, p. 8, 323-325).

Whilst she still partly refutes the notion of what spirituality might mean to her in logical terms, she is finding it helpful in practice. This is another example of the freedom clients are

given to tailor the therapy to suit them, and it is testament to Emma that she was able to take a previously difficult concept for her, and apply it to her everyday life.

The non-judgemental, observing and ‘active non-reacting’ to thoughts, impulses and emotions appears pivotal for all participants. Going from a place of being out of control, in chaos and desperation, to a place of considered and observed reactions, would inevitably be life-changing. As Rachel describes:

“I said in the group, can we talk about empathy. Because I do think that if you, if I can get better as seeing myself and trying to work out what’s going on with myself, then I think that feeds into being able to see what is going on with other people. And I think that’s a good thing. I really think that’s a good thing.” (Rachel, p. 21, 699-702).

The sense here is that through her own reflective practice she has created the space and energy to be able to look around and build connections with others, which may previously have been unavailable to her through having to manage her own internal chaos. The emotional and psychological gain here is apparent, going from a previous lonely existence of pain and suffering to one with potential for human connection and emotional reward.

Charlotte sums up this theme nicely in revealing how she now connects with people in her life that can help her get in touch with the more spiritual aspect of the self:

“I am lucky to have a boyfriend who is like, woah, relax, calm. Mistakes may happen. Put a bit of Zen in there. And I am like, oh ok.” (Charlotte, p. 15, 514-515).

Charlotte appears to have brought the right people into her life and perhaps is reflective not of ‘luck’, but having unconsciously embedded skills that enable her to make the right connections with others. The ‘oh ok’ is suggestive of having learnt skills that are now known to her and she can apply in her life.

3.4.2.1 Summary sub-theme ten

The engagement with the spiritual aspect of the self through the practice of mindfulness is shown here, giving a sense of the possibility of richness and depth - in the inner and outer lifeworlds of participants. Choosing to be in touch with the now more familiar spiritual self, enables observed reactions in a wise-mind, as opposed to detrimental impulsive behaviours.

3.4.3 Sub-theme eleven: Hope & Joy

All participants mentioned ‘hope’ being cultivated through the process of the therapy. This occurred for participants at different stages, sometimes in the DBT Pathway with hope for what DBT may offer, in the relief of belonging, in the acquisition of new skills or in the outcome post-treatment where there is hope about living in the world as opposed to surviving in the world. This happened for James early on:

“I got more hope and I guess, felt positive that erm, yeah, I would actually.... I dunno how to.... I felt, yeah. I felt hope because erm, I guess I had never, I always thought there was something not quite right with me in terms of the way I manage my emotions, and coming to the group, yeah, I thought oh right, I may have actually found something that can help with this...” (James, p. 6, 202-206).

For Rachel the hope resided in the disciplined nature of the programme:

“it had focus. And it also, the whole approach is quite disciplined, erm, I think, helped me give real focus and...hope sounds poncy...but I really liked the sort of, ‘this is what we are going to do’.” (Rachel, p. 22, 751-753).

She goes on to describe how seeing herself differently brings about positive emotions:

“Interviewer: So DBT has helped you look at yourself differently?”

Rachel: Yes, I am not disgusting and I am not abnormal.

Interviewer: Ok, so how does it feel to say that as opposed to what you would have said...

Rachel: [laughs] Gleeful. I think because it is still quite a new feeling it’s glee. I have had (a lifetime) of... And don’t get me wrong, it’s not plain sailing.” (Rachel, pp. 20-21, 691-695).

This pivotal shift in how she views herself, possible through her readiness to change, her commitment both internal and external, and integration of DBT into her life, has enabled her to feel ‘glee’. There is a sense that she has worked incredibly hard to achieve this, and it is still not ‘plain sailing’ but that she can use the skills of observing her emotions non-judgementally in order to have the capacity to feel positive emotions as well as the more painful ones.

For James, the process of feeling positive emotions was gradual:

“I sort of reached a point where... began feeling... I think I started to realise that I was having more moments of I guess...of contentment, or actually enjoying life. So yeah, I guess that dawned on me slowly but surely.” (James p. 14, 489-491).

The ‘dawning’ is revealing of something fresh, new and previously unknown. It instils hope that more is on offer in life in the wake of a painful and tormenting journey through the darkness.

3.4.3.1 Summary of sub-theme eleven

DBT has often been framed as a therapy that ‘builds a life worth living’ (Linehan, 1993a & 1993b), and this is reflected here in this theme. Participants go on to voice feelings of joy which is fairly poignant considering the voices in the first master theme of crisis and desperation.

3.4.4. Sub-theme twelve: Objective to the Subjective self

This sub-theme was formed based on the marked shifts in perceptions of the self and forming new identity. In contrast to the need to ‘refute insanity’ pre-DBT, the participants actively engage with the self in a new way, with less of an extreme black and white emphasis. There is a feeling of integration of different aspects of the self, poignant to building a life worth living. Emma describes her shift from being judgemental to connecting with a more deserving self:

“I think I can be very harsh on myself and judgemental, and to others as well, which is great! So I quite often deny myself things, you know, and so on and so forth, based on this arbitrary idea of whether I have done enough worthy things to deserve it.

Interviewer: And how do you feel the DBT helped with that?

Emma: I think on the whole it made me see some of these things as rewards or treats but just as, sort of self-care, on a similar plane of making sure I have decent sleep hygiene and that I eat well. Just sort of ‘upkeep’ things.” (Emma, p. 9, 360-366).

The previous stance was to intolerantly interrogate the self, giving the message of there being a deficit which needed correcting. The self was an object to be policed and questioned, in a relentless battle with objective views on what it meant to be ‘normal’. This objectivity shifts to now being able to identify with previously refuted ‘insane’ parts of the self. As opposed to being caught up in the detrimental chase of an objectively ‘normal’ self, she is able to

observe this part of herself in a non-judgemental capacity. These aspects are now integrated, tolerated, and nurtured, through the skills of self-care. She now gives herself the permission to nurture the vulnerable part of the self. Rachel describes how this occurred for her:

“When I was in here...we were in the canteen, and (my friend) said, it’s scary, cos you look around and everyone looks normal. And I was like, they are normal! We are normal... I mean, my previous idea of what was normal and what I had to be and think and feel was so harmful. So harmful.” (Rachel, p. 20, 685-690).

There is a sense that she has moved from being ‘madly-sane’ to ‘sanely-mad’, having deconstructed previously harmful rhetoric. This enables space for a subjectivity which previously had to be refuted through fear of shattering the false-self, built up in phantasy and based on societal constructs. Tolerating the subjective means that she is able to engage with herself and the world in a new way, paving the way to self-acceptance. There appears to now be space for growth in psychological, emotional and spiritual paradigms, which would alleviate the previous distress experienced in the old quest for the objective self.

The objective self relays a message of disconnection with the embodied, whilst the DBT skills would challenge clients to label and feel their emotions as part of themselves, as body sensations. This new way of experiencing the self is explain by Rose:

“Since then (DBT), I do say to myself, how do I feel, do I feel anything anywhere in my body. So I am trying to sort of really find out...” (Rose, p. 9, 292-294).

There is the sense that looking at the embodied nature of emotions is new and unfamiliar, possibly the gateway to a subjective reality with the potential for revealing a previous unknown part of the self:

“it just means to find a way to break that barrier, to find out how I am really feeling inside... I suppose it’s more that I have discovered that there is an issue there. So therefore, I can then now concentrate on that and see if I can break that barrier, to find out how I really feeling, whereas I didn’t know that before.” (Rose, p. 9, 303-305).

The latent nature of what she embodies is apparent, described as a barrier to an unknown part of the self. The DBT has enabled a questioning of the self in a gentle and non-judgemental way, by focussing on body sensations. This feeds in well to the phenomenon of the self and emotions as embodied, defined through the intentionality of action. It is as if she is engaging

in a new hermeneutic of the self, with the DBT skills providing a framework for this is occur, as she explains in the use of diary cards:

“so when you are in a situation you think, oh I have had an awful day, I’ve had an awful day, but then when you think about it with hindsight you are thinking, well actually it wasn’t as bad as I thought it was, or, it was very bad, and looking, that was Monday and I am still feeling rubbish. So then you can use that to bring up in the session.” (Rose, p. 12, 403-406).

Rose had been describing the diary cards as a chore, but that on reflection, she was able to see how they enabled her to question herself and her experience, and bring her thoughts and feelings to the group with the unconscious engagement with a different part of the self, enabling a process of discovery. This hermeneutic of empathy towards the self feels gentle and explorative, giving time to a previously latent part of the self to be examined, nurtured, understood and soothed.

3.4.4.1 Summary of sub-theme twelve

Moving from the objective to the subjective is described here as a form of progress in terms of what new opportunity may lie ahead due to a different engagement with the self. For the self to be viewed by participants as complex breathes and air of insight, pleasant surprise, and calm.

3.5 Overarching Theme - The Context

The context is implicit in all master themes and sub-themes presented above. However, close attention to the context was perceived as an important part of the analytic strategy to give voice to the way in which the participants experienced the therapy in a private psychiatric setting. This may be able to sit alongside research conducted on a similar topic but different settings such as the NHS or in the community.

