FIRST DO NO HARM: CLIENT AND STAFF EXPERIENCES OF NEGATIVE EFFECTS FROM DIALECETICAL BEHAVIOUR THERAPY

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ABSTRACT

Background: Research has shown that Dialectical Behaviour Therapy (DBT) is effective in reducing self-harm and suicidal ideation. However, research regarding experiences of DBT, particularly those of a negative nature, is sparse. The limited findings suggest that clients have reported difficulties in the therapeutic relationship, and staff have observed DBT to overly rigid, and constrained by organisational factors. However, no research has focused on both groups' understandings of negative effects.

Aims: To explore client and staff experiences of the negative effects from DBT and investigate how their understandings compare. In addition, to explore how staff address any negative effects that arise.

Methodology: Underpinned by critical realism, this research adopted a qualitative approach. Eight client participants and seven staff participants, who had experienced or witnessed negative experiences from DBT, engaged in semi-structured interviews, the transcripts of which were analysed using reflexive thematic analysis.

Analysis: Four themes relating to client experiences were generated: "I'm the problem", "DBT can do no wrong", "No understanding of trauma", and 'An unhealthy "blueprint for relationships"'. Five themes relating to staff experiences were generated: "It's not me, it's the client", 'DBT or nothing', "We don't do 'why' in DBT", "We did make some changes", and 'Organisational "restrictions"'.

Conclusion: Both staff and clients understood negative effects from DBT to include pathologization and re-traumatisation. However, whilst clients related negative effects to the therapeutic relationship, staff highlighted the impact of organisational restrictions. Given the study design and selection bias, this study cannot ascertain the prevalence of negative effects from DBT. Nonetheless, the findings support recommendations for practice, including adapting DBT to become trauma-informed, and prioritising informed consent.

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1.0. INTRODUCTION

1.1. Chapter Overview

This chapter outlines both the historical and current context in which this research is situated. The chapter begins with a critical exploration of relevant terminology. Next, the development of Dialectical Behaviour Therapy (DBT) is explored, and a description of its current presentation and context within the UK is provided. Subsequently, there is an overview of the research on negative effects from therapy, including their prevalence, identification, and possible causes. Findings from a scoping literature review indicate the originality of this research's contributions. Finally, aims, clinical relevance, and research questions are outlined.

1.2. Terminology

1.2.1. Negative Effects

Within the literature on negative effects, several terms have been used, including clinical deterioration, side effects, negative outcomes, negative effects, and iatrogenic harm (Parry et al., 2016). This wide range of terms likely reflects the fact that negative effects from psychological therapies are multidimensional (Lilienfeld, 2007) and therefore difficult to capture using one word or phrase. However, there have been concerns raised that the limited research regarding harm from therapy could be in part due to confusion regarding terminology. As a result, there have been recommendations for an increased standardisation in the language used (Parry et al., 2016).

Parry et al. (2016) for example suggested that three aspects of negative effects should be considered when conducting research to evaluate psychological therapies. The first of these were adverse events, which the researchers defined as any that occur during or soon after a psychological intervention and that appear to be caused by the therapy. The second aspect named was clinically significant deterioration, which may include newly occurring distress. The final aspect was client-experienced harm, which it was acknowledged may not be easily identified by using standardised outcome measures. Within this thesis, the term ‘negative effects’ is used to refer to all three of these aspects, as well as any other idiosyncratic client experiences that they perceive to have been negative in any way.

1.2.2. ‘Borderline Personality Disorder’

According to the DSM-V, ‘borderline personality disorder’ (BPD) is defined as a pervasive pattern of instability in relationships, self-image, and emotions (American Psychiatric Association, 2022). The National Health Service (NHS) describes DBT as a therapeutic approach designed to treat people given a diagnosis of ‘BPD’ (NHS, 2022) and therefore, before continuing, it is essential to note the controversy surrounding this diagnostic label, otherwise known as ‘emotionally unstable personality disorder’ (EUPD).

Firstly, between 30% and 90% of clients who have been given a diagnosis of ‘BPD’ have experienced some form of childhood abuse (Bozzatello et al., 2021). Labelling patterns of trauma responses with a diagnosis arguably locates the ‘problem’ not within the system that has caused it, or with the perpetrators of abuse, but within the individual (Penfold & Walker, 1983), thereby pathologizing their survival strategies (Nicki, 2016) rather than viewing them as an understandable response to an intolerable situation (Shaw & Proctor, 2005). Indeed, inherent in the terminology of ‘personality disorder’, is the potentially damaging and dangerous assumption that one’s personality can be intrinsically flawed (Langley & Price, 2022). According to a feminist critique, the existence of the ‘BPD’ label is located within the history of sexual abuse denial, whereby survivors were silenced by being labelled as ‘mad’ (Ussher, 1991).

Secondly, research has shown that clinicians are more likely to give a ‘BPD’ diagnosis both to those assigned female at birth (Wupperman & Edwards, 2017), and to ‘sexual minority’ clients, independent of presenting symptoms (Rodriguez-Seijas et al., 2021). Furthermore, survivor research has described the damaging ways in which members of the LGBTQ+ community have experienced their sexuality or gender identity being conceptualised as a symptom of their supposed ‘personality disorder’ (Lomani, 2022). This is often then used to justify the “punishment” (Langley & Price, 2022, p. 15) of LGBTQ+ people for falling outside of societal expectations regarding gender roles.

Finally, clients given a label of ‘BPD’ have been found to be viewed negatively by mental health practitioners (Veysey, 2014). Research has found that given the stigma behind this label, members of staff emotionally distance themselves from individuals, minimise their distress, and overlook their strengths (Aviram et al., 2006). Given all of the above, it is perhaps unsurprising that survivor research has detailed the ways in which people have been “profoundly harmed” (Lomani, 2022, p. 3) by the construct and label of a ‘personality disorder’. Accordingly, in this thesis the researcher will not describe a person as having ‘BPD’, rather as having been given a diagnosis of ‘BPD’. More generally, the critical realist approach taken here recognises that psychiatric diagnoses such as ‘BPD’ are not an objective reality, rather that mental distress in the context of certain societal factors constitutes a real problem for those implicated (Pilgrim, 2014). In alignment with this, the medicalisation of distress in the form of a ‘language of disorder’ (Kinderman et al., 2013, p. 2) with its emphasis on pathology, will be avoided throughout this research.

1.3. Dialectical Behaviour Therapy

1.3.1. Historical Context and Development

To understand the context in which DBT emerged, it is necessary to take a closer look at the researcher who developed it (Marsha Linehan), and the various influences on her work. This section will begin by providing an overview of the religious and spiritual influences on Linehan’s work. It will then summarise Linehan’s lived experience and explore the impact this had on the development of DBT. Finally, the behaviourist roots of DBT will be outlined.

Linehan’s work draws inspiration from a variety of religious sources, including German Benedictine Monks. Indeed, Linehan is a practising Roman Catholic and has described developing DBT as her way to “fulfil my vow to God” (Linehan, 2020, p. 7) to help others who were struggling. With this context in mind, it is interesting to reflect on certain facets of DBT that mirror aspects of Catholicism. For example, the agreements and commitment strategies in DBT (Vaughn, 2022) arguably echo the Catechism of the Catholic Church.

Although Linehan often cites a 1980 grant from the National Institute of Mental Health (NIMH) as the starting point for DBT, arguably her true inspiration is drawn from lived experience, and a commitment made to support others in similar situations (Linehan, 2020). Linehan spent over two years in a locked psychiatric ward, where she recalls regularly self-harming, and being labelled as “one of the most disturbed patients in the hospital” (Linehan, 2020, p. 21).