3.5.1 The Private Setting: “The Heterotopia”

A heterotopia is defined in Foucauldian philosophy (O’Farrell, 2005; Street, 2012) as a place of *otherness*, and is linked directly to the participant accounts who perceive the hospital as a means of escape from the repression of the self and the stigma generated from societal constructs of the ‘norm’. A *heterotopia of deviance* is defined as an institution, such as a hospital, where we place individuals whose behaviour is outside the norm. Participants experience this in a positive sense, whereby this escape from the norm presents a set of

conditions whereby they are accepted and understood in a way previously unknown to them. The negative connotations of the 'psychiatric hospital' actually, are experienced positively and merits the label of a heterotopia. It is a place of escape & refuge, providing core conditions to enable self-acceptance and self-actualisation. The premise of having to go back into the 'real-world' following completion of the therapy therefore represents a loss. The participants are faced with a conundrum – that of the positive assumption of having completed the therapy and able to re-join society, compared to the more stark experience of loss. That loss is of something unique, bonding, safe, and accepting. This comes up in participant accounts as a distinction between 'in here' - the heterotopia, and 'outside' – society. As Rachel alludes to:

"I feel I have to do that, with so many people, outside of the hospital, I have to be fine and upbeat. And in fact, people in the outside world get in, oh you know she's...and I do think there is an element of turn that frown upside down..." (Rachel, p. 17, 576-579).

The loss for Emma is presented as something she is ready for, whilst also alluding to what the real world entails, following group sessions enjoyed in the calm surrounds of the hospital grounds:

"I remember we did a few sessions out on the lawn, because it was sunny... I had spent almost 6 months in and out of (the hospital) and I was really ready to sort of get out to the real world." (Emma, p. 5, 192-194).

She goes on to give an example of how the groups enabled her to show her competitive spirit as well as having made friends:

"we did a mindfulness exercise...it was a word play game kind of thing...and I am very very competitive!...and afterwards we talked about our emotions and another girl said 'I was really competitive about this, I wanted to win!' and I was like 'me too!'. And we had this long conversation about how we were trying to like out snipe each other with longer words each time!" (Emma, p. 5, 198-203).

There is a sense that what she had gained in the therapy made her 'ready' to be in and live in the real world, but with an underlying apprehension of whether the real-world would allow her the same freedom to question, be around others, and experience her competitive nature. This also brings to light the length of the programme. The 12 weeks enabled some

participants to develop the skills necessary to tolerate the loss of the therapeutic setting, but others felt that repetition was necessary:

“Rose: before, when I finished the sessions, life went back to normal, I went back to work and everything and now, I can still remember bits, I can still remember things.”

Interviewer: And what do you think has made that difference?

Rose: I think doing it again. Doing it again. And I think wanting more and more to get better. Because when someone is really ill and here as an inpatient, you literally just go through the routine of going to the therapy sessions, how much of it really goes in I don't know.” (Rose, p.12).

Rachel nicely encapsulates the experience of DBT in the realm of the private healthcare system, whereby clients are forced to contest with the pressures of insurance cover:

“my consultant was saying...well let's apply for funding to do another session...my understanding is that it is run here as 12 week block because insurance companies, private insurance companies, that is basically the most that they will authorise in any one block and then you ask them to redo it. From that perspective I think that is eminently sensible. I think constantly how unbelievably lucky I am to get it on the NHS, sorry, on private healthcare. I mean I know it is available on the NHS and I know it's 12 months on the NHS because a couple of my friends have been doing it, friends from here. And that is something that I will look at if my health insurance doesn't extend.”

The lived experience for Rachel is perhaps one of gratitude, whereby she has escaped the NHS and has been able to enjoy an ‘eminently sensible’ approach to her health care. The Freudian slip of feeling lucky, may perhaps denote the same ‘luck’ that one feels when they get good NHS treatment free of charge. Even though on paper she is paying for her therapy through private health insurance, she feels ‘lucky’, *as if* getting it for ‘free’. In terms of the hermeneutic circle and taking into consideration the whole interview, I believe that Rachel’s experience is one of belonging to an ‘elite’ form of health care, and she feels appreciative of this – secretly dreading having to renegotiate her life commitments and ‘down grading’ into the NHS. That said, there is a constant underlying pressure on clients here, in that they may wish to redo the programme but it be subject to funding, as opposed to being offered a 12 month programme free of charge on the NHS. It alludes to the context demanding a sense of commitment and ‘know how’ from clients, in that they need to have appropriate discussions

with psychiatrists in order to be ‘approved’ for further therapy. These connotations may have implications to how clients engage in therapy, perhaps lending to a higher sense of commitment to DBT in this setting, as opposed to the funded NHS.

Charlotte discriminates between the ‘inside’ and ‘outside’ world, voicing her experience of what she felt were the differences. She describes both the notion of what was made possible in the heterotopia in comparison to the outside world, with a feeling of being understood:

“it’s quite nice, it becomes like your family, you become really close to these people. You, you know, you say, how did you find that. And you say, oh it’s alright! And you... I can’t explain it. But it’s nice to have that understanding. I think this is the only place where people understand me. Doesn’t matter if people say they do outside, they never truly will know.” (Charlotte, p. 6, 191-195).

There is a sense of sadness about the prospect and realisation of what has been lost through ending therapy. Charlotte’s use of the word ‘family’ highlights a strong sense of warm and nurturing attachments, unlikely to be fulfilled in quite the same way in the outside world. However, this experience may have created a possibility of being able to recognise flavours of the same thing occurring for her in the real world. There is potential for an existential shift here - in the way she may choose to live and ‘be’, and with whom - now that she has experienced herself and others in new ways, all possible in the context of a heterotopia.

3.6 Summary of findings

This analysis has aimed to encapsulate the way in which clients experience DBT in a private psychiatric hospital, and its perceived role in the process of change. The journey of the participants started as one of crisis, and through the DBT process they found a place of belonging, togetherness and supported by core conditions to enable learning and pave the way to recovery. Post-therapy they are able to look back on their journey with a sense of relief that things are less of a struggle than they once were, together with a sense of optimism about the future. The private setting overarches the themes providing a sense of the lived experience of having to negotiate with insurance cover and a lengthy referral process. The private setting did however provide clients with the environment and surrounds necessary to feel like responsible adults dealing with complex issues, reinforcing a sense of drive to become ‘well’. The analysis is positive about DBT, in its 12 week adapted form, in this particular setting. It tells us something about what these participants thought worked for them, and how they experienced change. Despite ongoing struggles, it would appear that this

form of DBT delivered in the way it was in this setting worked very well, and could provide a platform for replication. More will be discussed in the next chapter, together with limitations of the study and implications for future research and for Counselling Psychology.

CHAPTER FOUR

Discussion

4.1 Introduction

This study aimed at understanding and giving voice to the client experience of an adapted DBT programme, as well as the experience of receiving therapy within the private healthcare system. These features have built on other qualitative studies on client experience of DBT which have focused on DBT for BPD specifically, or in community settings (Cunningham et al., 2004; Hodgetts et al., 2007; McSherry et al., 2012; Perseius et al., 2003). This study was the first of its kind to attempt an in-depth inquiry into client experience of a transdiagnostic, DBT-informed programme in a private setting, and furthermore, with a focus on perceived role in the process of change. Research to date has advocated that change processes should be specified at the level of the client, therapist and service delivery setting in order to ascertain what we must know and do to get good outcomes in DBT (Koerner, 2013). This study's conclusions will therefore aim to contribute to the field by adopting this approach, which may offer advantages that apply to the dissemination and implementation of DBT, adapted DBT or DBT-informed models in a variety of settings and client groups. Structured around the research questions, the discussion aims to offer implications for future research and more specifically to Counselling Psychology.

4.2 Synthesising the DBT Experience

This section will aim to bring together the elements of the therapy described and interpreted in the themes of the analysis, pertaining to the research question of how clients experience DBT, and enabling a synthesis of conclusions pertaining to what worked for these particular clients in this particular setting.

4.2.1 The clients' experience

The experience of DBT for all participants began with tumultuous emotions and symptomology, ranging from suicidal and impulsive behaviours, to more complex underlying emotion dysregulation. By the end of the 12 week programme, all participants had experienced a shift in symptoms, which is in line with literature advocating DBT's efficacy and effectiveness (Bateman & Fonagy, 1999; Feigenbaum et al., 2012; Koerner & Linehan,

2000; Koons et al., 2001; Linehan et al., 2006; Stepp et al., 2008; Stoffers et al., 2012). The voice of the participants gives the added layer of understanding how this experience was perceived. There was a sense that all began in a place of crisis and chaos, with numerous problem behaviours. The pathway to surrender seems to have come through mindfulness, group cohesion and validation. It is validation which provided the key to move forwards in their journeys, together with an underlying connection to the spiritual aspect of the self (Kabat-Zinn, 2011; Linehan & Wilks, 2015). Once this part of the journey was passed through, a preventative psychological buffer was created, where participants were more in control, and could choose whether to continue engaging in problem behaviours or to use newly acquired skills to reach a place where there is a life worth living. In this place they were more in control, sitting on a repertoire of skills and knowledge, with mindfulness practice as an umbrella to their processes.