Many of the skills taught in DBT programmes today can be traced back to Linehan’s experiences during this hospital admission. Some experiences Linehan found helpful and incorporated into DBT. For example, after finding that ‘cold pack’ therapy helped to regulate her emotions, Linehan introduced ‘ice diving’ to the DBT skills repertoire. Other experiences Linehan found less helpful and so attempted to avoid or address. In Linehan’s memoir *Building a Life Worth Living* (2020), she reflects on how compassion and attempts to understand her behaviour were in her opinion insufficient. According to Linehan, her own ‘suicidal behaviour’ was being positively reinforced by staff’s efforts to help her. For example, in response to self-harming behaviour, staff on the ward would put Linehan in a seclusion room where she felt safe, which she believes encouraged the ‘problem behaviour’. Perhaps in response to this, Linehan has stated that DBT is not an ‘individual psychotherapy approach’, but rather a ‘behavioural treatment program’ (Linehan, 2020).

Linehan holds behaviourism in high regard, having completed a post-doctoral fellowship in behaviour modification. Indeed, she has stated that reading *Principles of Behavior Modification* (Bandura, 1969) played a key role in her professional development. In keeping with this, the origins of DBT are, in essence, behavioural. DBT emerged from a series of unsuccessful attempts in the 1970s to apply behavioural principles and social learning theory (Staats & Staats, 1963) to the treatment of people referred to as ‘chronically suicidal’ (Linehan & Wilks, 2018). Perhaps unsurprisingly, clients reported that the focus on behavioural change was invalidating and often lead to them withdrawing from therapy, and even in some cases attempting to end their lives (Dimeff & Linehan, 2001). To address these difficulties, Linehan and colleagues introduced several adaptations, including validation and radical acceptance, drawing on Zen and contemplative practices (Linehan & Wilks, 2018). These alterations facilitated a shift from a purely behavioural focus to a more acceptance-based approach that encouraged temporarily tolerating distressing experiences (Linehan & Wilks, 2018). However, the emphasis on acceptance left some clients feeling hopeless (Linehan, 2020). This balance, or ‘dialectic’, between acceptance and change is the cornerstone of DBT as it is known today. Drawing on dialectical philosophy, DBT therapists seek to balance validation with behaviour change (Chapman, 2006).

In terms of the development of DBT and its relation to the diagnostic label of ‘BPD’, Linehan was clear that she was never interested in treating a disorder. Instead, she set out to target suicidal ideation and other signs of distress that were “turned into a disorder by others” (Linehan, 2020, p. 304). Indeed, in order to qualify for a NIMH grant for her DBT research, the requirement was to be studying clients with an official diagnosis. Linehan was informed that studying people experiencing suicidal ideation would not meet the criteria, and so chose to study a recognised condition that she believed related to this: ‘BPD’.

1.3.2. What are the Key Elements of DBT?

DBT is a skills-based cognitive behavioural therapeutic modality, underpinned by the biosocial model. This model states that an interaction of predisposing biological factors and later environmental triggers contribute to a client’s presentation (Crowell et al., 2009). DBT purports to serve five key functions, which are: enhancing capabilities, generalising capabilities, increasing motivation, enhancing therapist capabilities, and structuring the environment (Lynch et al., 2007). It seeks to address symptoms according to a hierarchy, with the priority being life-threatening behaviours. This is followed by addressing ‘therapy-interfering behaviours', and finally focusing on behaviours that may decrease the client's quality of life (Lynch et al., 2007).

A full DBT programme adopts four modes of treatment: group skills training, individual therapy, telephone coaching, and a therapist consultation team (Robins et al., 2010). Skills teaching takes place during weekly two-hour groups, and consists of four modules: mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance (May et al., 2016). Many of the interpersonal skills draw on assertiveness training (Linehan & Egan, 1979), for example the skill known by its acronym DEARMAN, which attempts to teach clients how to make requests. All skills teaching has a didactic focus, and entails instructions, modelling, coaching, and homework assignments (Linehan & Wilks, 2018).