DBT skills specifically mentioned as helpful were self-soothing, distress tolerance techniques such as eating a sour sweet or biting a chilli, acting opposite, and developing mindfulness practice. The key concepts thought of as helpful were validation, radical acceptance, and using the wise-mind approach. It was mentioned that some skills are overly complex or alienating, such as the reference to a 'higher power'. This is in accordance with McSherry et al. (2012) who reported participants finding concepts as difficult to grasp. For clients with no religious background, this could be difficult to work with. It would appear that it is the flexibility of the approach of the therapists which can harness this process, by allowing clients to come up with their own terminology with the freedom to criticise but not refute the concepts completely. Recent DBT literature advocates the need for research to focus on identifying which skills are helpful for which problem area and for whom (Linehan & Wilks, 2015). It is therefore possible to conclude that this sample of participants found the aforementioned skills helpful for problems with emotion dysregulation and impulsivity, enabling them to embed the skills within the 'DBT Lifestyle'.

4.2.2. Potential harm through other treatment models

Interesting in this study were the participants' responses to other forms of therapy, most notably, CBT. Focus on treatment modality did not form part of the research questions or the interview schedule per se, but came up in four of the individual participant accounts during semi-structured interview. These participants advocated CBT as either unhelpful to potentially damaging. One participant viewed psychodynamic therapy as nebulous. It was

found that cognitive restructuring as part of CBT actually led to a catastrophic cycle of ‘policing thoughts’, whilst being tasked with ‘positive thinking’ led one participant down a spiral of internal self-sabotage.

Whilst much of the pro-DBT literature would recommend the DBT model over CBT for those diagnosed with BPD (Linehan, 1993a; Linehan & Wilks, 2015), there are few studies which go as far to report potential harm to clients engaging in CBT. Some literature takes the opposing view such as Matusiewicz et al. (2010) who found that CBT can be effective for personality disorders. Specifically, they found that cognitive restructuring and skills training are both associated with positive gains in treatment, which is in stark contrast to participant accounts in this study. However, one participant did receive CBT in the NHS specifically for eating disorders which was perceived as helpful to some extent. Haefel’s (2010) research into cognitive skills training underscored the importance of identifying individual difference variables that moderate intervention efficacy.

In order to prevent further distress to vulnerable clients, future research could look at participant experience and outcome of CBT for clients with NSSI, emotional dysregulation and impulsivity, to ascertain if there is further empirical evidence to suggest harm to clients engaging in certain interventions. With the small sample size of this study, this finding is understandably only a slight representation of overall client experience, but nevertheless should be taken forwards in further research, due to the ethical dilemmas arising from such a finding.

4.2.3 The role of the therapists

Koerner (2013) surmised that little is known to date about what therapists must know and do to get good outcomes in DBT. Whilst client, therapist and treatment assumptions in DBT exist (Linehan, 2015; Pederson, 2015), the actual specific interventions which make a difference are less documented in the literature. According to the participant accounts, the approach of the therapists was deemed as important in creating a validating environment. The approach was experienced as genuine, with no reading from scripts. The therapists were perceived as well-trained with the ability to hold the group and psychopathology of individual clients. The creation of core conditions using empathy, acceptance, validation, in a holding and supportive environment, meant that clients were able to feel safe and surrender

to the therapeutic process. It is therefore possible to conclude that therapist training and expertise was perceived as important in providing an environment which facilitated a strong therapeutic alliance (Ardito & Rabellino, 2011; Duncan, 2014; Horvath, 2001; Horvath & Symonds, 1991). This was reported as being achieved with constant check-ins by the therapists with group members, remembering the clients' individual backgrounds and needs, feeding back to clients about their contributions, validating, and allowing clients to challenge within the boundaries of the therapeutic environment. The result was a client group willing to engage, interact, learn, and tailor the therapy to suit their needs.

4.2.3.1 Therapist Self-Disclosure

Furthermore, the therapists used self-disclosure which was positively received. This enabled a more transparent and humanistic stance to be achieved (Audet & Everall, 2010; Cooper, 2009). This client group is one that suffers with psychological trauma (APA, 2013) where trust is difficult to build and serves as a barrier to treatment (Pederson, 2011). It can be surmised that the stance adopted by the therapists enabled a trusting therapeutic alliance to be formed (Pederson, 2015). The therapists were perceived as part of a team of 'leaders' which also added to the trusting dynamic and sense of cohesion. In Counselling Psychology, the therapeutic alliance is seen as the key element in client recovery (Horvath, 2001; Horvath & Symonds, 1991), which has implications for the way DBT should be delivered regardless of adaptation or setting. It places firm importance on therapist training and delivery, with a focus on developing the therapeutic alliance to enable recovery, regardless of whether it is DBT, CBT or other models.

4.2.3.2. Therapist Training, Support and Self-Care

It can be surmised from participant accounts that therapists' knowledge and training is important, where they are supported by other team members and given an opportunity to practice self-care in line with the therapeutic model they are delivering (Linehan, 2015; Pederson, 2015). Stress and burnout amongst therapists working with DBT is well documented (Koerner & Linehan, 2000; Perseius et al., 2007) due to the intense nature of working with highly complex individuals at risk due to impulsive behaviours. Containment for the therapists therefore, is viewed in equal regard to that of the clients (Linehan, 2015; Pederson, 2015). If therapists are the enablers of recovery, then services should ensure that

proper and adequate support is in place for therapists. At present in treatment manuals, therapist support is advocated through consultation team meetings as well as practising skills themselves (Linehan 2015; Pederson, 2015).

From a reflexive stance and given the demanding nature of this client group, perhaps extra supervisory provision could be offered on a 1:1 basis for therapists not merely struggling, but dealing with the daily grind of extremely complex mental health issues. This is a factor often overlooked in our current healthcare system which is suffering in the face of current austerity cuts, leading to therapists leaving programmes to the detriment of client retention and recovery (Cunningham et al., 2004; McSherry et al., 2012). Investment in therapist training and support could be a way to reduce the dropout rates so often advocated in DBT as being a fundamental problem (Kroger et al., 2014; Linehan, et al., 2006; Rusch et al., 2008). Whilst DBT is a behavioural intervention, it would be a shortcoming to assume that all clinicians delivering the interventions adhere to the same orientation on a personal level. Some therapists may benefit from a more in-depth analysis of what is occurring for them in the therapeutic relationship. It is possible that psychodynamic supervision for example, could be of benefit to some clinicians needing to delve deeper to address issues confronting them with a client group prone to high levels of projective identification (Bateman, 1998; Klein, 1946; Spurling, 2003). This would lend well to recruiting a wide range of practitioners into DBT settings, enhancing the diversity and quality of care we provide to clients. Current Counselling Psychology training sets out to do this, by teaching students the Integrative model of therapy (Messer, 2001; O'Hara & Schofield, 2008; Gold & Stricker, 2001), whereby the therapists adapt the therapy according to the clients' needs, and the therapist's personal orientation (DiGiorgio, Glass & Arnkoff, 2010). This is a less prescriptive approach, allowing space for clients to be viewed as people with certain needs in their own right, which can be met through the strength of the therapeutic alliance.

Further research could look at interviewing therapists, to ask them how they experience delivery of the therapy, and what they feel they must 'know' in order to get good outcomes (Koerner, 2013). For example, Perseus et al. (2007) found via therapist self-report that mindfulness related to less stress and burnout in professionals treating clients with self-injurious behaviours.

4.3 The Process of Change

The process of change is highlighted in the analysis by tracking the journey of the participants' problems in line with current research (Higginson & Mansell, 2008). The DBT journey is conceptualised by moving from a place of ambivalence and intense distress, to a gentler and reflective position. These identified stages are not dissimilar to other research which has focussed on the process of change (Prochaska & Diclemente, 1983; Soler et al., 2008). Change was experienced as both subtle and gradual as well as in sudden 'Eureka' moments in line with research on how change occurs (Carey et al., 2007).

4.3.1 Change Models

There are several change models which have been developed to understand more about client change. The perceptual control theory (PCT - Powers, 2005) reports the reorganisation of neural networks through the therapeutic process which restores a sense of control. This is reflected in the participant accounts by seeing DBT as a 'giving' therapy, enabling clients through the development of skills which can be learnt and embedded giving rise to a sense of being in control, armed with potential tools to cope. The assimilation model (Stiles, 2001) is a conceptual model with principle components of change such as altering schema and problematic experience. This was illustrated in participant accounts whereby the way they ascribed meaning to their experience changed and became less critical and judgmental, more reflective, less reactive, and thereby leading to less problem behaviours. Each participant experienced change, be it gradual, sudden, or both. Each participant had their own way of perceiving and ascribing meaning to change, and the content of each participant's account of what had occurred for them was individual. This is in accordance with the PCT model which posits that the process of how change occurs is common while the content of what changes is idiosyncratic (Carey et al., 2007; Powers, 2005).

Carey et al. (2007) go further to advocate that in psychological treatment therefore, rather than teaching skills or providing information, it may be more important to facilitate progress towards an impasse and then to support the person while they experience this impasse and develop insights to resolve it rather than trying to avoid it. The freedom to question said concepts such as 'validation' led participants to those impasses, where participants were able draw on resources offered by the DBT programme, such as 1:1 therapy sessions or homework tasks, to develop insight to resolve. This current study therefore highlights in subtle ways, the complex nature of psychological change, in that it is multi-faceted and not possible to

reduce to a ‘one size fits all’ model. This is also in accordance with Clarkin & Levy (2006) who posit that improving knowledge of general principles of change may be of greater value than increased knowledge about any particular change technique. DBT has been shown to allow emotions to be metabolised with less projection of the ‘alien self’ onto others (Fonagy, Target, Gergely, Allen, & Bateman, 2003). This is picked up in the themes of moving from an objective, (and perhaps projective self), to a subjective and more integrated personality. The participants also give voice to this notion of change in the journey from refuting their insanity, or alien self, to having the capacity to experience hope and joy with the space for intimacy and human connection.

4.3.2 Spirituality

Overarching the change process was the more implicit experience of an awakening of the spiritual aspect of the self. DBT’s commitment to the Eastern spiritual traditions is well documented (Linehan, 2015; Linehan & Wilks, 2015) and permeates the entirety of this DBT programme. Participants describe mindfulness as a core component of the treatment, approached first with ambivalence before moving on to an understanding of the practice. It is with this understanding that a faith in the therapeutic process is seen and a surrendering to the treatment takes place. Once therapy is completed, participants perceive themselves as less judgemental, with an observational approach to thoughts as opposed to a reactive one. The language used by the participants is indicative of a spiritual connection within the self, evident in published reports on mindfulness with experts in the field using words to describe mindfulness such as non-judgemental, observational and non-reacting (Paulson, Davidson & Kabat-Zinn, 2013). Experts in the field such as Jon Kabat-Zinn are documented as finding the spiritual concepts as ‘difficult to describe’, which came up over and over in participant accounts. The notion is indicative of something occurring within the self, but in a place with no words.

Participants therefore struggled to find words to attribute to their spiritual experience. However, the process itself is clearer, moving from a judging and reacting self, to a more compassionate self. This is also accompanied by feelings of hope and even joy, indicative of spiritual movement (Kabat-Zinn, 2011 & 2003). Internal pain and struggle is still present at the end of all participant accounts, but the way in which they react which has changed, indicative of a spiritual connection within the self (Kabat-Zinn, 2003; Kornfield & Walsh, 1993). Interestingly, one participant still refutes the notion of spirituality per se, but believes

in the practice and the techniques. This is again indicative of a higher spiritual self which governs over everyday thinking, where the mind has moved to a place higher than thinking, and kinder than thinking (Kabat-Zinn, 2003).

The concept of neuroplasticity came up explicitly in one participant account, mirroring recent research which advocates daily mindfulness practice as altering neural pathways in the brain leading to new ways of being, behaving, and thinking (Lutz et al., 2016). This would help us to understand the participant's faith in daily mindfulness practice or in times of distress.

4.3.3 The self & identity

Participants highlighted certain features enabling them to form a new sense of identity and experiencing psychological integration. Namely, these were the ability to connect and make friends, to learn from being with others in similar forms of distress, learning and embedding skills, being able to tailor the programme to suit their needs and the practice of mindfulness.

The differing layers of the self and identity came across strongly in participant accounts giving voice to a persecutory punishing self at the beginning of the therapeutic endeavour, compared to a deserving and compassionate self towards the end of the programme. The notion of insanity was a difficult part of the self to grapple with, giving rise to a stigmatised and marginalised self, necessary to refute rather than to acknowledge. However, through the DBT framework and the therapeutic process, the participants were presented with the right conditions to unconsciously begin integrating these aspects of the self, the result being a more subjective view of themselves, of norms and of societal constructs. Whilst there is evidence to suggest that 'self-management education' alone can change the views of the self (Lorig & Holman, 2003), other research highlighted above suggests that change and recovery from trauma must come from within (Kabat-Zinn, 2003; Kornfield, 1993; Meili & Kabat-Zinn, 2004). The most effective change however, incorporates both, lending well to the balance in DBT of skills training incorporating mindfulness (Linehan, 1993b & 2015).

4.4 Application of DBT to a transdiagnostic group

This study's findings lend to seeing diagnostic criteria merely as a pathologising prerequisite necessary in the healthcare system, in accordance with a review of the positioning of the DSM in the current climate (Barlow et al., 2004; Barlow, Sauer-Zavala, Carl, Bullis & Ellard, 2014; Khoury, Langer, Pagnini, 2014). A diagnosis then, should perhaps not be the only means of signposting clients to a suitable form of treatment (Barlow et al., 2014; Swales et

al., 2012). DBT has been found to rely on effective and accurate case conceptualisation strategies that allow the therapist and client to collaboratively address multiple diagnostic and quality-of-life related issues (Ritschel et al., 2015). This is in line with how DBT first came to fruition, in that Marsha Linehan (1993a) was keen to develop a programme for suicidal individuals, and upon finding that most people in this group had a diagnosis of BPD, was able to apply for funding from the APA on that premise. The target of the intervention however, was not strictly for BPD clients, but for those who could benefit from the model and those labelled in the psychiatric community as ‘difficult to treat’ (Linehan & Wilks, 2015).

Two of the five participants did not have a diagnosis of BPD - they were accepted onto the programme based on questions around emotion regulation skills, impulsivity and substance use. The experience of being in a group with members with a range of diagnoses was perceived as nebulous, in that it was not the diagnoses per se that enabled group cohesion to occur, but that it was comprised of people who had similar ways of experiencing and expressing their distress. This is in accordance with research which advocates the transdiagnostic application of DBT to those suffering with co-morbid conditions or ‘neuroticism’ (Barlow et al., 2014; Brake, Sauer-Zavala, Boswell, Gallagher, Farchione & Barlow, 2016).

Furthermore, all participants commented on being able to make friends with others that experienced impulsivity or emotion dysregulation in a similar way, and through this experience were able to find space for intimacy and connection. This highlights the importance of signposting clients to treatments based on their personality characteristics, as opposed to diagnosis (Brake et al., 2016). The current study could therefore provide a platform for further research into the application of DBT with transdiagnostic groups, differing to those which focus on homogenous groups such as binge eating (Klein et al., 2013) gambling (Christensen et al., 2013) and stalkers (Rosenfeld et al., 2007). This study would advocate assessments, as described by participants, as focussing on emotion dysregulation, problem behaviours, impulsivity, substance use or ‘neuroticism’ (Barlow et al., 2014).

4.5 Adapted DBT

Current debate around fidelity to the DBT model and protocols gives the impression of a wide range of arguments with regards to how far DBT can be adapted and for whom (Dimeff et al., 2007; Swales et al., 2000; Swales et al., 2012; Pederson, 2011). The current study was a 12 week adapted programme whereby the therapists role-modelled a flexible approach to the treatment. It could therefore be concluded that it is a ‘DBT-informed’ therapy (Dimeff et al., 2007), as opposed to standard DBT. The programme has been previously adapted and adopted as a 12 week programme but usually for adolescents requiring a less rigorous or intense commitment (Miller et al., 2007; Rathaus et al., 2015), or in an inpatient setting (Kroger et al., 2006). This study could pave the way for further research into adapted 12 week versions of the model, given the positive findings of this current DBT-informed programme. Future research could aim to pacify debates around correct adoption of terminology of treatment models, so that more clarity is achieved in the field as opposed to creating divisions between ‘DBT purists’ and others using flexible adaptations (Marra, 2005; Pederson, 2015).

It is also worth noting that several participants re-took the 12 week programme, feeling that the skills required a longer therapeutic input to understand and embed. It is perhaps symbolic of the private healthcare system where most insurance will cover patients for a stay of 12 weeks, and the hospital found an appropriate treatment length accordingly. It is therefore difficult in this study to determine whether the 12 weeks was perceived as an overall positive of the programme or influenced by other factors. On the one hand it provided participants the opportunity to engage in insured therapy for 12 weeks, whilst reporting that they would have benefitted from longer-term treatment. Literature would advocate that clients do benefit from short interventions (van den Bosch et al., 2013), but further research is necessary to ascertain which treatment durations work and for whom.

The group was an open group whereby the participants revealed the opportunity to learn from more ‘experienced’ group members. This aided in the ‘rabbit in the headlights’ experience upon joining a DBT group, enabling a learning environment to be cultivated whereby learning from others was key. This learning from others came in several forms - that is through the verbal ideas of how to manage distress such as distress tolerance techniques, opportunities for altruism by giving ideas or objects to other group members, and learning from the process of others. Visibly witnessing the process of others in the group was

provided a powerful learning curve – becoming a spectator to their own psychological and emotional processes. This factor was perceived as helpful in the process of change, by providing participants with a mirror into their own dysfunctional and destructive processes enabling them to make real life changes (Higginson & Mansell, 2008).

In summary, this particular DBT-informed programme is a good example of how the model can be adapted and adopted to positive effect. It pertains well with literature which has adapted DBT-informed treatment into different settings, with a focus on the needs of the client group in that particular service (Pederson, 2015; Ritschel et al., 2015; Ritschel et al., 2012). Perhaps assessments prior to adapting and adopting DBT are necessary within services, to ascertain which facets of the standardised model are necessary to treat the client group receiving the treatment alongside a sound understanding of the standardised model and good rationales for adaptation (Dimeff et al., 2007; Koerner, 2013; Swales et al., 2000).

4.5 The Private Healthcare Setting

Koerner (2013) advocate the importance of looking at the conditions in which therapy is delivered, so that further research can ascertain what in DBT works, for whom, and under what conditions.