During weekly individual therapy sessions, DBT facilitators are encouraged to communicate in both a reciprocal style, to encourage acceptance, and in an irreverent style to facilitate change (Robins et al., 2010). Telephone coaching is available between sessions and is designed to be used for skills coaching. However, if a client harms themselves, telephone contact is prohibited for 24 hours (Scheel, 2000). The final mode of treatment, the consult, entails all therapists meeting on a weekly basis, with the aim of ensuring adherence to the model, managing burnout, and providing mutual support (Linehan & Wilks, 2018).

1.3.3. Current Context in the UK

The National Institute of Health and Clinical Excellence (NICE) recommends considering DBT for clients who have been given a diagnosis of 'BPD' (NICE, 2009), especially where clients are engaging in self-harming behaviour. There have also been adaptations of DBT for the treatment of clients who have been given other diagnostic labels, including substance misuse (Linehan & Dimeff, 1997), binge-eating disorder (Telch et al., 2001), and attention deficit hyperactivity disorder (ADHD; Hesslinger et al., 2002). Additionally, DBT has been adapted for use in inpatient forensic settings and prisons (McCann et al., 2000).

The first UK teams began to train in DBT in 1994 (Swales et al., 2012). Perhaps in part due to data indicating the cost-effectiveness of DBT (Brazier et al., 2006), it has since been widely adopted in NHS trusts throughout the UK. Indeed, a total of 105 teams began DBT training between 1994 and 2007 (Swales et al., 2012). However, the development of a DBT provision is initially resource intensive, involving a reorganisation of services and intensive staff training (Swales et al., 2012). It is unsurprising, therefore, that not every NHS trust offers DBT, with some describing their chances of receiving the therapy as a postcode lottery (Cole, 2021).

1.3.4. Evidence Base

The first clinical trial for DBT took place in 1991. It found that compared to participants in the 'treatment as usual' condition, those who had DBT spent less time in hospital, had fewer suicide attempts, and were more likely to remain in treatment (Linehan et al., 1991). Linehan releasing the full DBT treatment protocol in 1993 prompted the development of several randomised controlled trials (RCTs), which continued to be published over the next two decades (Flynn et al., 2021). A systematic review of 75 such RCTs found that overall DBT was effective at reducing self-harm and improving psychological functioning (Storebø et al., 2020). In part based on the evidence from these RCTs, which also indicated, for example that participants allocated to DBT showed significantly larger reductions in depression and hopelessness (Koons et al., 2001), DBT began to develop in popularity. It was subsequently selected by both the American Psychiatric Association and the UK Department of Health as a recommended treatment for those given a label of 'BPD' (Feigenbaum et al., 2011). However, it should also be noted that the majority of the RCTs conducted had small sample sizes and a high risk of bias (Storebø et al., 2020). Indeed, the efficacy of DBT when compared to alternative psychological treatments remains highly debated (Little et al., 2017).

Randomised controlled trials have also been conducted to investigate applications of DBT for populations other than those given a diagnosis of 'BPD'. Lynch et al. (2003) for example, found that older adults allocated to a DBT and antidepressant medication condition showed significantly greater reductions in self-reported depression than those allocated to antidepressant medication alone. In addition, Safer et al. (2001) found that participants diagnosed with bulimia nervosa who were allocated to DBT as opposed to a waitlist control engaged in significantly fewer binge-and-purge episodes. Finally, Linehan et al. (2002) found that those allocated to DBT as opposed to Comprehensive Validation and 12-step were more likely to maintain reductions in opioid usage. However, there is also evidence to suggest that one adaptation of DBT, which involves engaging in brief skills training, increases the risk of self-harming behaviour (Simon et al., 2022).

Examining the evidence base surrounding DBT for diagnostic labels other than 'BPD' is of particular importance given that people do not tend to experience distress in only one area and given the risks of misdiagnosis (Levy & Pantelides, 2020). There is, in particular, a large overlap in the diagnostic criteria between the labels of 'BPD' and 'Complex Posttraumatic Stress Disorder (C-PTSD)' (Jowett et al., 2020). Interestingly, the International Society for Traumatic Stress Studies Expert Consensus Guideline for C-PTSD (Cloitre et al., 2018) recommends a three-stage treatment model, the first of which sounds remarkably similar to DBT. Indeed, Phase 1 is said to focus on "reducing symptoms, and increasing important emotional, social and psychological competencies" (p. 5). Perhaps then, DBT does include some stabilisation techniques for clients who have experienced trauma. However, the question then remains as to whether this is an excessively long period of stabilisation, without any guarantee of trauma re-processing work to follow.

1.3.5. Staff Experiences of DBT

Although the process of establishing DBT teams within NHS trusts has been well documented (Baillie et al., 2010; Lew et al., 2006; Morrissey & Ingamells, 2011), the focus has tended to be organisational, rather than on team members' experiences. Qualitative research into staff experiences of delivering DBT is relatively sparse.

Fortunately, there are a limited number of papers qualitatively exploring staff experiences of DBT. A study by Araminta (2000) for example, which explored both client and staff experiences of DBT, found that both participant groups described the structure and relational aspects of the programme as most helpful. However, whilst in clients' experiences, therapist self-disclosure was most valued, staff tended to emphasise the value of particular skills and techniques. Perseius et al. (2007) also investigated staff experiences of DBT, with an emphasis on occupational stress and burnout. Participants in this study described the ways in which working as DBT facilitators had positively changed their opinions of clients who had been given a diagnosis of 'BPD', and more generally had been a positive personal experience. However, participants also outlined their views of the wider psychiatric organisation as being inflexible and difficult to work within.

A later study by Hutton et al. (2017), which used semi-structured interviews to investigate NHS staff experiences of delivering DBT, found that overall, being a DBT facilitator positively impacted participants both personally and professionally. However, they also found that working within the wider service context was associated with stress (Hutton et al., 2017). Similarly, Flynn et al. (2020) found that DBT therapists experienced several organisational challenges to the implementation of DBT, including a lack of resources, insufficient administrative support, and resistance from other staff.

1.3.6. Client Experiences of DBT

Despite the wealth of research, concerns have been raised regarding the robustness of the evidence base for DBT (Feigenbaum, 2007). In particular, the focus within existing literature appears to have been on symptom reduction rather than client experiences.

Encouragingly, there are some studies that have focused more on client experiences. Little et al. (2017) for example, conducted a systematic review with the aim of summarising client experiences of DBT. Seven studies met their inclusion criteria, and four themes were identified: DBT facilitating an increase in hope, the importance of the therapeutic relationship, the development of self-efficacy such as learning skills, and a shift towards more positive views of self and future throughout the therapeutic process.

There is also a wealth of grey literature detailing first-hand client accounts of their experiences with DBT, some of which echo the themes generated by Little et al. (2017). Dominee Calderon (2016) for example, in a blog post entitled “Why I love DBT”, wrote that DBT had been “helpful in whatever ways I’m trying to improve myself”, and concluded that “I think it’s something that we should all learn just because it teaches us really good coping skills”. Similarly, one of the anonymous authors in the blog “The Experience of Doing DBT” (Mader, 2017) recalled realising that “by using DBT skills, I could get out of suffering and into the present moment”. Also referring to a positive experience of learning skills, an anonymous blogger (2014) for the charity Mind wrote of their life after DBT, “I feel like I now have a better handle on things in my life… I have a toolkit of things I can try before turning to harmful behaviours of the past.”

Whilst these blog posts touch on the helpful impact of DBT, there are also several personal accounts focusing on experiences of engaging with DBT, which seem to be less positive. For example, a blog post by Hollie Berrigan (2022) details the ways in which she found DBT to be rigid, poorly resourced, and not sufficiently trauma informed. Similarly, in a YouTube video, Ostara (2019) describes how her experience of DBT was one of perpetuated shame, confusion, and suppressing emotions.