4.5.1 Private Health Insurance

The negotiation and commitment involved is documented in participant accounts, together with the pressure they felt to make the most out of an otherwise costly programme, for which they would have to apply for another insurance claim to repeat. It is surmised that this had implications on the therapeutic process, perhaps giving rise to a conscious commitment to the programme lacking perhaps in NHS settings, where the clients are not necessarily paying for treatment. There are implications here for future research, whereby the commitment demanded by default by the private healthcare system may impact dropout rates. Dropout rates are an ongoing issue with DBT (Kroger et al., 2014; Linehan et al., 2006; Rusch et al., 2008), and perhaps future research could focus on commitment to programmes in the NHS as well as the private healthcare system. This would help ascertain if it is the financial commitment which keeps clients engaged in treatment, or if other factors override this.

4.5.2 The Heterotopia

In terms of language used to describe spaces, the hospital is represented as a place set off and isolated from everyday social space – a microcosm of society. Street & Coleman (2012) link the hospital space to that of Foucault's heterotopia (O'Farrell, 2005; Street, 2012). This term captures the complex relationships between order and disorder, stability and instability that define the hospital setting. The participant accounts are rich with references to the hospital setting as a heterotopia, differing from 'outside' and making it into a place of otherness, where unique experiences can occur. This is cited in the accounts as references to being understood in new and unique ways by others, which is in contrast to how they felt perceived by others and society, in 'the real world'. This richness offers the reader a glimpse into the lifeworld of the participants who through a new experience of themselves, within the conditions and parameters of the heterotopia, were able to develop new ways of embedding new identities once discharged.

However, there is a body of literature which argues for a more fluid approach to the confines and parameters of a hospital as a heterotopia. Van der Geest & Finkler (2004) contrast new hospital ethnography with earlier functionalist models, noting that life in the hospital should not be regarded in contrast with life outside the hospital: *"The hospital is not an isolated subculture or an "island," rather it is a microcosm of the larger society in which it is situated."* (p.18).

So as opposed to being an isolated island, it is one with permeable boundaries, a mirror which reflects and reveals the core values and norms of the broader society. This would depict the hospital as a permeable and microcosmic window onto the society where it is situated (Street & Coleman, 2012). This is reflected somewhat in the notion of moving to a more subjective view of the self in the participant accounts. They come to know that it is not society nor the 'real-world' per se that is the issue, but that they were aligning themselves with the stigmatising and marginalist responses to mental health which exist in some sections of society (Henderson et al., 2016).

It is surmised that through adopting a new position and identity, participants were able to feel differently in the 'real-world', once they had experienced the concepts open to them in the heterotopia. It is not that these concepts did not previously exist in the 'real-world', but rather they had not had the opportunity to experience them due to their positions in society and/or their relationships with stigmatising others. It is the opportunity presented to the

participants' in the context of the heterotopia which enabled a new experience of themselves to be lived. This gave rise to the possibility to explore and develop a fresh sense of identity, possible in the heterotopia with its permeable boundaries with a less judgmental and stigmatising cross-section of society and social life (Henderson et al., 2016).

4.6 Limitations

Whilst qualitative research can give rise to new and previously unknown phenomena even with a small sample, it is more difficult to ascribe meanings to a wider group. The sample size should not be a limitation of qualitative research (Smith, 2011), as this enables more attention to the ideographic nature of the accounts with an in-depth inquiry into rich data. However, findings are limited to this particular group of people, who undertook this particular programme, during a particular time period. Whilst therefore the suggestions for further research are of interest, they are based on this study's findings together with the existing literature in the field and should not be taken as a full representation of clients who experience DBT in the private healthcare system. Rather, the findings can pave the way for other studies to ensure constant contribution to the field, at the level of the clients to whom we deliver our services.

In this regard, the homogeneity and heterogeneity of the sample was also discussed in the context of the private psychiatric hospital offering a 12 week 'DBT-informed' therapy programme. It has been advocated that IPA should strive for as homogenous sample as possible, in line with research on change processes (Higginson & Mansell, 2008) thereby indicating a limitation of this study's sample. The question in IPA however is whether a sample is 'homogenous enough' in light of the body of literature and accessibility of the participant group. As opposed to limiting the analysis, the heterogeneity of the sample provided this study with possibilities of understanding more about the experiences of hard-to-reach clients, with a range of histories with psychiatric services and of differing clinical diagnoses. This enables a fuller picture to be captured for dissemination to various audiences. Furthermore, the very specific way in which DBT has been adapted in this setting could pave the way for further research into how and to whom DBT can be adopted.

The analysis incorporates twelve sub-themes and an overarching theme, which could be perceived as a limitation as themes could be read as being 'too thin' and in need of condensing with others. However, having considered this, I felt the dissemination of research to audiences, such as to clinicians delivering DBT, should be as accessible and interesting as

possible, so that the features of analysis are fully captured, and also made available later in a one-page diagram of themes. This would hopefully lead to a more publishable form of research, which could encapsulate neatly the main elements of client experience, with a view to *'make research matter'*. I felt that condensing themes would inadvertently divert the attention and focus of audiences to whom the research may implicate and we may lose certain aspects of experience if not presented in a particular way. As it stands, the analytical strategy was a thought through genuine process, and I would feel that I was not giving justice to the voice of the participants and the richness of perceived 'thin' themes, if they were to be condensed.

This study has aimed at taking a critical realist and phenomenological position, highlighted through a critical literature review, methodology and analysis. A critical stance on phenomenology was adopted to enable myself as the researcher to take up and embody a position reflective of my work as a clinician with an interest in psychodynamics. However, this has meant that the phenomenology is less highlighted in some areas, especially where the analysis takes a critical and interpretative stance. This could therefore be seen to limit the phenomenological approach, where the tension of myself as the 'expert' clinician overrides my phenomenological voice. However, I have taken this stance in a reflexive manner which has been reflected on throughout the work. Use of the reflexive diary was important in keeping the phenomenology to the fore of the study, used to unpick the various tensions with regards to bracketing prior knowledge, vis a vis my own emotions experienced throughout the process.

4.7 Summary of discussed findings

This qualitative inquiry aimed to give voice to the experience of clients, deemed as misrepresented in society and often marginalised (Henderson et al., 2016). Literature has also advocated the need to know more about therapist-client interactions in DBT, at the level of the client (Koerner, 2013). The study was able to conclude that this group of participants found DBT a helpful and positive experience, the result of which was the ability to build a life worth living. This was achieved by taking forwards the concept of validation together with distress tolerance skills, combined with a group sense of cohesion in the presence of well-trained and empathetic therapists who were able to hold and challenge the participants. The findings also pertain to subtle and sudden change processes, which, given the correct setting and conditions, the participants were able to embed. Ideas for future research and

contribution to Counselling Psychology have been highlighted throughout. The aim of these implications is to pave the way for future work to improve service delivery, serving to inform clinicians about the lifeworlds of the clients they treat, to highlight the need to reduce dropout rates, and finding ways of adapting therapy in line with protocols but with flexibility according to the needs of the clients. As Shafran et al. (2009) state: “*researchers should provide practitioners with guidelines that facilitate local adaptations without losing efficacy*” (p. 905).

Furthermore, the work has highlighted the importance of the client voice, placing participants in the position of ‘expert’. This reflects their newly obtained high level skills such as reflective practice. To me, their knowledge and lived experience of applying these skills to alleviate distress would show that they potentially have much to offer in terms of disseminating their experience to help others. This should not be restricted to people diagnosed with mental health issues, but should encompass the lay population, evermore out of touch in today’s society with spiritual and reflective practices. In a rapidly changing world, the general public is faced with increasingly complex problems, whereby the application of mindfulness and reflective practice could serve to the benefit of wellbeing. Public awareness of these practices, and the lived experience of those who have used these skills, feels of paramount importance in developing and enhancing good mental health across society and the lifespan.

4.8 Final comments on reflexivity & conclusive remarks

Having worked in an inpatient setting delivering DBT, I was keen for this research to contribute to service delivery. As a more psychodynamically inclined practitioner, I found the purely behavioural stance of the therapy and the supervision challenging and disappointing. This client group is prone to high levels of projective identification (Klein, 1946), leading to therapist burnout (Persieus et al., 2007). I felt that I needed to know more about the dynamic between myself and the clients, to become a robust professional with the ability to draw good therapeutic boundaries. I therefore sought psychodynamic supervision off the ward, so that I could unpick the transference-countertransference dynamic. This enabled me to continue working with this client group, and the clients were fortunate to have a well-rounded team of more behaviourally inclined practitioners as well as those listening to them on a psychodynamic level. I feel this is an important balance for services to strike, so that we can enhance the quality of the teams that work to deliver DBT in both inpatient and

outpatient settings. Since it is the therapeutic alliance that keeps clients engaged in treatments, this possibly may serve DBT dropout rates to positive effect.

Another facet of my intrigue in the study's findings is my personal interest in the spiritual path. I am a trained yoga teacher and meditator, and therefore have a firm belief in the changes possible through pursuit of the spiritual aspects of the self. I was therefore particularly engaged by the participant's responses to mindfulness, as well as the development of compassion. In a society that is becoming increasingly intrigued by Eastern approaches to wellbeing, it felt pivotal that this group of participants were experiencing benefits from spiritual practices.

This study has been a journey for myself as the researcher, and I hope that the reflexive accounts have added a layer of depth to the thesis. I am keen for implications regarding signposting clients to correct treatment models to be taken forwards, with the message of enhancing the quality of mental health services with good outcomes. I also hope to have made a contribution to the field of Counselling Psychology in particular, which flies the flag for a non-pathologising humanistic approach, holding in awareness the intersubjective influences presented to us whenever we take on work with clients.

5.0

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APPENDICIES

Appendix A

Interview Schedule

Title: *Client experiences of receiving adapted Dialectical Behaviour Therapy (DBT) and its perceived role in the process of change*

Research Questions: How do client experience and perceive receiving adapted DBT in a private setting?

How do clients and experience and view their progression through the 12-week programme?

What is the perceived role of adapted DBT in any changes clients may identify, if any?

1. What was is like to take part in the 12-week DBT programme?
 - a. *What was the assessment like?*
 - b. *What was it like to be in a group?*
 - c. *What were the other people like in the group?*
2. What is your understanding of DBT?
 - a. *What do you think DBT is?*
 - b. *If you had to explain what DBT was to a friend, what would you say?*
3. How did you progress through the therapy?
 - a. *How did you experience things at the beginning of the programme?*
 - b. *How did you experience things in the middle of the programme?*
 - c. *How did you experience things at the end of the programme?*
 - d. *How did you experience your symptoms through the programme?*
4. Can you remember a time in the therapy when things seemed to change for you?
 - a. *Can you remember a group when you felt something change, or something different?*
 - b. *Can you describe what happened?*
 - c. *Can you describe what you were feeling or thinking at that time?*
5. How do you think the therapy impacted on you, if at all?
 - a. *Can you think of some positives and negatives of the programme?*
 - b. *Can you describe if there has been any change in your symptoms or day-day life and activities?*
6. How do you think the therapy worked, if at all?
 - a. *What was it about this therapy that helped you, if anything?*
 - b. *How do you think DBT might be different from other types of therapy?*
 - c. *Would you recommend DBT to someone you know?*

Appendix B

Participant Information Sheet (PIS)

University of East London, School of Psychology
Stratford Campus
Water Lane
London E15 4LZ



Principal Investigator
Jasmine Childs-Fegredo
U1218817@uel.ac.uk
07843 424066

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in a research study. The study is being conducted as part of my Professional Doctorate in Counselling Psychology at the University of East London.

Project Title

Client experiences of receiving adapted Dialectical Behaviour Therapy (DBT) and its perceived role in the process of change

Project Description

To date, research has proven that DBT can be a helpful form of therapy for people suffering with a variety of symptoms. However, the research has not been focused on the way clients experience the therapy, in their own words. This study is interested in finding out how clients experience the therapy, from beginning to end, and how they explain the changes that might have occurred for them over the course of the 12-week DBT programme. Furthermore, the project is aimed at understanding more about the way clients experience their journey through the programme and if there has been any impact on them.

Interviews

Participants interested in taking part would be interviewed by the investigator, at the Priory Hospital in Roehampton, or at the UEL Campus in Stratford. They would be asked a few questions about how they experienced the therapy, to be answered in their own words. There are no right or wrong answers to the interview questions, the investigator is interested in each individual's unique experience. The interview would last for approximately 60 minutes.

Participants would have the right to withdraw at any time. If during the interview participants should feel any distress, they can choose to end the interview or take a break and resume when they feel ready.

Should participants feel they need support for the distress they incur, they can choose to see a member of the therapy team known to them at the Priory Hospital where the interviews will take place, or contact their own personal therapist. Participants would also be given numbers of supportive agencies to call after the interview, if they find that emotions are surfacing and they would like some support.

The interviews do not form part of any treatment plan, and taking part in the project would not affect the participant's treatment, therapy or follow up treatment.

Confidentiality of the Data

Data collected will be transcribed and analysed as part of the project findings. All participants will be anonymised in the interviews, so anyone reading the transcript would not be able to identify the participant. Any identifying information would be omitted. The data would be confidential – it would not be shared or discussed with any person apart from the supervisor of the project. This is in accordance with the Data Protection Act.

Once the project is completed the stored audio data will be destroyed. The transcripts that form part of the appendix of the project write up will be fully anonymised and confidential.

Location

Therapies Department, The Priory Hospital Roehampton, London, SW15 5JJ

or

UEL, University Square Campus, Stratford, London, E15 1NF

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you withdraw, you reserve the right for the data gathered during your interview to be destroyed and not used as part of the project.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor Dr Edith Steffen, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Email: e.steffen@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Tel: 020 8223 4493

Email: m.finn@uel.ac.uk

Thank you in anticipation.

Jasmine

December 2014

Appendix C

University of East London, School of Psychology
Stratford Campus
Water Lane
London E15 4LZ



Consent to participate in a research study

Client experiences of receiving adapted Dialectical Behaviour Therapy and its perceived role in the process of change

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:

Appendix D
Participant Demographics

Participant Demographics						
#	Alias	Diagnosis	Education	Times completed DBT	History Prior to DBT	Int. Date
1	James	BPD	Not disclosed	1	Addiction treatment & 1:1 (private)	Dec-14
2	Emma	BPD	Graduate	1	CBT (NHS) & inpatient (private)	Jun-15
3	Rose	Depression	Not disclosed	2	CBT for Eating Disorders & 1:1 (NHS)	Jul-15
4	Charlotte	Bi-polar	Not disclosed	2	Inpatient/outpatient (private)	Jul-15
5	Rachel	BPD	Post-grad	2	Pharmacological; some CBT (private)	Sep-15

Appendix E

Ethics Approval – University of East London

ETHICAL PRACTICE CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Edith Steffen

ASSESSOR: Mark Finn

STUDENT: Jasmine Childs-Fegredo

DATE (sent to assessor): 23/07/2014

Proposed research topic: Client experience of receiving adapted Dialectical Behaviour Therapy (DBT) and its perceived role in the process of change

Course: Professional Doctorate in Counselling Psychology

- | | |
|--|----------------------|
| 1. Will free and informed consent of participants be obtained? | YES |
| 2. If there is any deception is it justified? | N/A |
| 3. Will information obtained remain confidential? | YES |
| 4. Will participants be made aware of their right to withdraw at any time? | YES |
| 5. Will participants be adequately debriefed? | YES |
| 6. If this study involves observation does it respect participants' privacy? | NA |
| 7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? | YES but see comments |
| 8. Is procedure that might cause distress to participants ethical? | YES |
| 9. If there are inducements to take part in the project is this ethical? | NA |

10. If there are any other ethical issues involved, are they a problem? NA

APPROVED

	YES	
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MINOR CONDITIONS: The application is approved and does not need to be re-submitted but please consider the following suggestions and minor conditions.

Suggestions:

- The applicant could re-consider recruiting for the research at the beginning of the DBT treatment course. Participants do not need 12 weeks to consider the participant invitation letter. While non-coercion is made clear, it might be best to recruit later so that clients do not understand receipt of DBT therapy to be in any way conditional on participation in the research. The participant invitation letter also states that 'DBT is proven to be a helpful form of therapy' and for participants to be told this on the invitation letter at the start of the therapy is unfairly guaranteeing a positive outcome.
- Consider giving participants the right to withdraw their data up to the point of analysis and that after this point the researcher reserves the right to keep it. This is to avoid possible re-write of analysis.
- In the invitation letter participants are told that anonymised extracts will be seen by the supervisor and examiners. The applicant may also want to include use of extracts in possible publication and conference presentation.

Minor conditions:

- In the participant invitation letter, amend statement about DBT as a helpful form of treatment to '*can* be a helpful form of treatment'. This will account for clients and participants who may not have perceived the therapy as helpful.
- Similarly, the proposed interview questions tend to assume that change occurred and that the therapy worked. Please amend working with inclusion of necessary caveats (such as 'if at all', as has been worked into other proposed interview questions).

- Attend to a couple of missing words in sentences in the invitation letter.

REASONS FOR NON APPROVAL:

Assessor initials: MF

Date: 28/07/14

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Edith Steffen

ASSESSOR: Mark Finn

STUDENT: Jasmine Childs-Fegredo

DATE (sent to assessor): 23/07/2014

Proposed research topic: Client experience of receiving adapted Dialectical Behaviour Therapy (DBT) and its perceived role in the process of change

Course: Professional Doctorate in Counselling Psychology

Would the proposed project expose the researcher to any of the following kinds of hazard?

- | | | |
|----|-----------|-----|
| 1. | Emotional | YES |
| 2. | Physical | NO |
| 3. | Other | NO |

(e.g. health & safety issues)

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: LOW

APPROVED

YES		
-----	--	--

Assessor initials: MF

Date: 28/07/14

For the attention of the assessor: Please return the completed checklists by e-mail to ethics.applications@uel.ac.uk within 1 week.

Appendix F

PRIORY

To whom it may concern.

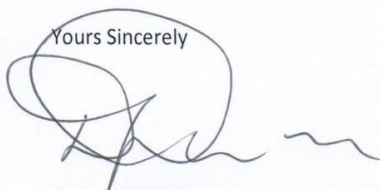
17th July 2014

Re Ms Jasmine Child-Fegredo

This is to confirm that Priory Hospital Roehampton have approved through Clinical Governance Jasmine Child-Fegredo's research proposal on Client experience of receiving adapted Dialectical Behaviour Therapy and the process of change in reducing symptoms of Borderline Personality Disorder.

We are happy to support this research and provide her with the information and tools to conduct the research.