In a letter written to the BPS, Rebecca Donaldson described her experience of DBT as silencing, and in misalignment with her values (Donaldson, 2021). Donaldson (2022) later published a poem entitled “A Middle Finger to Oppression and DBT”, in which she writes:

> Really, Linehan, your treatment has done more harm than good
> I’d have the world know this if I could
>
> I don’t see a difference between this system and prison
> Patient or prisoner, it’s the same definition

> May one day this field start treating people like human beings once and for all.

In 2021, Donaldson started a Facebook group called “Stop Dialectical Behavioral Therapy”. The group now has over 800 members, some of whom gave permission to share their quotes in an article for Mad in America (Donaldson, 2022). One anonymous quote reads: “DBT was the worst thing that ever happened to me. I needed trauma therapy for years just to process the abuse that DBT was.” Another says: “I felt minimized and dismissed… all agency was stripped from me, and my voice was ignored.”

1.4. Negative Effects

‘Primum non nocere’, or ‘first do no harm’, has become one of the fundamental guiding principles for healthcare professionals (Travers, 2018). The third principle in the British Psychological Society’s (BPS) Code of Ethics and Conduct features a similar notion, stating that psychologists’ practice should include “the avoidance of harm and the prevention of misuse or abuse of their contributions to society” (BPS, 2021, p. 18). However, in contrast to the significant interest in the potential negative effects of psychotropic medication (Sharp & Chapman, 2004), until recently there has been very little research into or documentation of the negative effects of psychological therapies (Duggan et al., 2014; Jonsson et al., 2014; Vaughan et al., 2014). Indeed, a review of 132 mental health trials found that only 21% of them had monitored negative effects (Jonsson et al., 2014).

Instead, the emphasis within research, especially in the early 2000s, was on the rapidly developing evidence base for psychological therapies, and the drive to increase access to these. Fortunately, there is a more recent move towards emphasising the importance of recognising negative effects as a key role of competent healthcare practitioners (Linden, 2013; Wolpert, 2016). Drawing on Lilienfeld’s (2007) concept of Potentially Harmful Treatments (PHTs), there appears to be a heightened awareness within the literature that negative effects from psychological therapies do exist (Berk & Parker, 2009; Bystedt et al., 2014).

1.4.1. Prevalence

Extensive research has suggested that between 40 and 60% of clients do not reach the defined recovery criterion after engaging in psychological therapy (Gyani et al., 2013). In terms of negative effects, their prevalence varies both according to therapist, and based on client characteristics (Saxon et al., 2017). Indeed, Crawford et al. (2016) found that clients who are racialised, queer, and over the age of 65 were more likely to report negative effects. Further research found that 39% of clients receiving therapy for depression (Moritz et al., 2019) reported at least one negative side effect, and 93% of those receiving therapy for obsessive compulsive disorder (Moritz et al., 2015) reported one side effect. This supports the hypothesis that the likelihood of experiencing negative effects from therapy is dependent on a variety of both clinician and client characteristics, perhaps including diagnostic label.

However, there is some consistency in the research, which suggests that overall, between approximately five and ten percent of all clients have experiences of negative effects from therapy (Hansen et al., 2002; Hatfield et al., 2010; Lambert, 2013). This estimate is congruent with research by Crawford et al. (2016) who found that out of 15,000 people who had experienced psychological therapies in England and Wales for anxiety and depression, one in 20 of them reported that this had a lasting negative effect. Similarly, a study by Schermuly-Haupt et al. (2018) found that nine percent of clients who had received CBT reported a worsening of symptoms. Of these nine percent, 21% reported that the negative effects were either severe or very severe, and five percent reported that the negative effects were persistent.