Yours Sincerely



Dean Nicholson

Therapy Services Manager

Appendix G
Ethical Amendment I
UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Mark Finn (Chair of the School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Mark Finn at m.finn@uel.ac.uk
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

Name of applicant: Jasmine Childs-Fegredo

Programme of study: Professional Doctorate Counselling Psychology

Title of research: Client experience of receiving dialectical behaviour therapy and its perceived role in the process of change.

Name of supervisor: Dr Edith Steffen

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
The original proposal was for clients to be interviewed at The Priory Hospital in Roehampton. I would like to request clearance from the Ethics Committee to also undertake interviews at UEL, Stratford, as requested by participants.	A participant has contacted me and has requested to be interviewed at UEL Stratford, as it is closer to his work and home. I would like to offer this opportunity to this participant, and others, as requested. I believe this will increase the likelihood of participants' ability to take part in the research and offer some flexibility. I have spoken with the School of Psychology who have informed me that it is possible to book a room for such a purpose. The participant has just completed the 12 week DBT programme and would like to be interviewed before the Christmas Break, 2014. I would

	be sure to give numbers of supportive agencies following the interview, as originally proposed, to meet any concerns with regards to any distress following interviews.
--	---

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	

Student's signature (please type your name): J. Childs-Fegredo

Date: 15/12/2014

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: M Finn

Date: 17/12/14

Appendix H
Ethical Amendment II
UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Mark Finn (Chair of the School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

7. Complete the request form electronically and accurately.
8. Type your name in the 'student's signature' section (page 2).
9. When submitting this request form, ensure that all necessary documents are attached (see below).
10. Using your UEL email address, email the completed request form along with associated documents to: Dr Mark Finn at m.finn@uel.ac.uk
11. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
12. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

4. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
5. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
6. A copy of the approval of your initial ethics application.

Name of applicant: Jasmine Childs-Fegredo

Programme of study: Professional Doctorate Counselling Psychology

Title of research: Client experience of receiving dialectical behaviour therapy and its perceived role in the process of change.

Name of supervisor: Dr Lisa Fellin

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
The original proposal was for clients to be recruited from the Priory Hospital Roehampton. I would like to apply for an amendment to be able to recruit participants from the Priory Hospital North London as well, which forms part of the same group of hospitals and delivers the same model of therapy.	I have been able to recruit 5 participants in the space of 1 year and 2 months, by going to the Priory Roehampton periodically and handing participant information sheets to clients engaged in the DBT group. However, the therapists there feel that there will not be many more participants in the current cohort of therapy who would be interested in taking part, and I have not had any interest shown. The therapists there suggested I contact the therapy team at the Priory Hospital North London, who deliver the same model of therapy to the same

	client group. I would then be able to expand the possibility of recruiting additional participants in order to make the project viable. Both hospitals are overseen by the same Clinical Governance committee who have already approved for the project to go ahead.
--	--

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	

Student's signature (please type your name): J. Childs-Fegredo

Date: 29/01/2016

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	NO
<p align="center">Comments</p> <p>I am happy to approve the amendment, having also seen written approval for the project from Priory Hospital North London</p>		

Reviewer: Mary Spiller

Date: 22/02/2016

Appendix I

Transcript of 3-pages of one participant with descriptive, linguistic and conceptual interpretation and emergent themes

CST as ineffective - relative attempt to no avail.

Not BPD - rejecting gravity of our condition perhaps?

Extremism - like Arrested Development - is not BPD, BPD is more rigid, more "stuck". Some of wanting to be subject person or not as "mad". Seeing myself as apart / separate, in a protective sense. Protecting myself from the "madness"? "Narcissy".

Medication as helpful
OCD as ^{conflict} intrusive thought - emphasis on distress. "New" - a different intruding experience, propelling into action.

Skin picking as symptom
Paranoia - unlike "crazy", i.e. the most simple of ways for everything living was impossible
Dread and terror of thoughts - space for nothing else.

Anxiety as life by condition
Anxiety felt physically - in the chest + stomach.

Anxiety as perplexing - no evidence of the process but readily intensity as if there is an external threat. The concept of anxiety as an unfounded response which could bring up question of "insanity" - anxiety doesn't make sense in the same-making world.

rounds of CBT since the age of 12, which had never really stuck. Because my self-harming were so ingrained, I think that was what they really wanted to get into. I didn't have... Like, most of the symptoms or expressions of Borderline Personality Disorder didn't really apply to me. So I didn't have problems with addictions or abandonment or anything like that. But I think the questions were mostly about the entrenched nature of my self-harming behaviours.
I: Ok, when you say the 'entrenched nature' of the behaviours and you have talked about 'anxiety' and 'OCD'. Would you mind elaborating a little bit about what those things feel like inside yourself?
P: Yeah, well the OCD, luckily that's not so much an issue anymore, as my medication is really really good for that. I was getting intrusive thoughts, almost constantly, very very distressing, which was something quite new for me. Throughout my life I've had some compulsive behaviours like skin-picking and things like that, but I have never had the intrusive thoughts before and that was very very distressing. And that would just be completely paralysing because there wasn't enough room in my head for any other thoughts when all the intrusive thoughts were going on so I found it really hard to do, or feel anything apart from dread and horror of what was happening inside my head. The anxiety is something I've had almost all my life really. And it's, like, it's basically its sort of a physical feeling in my chest, in my stomach, it's the feelings of heightened adrenaline fight or flight... it's like feeling very very threatened, but you can't actually find the threat. It would make it easier is there were a solid threat around you could go 'ok there is a bear that is about to attack

CST not effective.
Rejecting insanity
Life as "lifeless"
PC → DBT.

Paralysed by horror of intrusive thought

Symptoms as non-sensical.

Anxiety is inappropriate
keyed up - as if waiting for something to occur
Full - non perceiving the bad dream

Source of memory of assessment.
Being asked Qs.

DBT is helpful - increasing expressive degree of to which helped

OSA reduced
BCA as a preventative to OSA.

Concept that BCA could share, endorsement / guilt? i.e. 'I can't be harsh' induces

underlying anger / frustration at the behaviour and could be linked to uncomfortable feelings.

Distraction techniques as helpful
Midphases as a technique to learn how to not interact with thoughts.

Understanding previous therapy - 'stuff' indicating risk of relapse? was advised to be given

Cycle of distress - increased with CBT techniques
Thoughts that led to Distraction turning her into a 'person' to be with thoughts.
can't do that CBT techniques split the person into "you say" / "but we" thereby feeding the

issue - dealing with intrusive thoughts by ignoring + distraction.
permission - two balanced sides of being with together? one side being kind to the other side.
"Giving permission" about an integrated approach to respond to setbacks to self.

me, that is why I am feeling this feeling, ok so it's appropriate'. It is just that inappropriate feeling of being keyed up and full of dread the entire time.

: And when you were assessed for the DBT, do you remember what that process was like, do you remember actually being in the assessment?

P: I think I do, I think I was sitting down and going through questionnaires and being asked questions for an hour or so. It was with 'Therapist'.

: Ok, and if I asked what it was like to take part in the 12 week DBT programme, do you have any thoughts about that?

P: Yes, I actually found it immensely helpful I really did.

I've had barely any self-harming behaviours since then, mostly because I hated having to do the BCAs! The behavioural chain analyses! And that was like... such an incentive, because if I thought about self-harming and everything, 'if I do this, then I know I have to tell my therapist and I know I have to sit down for like half an hour and do the BCA and I can't be bothered'! [laughs].

Erm. And I think also a lot of the strategies for distracting yourself erm, and things like that were quite nice, and a lot of the Mindfulness kind of things about feeling emotions and not having to interact with them.

Because I think a lot of the stuff I had learnt in CBT, rightly or wrongly, was to try and challenge these thoughts, to try and understand them, to try to change them. But to be honest quite often that led me down

an obsessive spiral of just policing my own thoughts and arguing with myself and just getting more and more distressed. Whereas if I could just... I sort have just given myself permission to just ignore them and find you know, something to distract me, something to

Trying to remember.
Longer assessment

DBT as v helpful.

SA reduced

BCA as incentive not to SA.

BCA as evoking shame / anger.

Distraction

Midphases learning skills not to react.

Understanding prior therapeutic techniques - pointing

pointing to Permissive

<p>Self-soothing - as a mechanism to stop engaging <u>engaging</u> in <u>unhelpful</u> thoughts. <u>we changed</u> <u>thoughts</u>. <u>Engaging</u> <u>is</u> <u>unhelpful</u> <u>control</u> <u>over</u> <u>anxiety</u>.</p> <p>Questioning anxiety as unhelpful and potentially distressing</p> <p>Pretense to change thought / thinking of consequences leads to <u>acknowledging</u> <u>concept</u> <u>of</u> <u>the</u> <u>'Thought Palace'</u> <u>arising</u> <u>and</u> <u>creating</u> <u>space</u> <u>in</u> <u>mind</u> <u>as</u> <u>opposed</u> <u>to</u> <u>claiming</u> <u>the</u> <u>space</u> <u>of</u> <u>thoughts</u>.</p> <p><u>Caught / trapped</u> <u>in</u> <u>thoughts</u>. <u>Immobile</u> <u>&</u> <u>spiral</u>. <u>concerning</u> <u>creating</u> <u>mind</u> <u>unhelpful</u> <u>thoughts</u>.</p> <p>Mindfulness as separate from DBT.</p> <p>Thoughts become present but not <u>entirely</u> <u>with</u> <u>mind</u> <u>to</u> <u>engage</u>. <u>She</u> <u>was</u> <u>interested</u> <u>in</u> <u>the</u> <u>thoughts</u>. <u>Rabbit hole</u> - <u>having</u> <u>would</u> <u>bring</u> <u>her</u> <u>into</u> <u>the</u> <u>thoughts</u> <u>with</u> <u>no</u> <u>positive</u> <u>reflex</u>. <u>A</u> <u>door</u> <u>into</u> <u>a</u> <u>warrior</u>.</p> <p>Believing thoughts as driving and all consuming results in horror for the future</p>	<p><u>soothe</u> <u>me</u>, <u>which</u> <u>is</u> <u>really</u> <u>useful</u> <u>to</u> <u>just</u> <u>sort</u> <u>of</u>, <u>stop</u> <u>engaging</u> <u>with</u> <u>those</u> <u>processes</u>.</p> <p>I: Ok, so you have mentioned there policing your thoughts, and then ignoring your thoughts. Can you tell me a bit more about the difference in those two things?</p> <p>P: Yeah, because I think before, if I was having a fear, or a thought that was making me anxious or...any kind of distressing thought, I would probably try to do the whole thing of 'why am I feeling this, what is this making me feel, what does this mean, what could this lead to?'. And you know 'what could I change this to?' But more often, I would just end up catastrophizing. So if I was going 'what will this lead to', I would go 'it will lead to this thing that is worse, and then lead to this thing that is even worse than that!'. And I would be <u>caught up</u> <u>in</u> <u>this</u> <u>like</u>, <u>spiral</u> <u>of</u> <u>awful</u> <u>anxious</u> <u>thoughts</u>. Whereas, I think the DBT, in conjunction with Mindfulness, was a lot about seeing that the thought is there, and not ascribing meaning to it. Just going, 'that's a thought, I don't have to engage with it, I don't have to go down that rabbit hole'.</p> <p>I: Right, so those two feelings are very different for you?</p> <p>P: Yeah</p> <p>I: Can you describe a little bit about what that feels like in your body - when you are policing your thoughts, compared to when you are ignoring your thoughts more mindfully?</p> <p>P: Yeah, because when I am following the thought I will often zone out and of whatever I am doing, because it will take so much mental energy to focus on this whole internal dialogue and these projections for the future, which is inevitably horrible! Which makes it quite hard to do anything else. So it makes it hard to carry on a</p>	<p>Self-soothing Becoming exposed</p> <p>CBT as inducing the thought palace</p> <p>Trapped in thoughts.</p> <p>Perception that mindfulness is set apart from DBT.</p> <p>DBT as removing from "rabbit holes"</p>
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Appendix J

Example of sub-theme development from individual emergent themes

CONTEXT	The DBT pathway	Symptomology & Emotions
Heterotopia - release from	Long road into DBT (referral process)	Life as 'lifeless' pre DBT
Calm surrounds	DBT as last resort	Paralysed by horror of intrusive thoughts
Setting important	CBT not effective	Symptoms as non-sensical
Heterotopia Vs real world	Lengthy assessment	Pressure leading to impoverishment
Readiness for the real world	Combination of medication and therapy as helpful	Symptoms
Loss of core conditions of heterotopia in ending	Readiness for ending	Paralysed by horror of intrusive thoughts
Perceived bespoke group of people	CBT less helpful - Examining thoughts as separate to the self	Symptoms as non-sensical
Creative environment for self-soothing/Distress tolerance techniques	Unhelpful	Self-harm reduced
Importance of setting in experiencing elements of the self	CBT not effective	Reduction in self-harm
Helpful		Reduction in anxiety
		Combination of medication and therapy as helpful
		Feelings
		Ambivalence
		Refuting insanity
		Perception that mindfulness is set apart from DBT
		Letting go as taking time

Ambivalence/stigma	Refuting insanity	Relief/belonging/surrendering	Learning & Tailoring
Ambivalence	Refuting insanity	Strict rules and boundaries	Distraction techniques learnt v helpful
	Refuting insanity		Unlearning prior therapeutic techniques
DBT requiring commitment		Social group/making friends	Unlearning the 'thought police'
Change		Break times as bonding	Self-soothing helpful
Life as 'lifeless' pre DBT		Inclusivity	Tailoring the therapy to meet own needs
Unlearning prior therapeutic techniques		Similar ages	Disentangling from old habits
Unlearning the 'thought police'		Feeling safe	Self-soothing
Policing to permissive			Developing own coping strategies

Becoming empowered			Freedom to question and challenge
Ruminating Vs engaging with life		Therapist awareness of possible alienation	Homework enables embedding
Letting go		Building friendships	Ignoring impulses
Tailoring the therapy to meet own needs		Ongoing sense of togetherness	BCAs as incentive not to self-harm
		Fun group dynamic	BCAs as evoking shame based emotions
		Groups allowing freedom of expression	Use of distraction techniques
		Sharing similar aspects of the self with others	Tailoring the therapy to meet own needs
		Safe	Pushing away shame
		Respectful of others	Educational
		Urges and impulses as connecting factor	Tailoring the therapy to meet own needs
		Similar mind-sets	Spirituality as alienating
		Developing compliance as important boundary	DBT like school
		Being held	DBT as methodological
		Sessions length/breaks	Homework and diary cards helpful
		Group cohesion	Active role in treatment
		Sense of togetherness	DBT as practical and active
		Mutual support	DBT as very helpful
		Nurturance	BCAs as incentive not to self-harm
		Compliance as motivating factor	BCAs as evoking shame/anger
		Non-pathologising	Distraction techniques learnt v helpful
		Collective dedication to recovery	Mindfulness develops new ways to react
		Importance of supportive environment created	Self-soothing helpful
		DBT as framework	DBT as rescuing from 'rabbit holes'
		Groups as well paced	
		CBT as theoretical / DBT as practical	
		Grounding	
		Relief in the process of normalising the self	

Validating/debunking	Gradual v sudden change	DBT as lifestyle
DBT as very helpful	Self-harm reduced	Trying to remember
DBT as rescuing from 'rabbit holes'	BCAs as incentive not to self-harm	Perception that mindfulness is set apart from DBT
Letting go of being efficient	BCAs as evoking shame/anger	Trying to remember
Debunking black vs white	Becoming empowered	Skills becoming part of the self
Questioning the self	Letting go as taking time	Self-soothing as everyday activity
Debunking black and white extremes	Reduction in self-harm	Meeting own needs
Being held	Reduction in anxiety	Ongoing therapy post DBT
Questioning 'higher power'	Transformative emotional experience through relating to others' experiences	Integration of skills into everyday life
Flexibility of therapists	Personal growth through mirroring of the self in others	
Validation through others experience	Mirroring of the self in others as transformative/corrective	
Allowing competitiveness	Changing own behaviour	
Futility of pressurising the self	Subtle change	
Collective hope	From impulsive to considered	
Freedom to question	Mindfulness as tool to slow down impulsivity	
Interrogating the self in presence of others	Mindfulness as calming	
Normalising the self	Developing related hobbies	
	Detaching from thoughts	
	Increased awareness	
	Change due to medication	
	Change as difficult to detect	
	Boundaries as enabling commitment and change	
	Becoming less judgemental	
	Developing sense of ownership	

Reflective practice & Spirituality	Hope & Joy	Objective - subjective self
Mindfulness develops new ways to react	Ruminating Vs engaging with life	Policing to permissive
Letting go		Permission to self
Finding the middle path		Giving out Vs giving to the self
Trying to remember		Awareness of fragility
Remembering specifics as unimportant to recovery		Ending DBT - becoming a person not a patient
Observing aspects of the self		Experiencing different aspects of the self
Trying to remember		Experiencing the self as refreshing as opposed to shame based
Developing insight		Developing objectivity
Seeing other's issues clearly		The deserving self
Trying to remember		Becoming objective

Trying to remember		Less meaning-making as helpful
Becoming non-judgemental towards DBT		Relinquishing subjective negative idea of the self
Becoming non-judgemental towards the self		Compartmentalising versus integration
Reacting differently		From insanity to a sense of healthy identity
Developing compassion		
Giving to the self		
Kindness to the self		
Self-compassion		
Developed sense of calm		
Ongoing mindfulness practice		
Less judgemental		

Appendix K

Helpful and Unhelpful aspects of the therapy (based on Cooper & McLeod, 2016)

THE SETTING			
Calm surroundings/gardens	Health insurance	12 weeks – adapted DBT	
Transdiagnostic	Private referral process	Heterotopia	Rolling group

The Therapists

Assess

Create core conditions

Check-ins / feedback

VALIDATE

GIVE

Challenge / allow to be challenged

Educate

Self-disclose

The Clients

Feel ambivalent

Refute insanity

Understand & feel understood

ENGAGE

Commit / surrender

Do homework

LEARN skills / learn from others

Mindfulness; self-soothe; radical acceptance

Make friends

Tailor the therapy

Develop reflective practice

Explore the self / the selves

The Outcome

Develop insight & spirituality

Acceptance of the subjective self

Feel relief

Experience hope / joy

Gradual Vs sudden change

DBT as a lifestyle

Compassion for self & others

Curiosity of the self, the world & others