Although there is a consensus on prevalence, it should be noted that some researchers cite higher levels. Rozental et al. (2019) for example, found that according to responses to the Negative Effects Questionnaire, 50.9% of 564 clients who had received low intensity CBT, reported some form of negative experience. These discrepancies in findings regarding prevalence may occur due to studies being too broad in some ways, and too narrow in others, thereby respectively over or underestimating the occurrence of negative effects (Lilienfeld, 2007). For example, studies might overestimate prevalence by attributing deterioration to psychological therapy in cases where clients experienced heightened distress for other reasons. Equally, studies may underestimate prevalence by overlooking cases in which therapy may have delayed the occurrence of natural improvement. For example, clients for whom therapy produced slight improvements, but who would have improved more rapidly without therapy (Lilienfeld, 2007).

1.4.2. Possible Causes

Within the research on negative effects from psychological therapy, it has been rare for participants to cite a single cause (Hardy et al., 2017). Instead, causes have appeared to be multifactorial in nature, consisting of a variety of client, clinician, and therapeutic modality factors (Hardy et al., 2019; Jonsson et al., 2016). A model by Curran et al. (2019) outlined the ways in which different factors may interact to contribute to negative effects. The findings from the researchers' synthesis of service user testimony and qualitative research suggested that contextual factors and unmet client expectations contribute to negative therapeutic processes. These processes encompassed therapist behaviours which, in combination with power imbalances, contributed to clients feeling disempowered and silenced.

Parry et al. (2016) helpfully outlined key categories into which possible mechanisms for negative effects may fall. These include the therapeutic relationship, therapist factors, poor fit between client and therapist or intervention, specific intervention risks, and organisational factors, each of which will be outlined below.

1.4.2.1. Therapeutic relationship: Possible causes of negative effects pertaining to the therapeutic relationship include damaging interactions between client and therapist, as well as unresolved ruptures (Parry et al., 2016). Furthermore, the power imbalance between therapist and client has been repeatedly identified as a probable key contributor to negative effects (Berk & Parker, 2009; Linden & Schermuly-Haupt, 2014; Parry et al., 2016).

1.4.2.2. Therapist factors: Rigidity, violation of boundaries, misuse of power, and a lack of knowledge have all been outlined as therapist behaviours that are associated with clients feeling silenced, disempowered, and blamed (Curran et al., 2019). Additional therapist factors found to be associated with negative effects include lack of empathy, unethical behaviour, lack of clarity, and negative emotional reactions to clients (Hardy et al., 2019; Mohr, 1995).

1.4.2.3. Poor fit: Another potential explanation for negative effects could lie in an inappropriate match between client and the therapist or their preferred intervention. Indeed, a psychological therapy may be effective in general, but an inappropriate fit for certain presenting difficulties, or harmful for a specific population (Duggan et al., 2014). This could be exacerbated by clinician preference for a certain approach, gaps in therapist knowledge, incompatibility with client preferences (Farquharson, 2020), or differences in world view (Parry et al., 2016). Finally, there may be a poor fit in terms of the potential for a client's presenting difficulties to have a personal resonance for the therapist. For example, there may be a clinician who, for personal reasons, is unable to work effectively with clients presenting with grief (Parry et al., 2016).

1.4.2.4. Specific intervention risks: Some therapeutic approaches have been found to carry inherent risks of potential harm (Lilienfeld, 2007). Critical incident stress debriefing for example, has been found to interfere with individuals' personal ways of coping after a traumatic event, medicalise their distress, and therefore potentially cause harm (Rose et al., 2002).

1.4.2.5. Organisational factors: High caseloads, insufficient funding for training or resources, pressure to work beyond competence, lack of choice, and limited information are all organisational factors that have the potential to contribute to negative effects from psychological therapy (Hardy et al., 2019; Parry et al., 2016).

1.4.3. Identification

Research has found that therapists who rely solely on their clinical judgement are very poor at identifying negative effects in clients (Hannan et al., 2005; Hatfield et al., 2010). In addition, therapists rarely receive specific training on how to identify or respond to negative effects (Bystedt et al., 2014; Castonguay et al., 2010). This, in combination with the findings that it is rare for clients to spontaneously disclose negative effects (Hardy et al., 2019; Horigian et al., 2010), indicate just how important it is to consider formal methods of identifying harm. In addition, some short-term emotional distress may be an intrinsic aspect of worthwhile therapy (Schermuly-Haupt et al., 2018), and so a method of being able to distinguish this from harm caused by the therapeutic process itself is important.

Several measures have been published over the years, which have been designed to support the identification and recording of negative effects. The Unwanted Event to Adverse Treatment Reaction checklist (UE-ATR; Linden, 2013) for example, was developed with the intention of supporting clinicians to identify negative effects in their routine practice. However, it should be noted that the psychometric properties of the UE-ATR have not yet been researched (Farquharson, 2020). The Experiences of Therapy Questionnaire (Parker et al., 2013) by contrast, has had research conducted into its psychometric properties, which has supported its validity and internal reliability. Both the UE-ATR and the Experience of Therapy Questionnaire focus predominantly on negative therapeutic processes (McGlanaghy et al., 2021), and so are perhaps best used in conjunction with an additional measure that focuses on other potential negative experiences. The Negative Effects Questionnaire (NEQ; Rozental et al., 2016) for example, is a 32-item measure, which focuses more on client experiences of negative effects.

Research by McGlanaghy et al. (2021) found that, perhaps surprisingly given the subject matter, the views of service users are the least prominent in the literature on measures of negative effects from psychological therapy. In response to this finding, they conducted a study with the aim of understanding the perspectives of a panel of experts by experience. The researchers found that many of the items present in existing measures, such as a sense of failure or impact on work, were not rated by the panel as important. Furthermore, a number of new items were generated by the panel of service users, which were not present in existing measures. These included an increase in self-harm or suicidal ideation, vulnerability, painful realisations, pressure to use therapy in the correct way, and difficulties with the time limited nature of the therapeutic relationship (McGlanaghy et al., 2021). The fact that these factors have tended to be overlooked by clinicians, makes it even more important that they be attended to both in clinical practice, and in any research regarding harm from psychological interventions.

1.4.4. Response

Once negative effects have been identified, the next step should involve a multi-level response, at the levels of the organisation, the team, the therapist, and the relationship between client and therapist. At the organisational level, clinical audits should routinely include the monitoring of negative effects, drop-out rates, and any deterioration. This should then be followed up with a thorough investigation (Parry et al., 2016). In addition, intervening at an organisational level in advance, could help to alleviate negative effects. Indeed, research suggests that clients who have had their preferences for therapy met tend to report that therapy has been more helpful (Williams et al., 2016). Finally, when developing training for therapy staff, organisations would do well to include a core section on awareness, identification and understanding of negative effects (Castonguay et al., 2010).

Early intervention at the level of relationship between client and therapist is also key, in terms of co-creating explicit therapeutic contracts, scheduling regular reviews (Hardy et al., 2019), and the provision of transparent information. Indeed, Crawford et al. (2016) found that clients who had been given sufficient information prior to starting therapy were less likely to report negative effects. Any information provided to clients ahead of therapy should include not only the potential positive effects, but also the possibility of negative effects occurring. This is particularly important when considering the process of informed consent, which according to the BPS (2017) Professional Practice Guidelines should include clear and accessible information about the risks of any proposed intervention and any alternative options. Once the working relationship between client and therapist has been established, close attention should be paid to the quality of this relationship. Thought should be given to any potential power imbalances, and the client's perspective on this. Finally, to provide opportunities for repair, therapists should be able to readily notice, name, and explore any ruptures in the therapeutic relationship (Farquharson, 2020).

At the team level, therapists discussing negative effects with their supervisors is one recommended way of responding to their occurrence (Linden, 2013). Furthermore, supervisors should support therapists to recognise when cultural biases are negatively impacting on the therapeutic relationship and help them to develop cultural competence (Bhui et al., 2015; Sue, 2009). Unfortunately, Hardy et al. (2019) found that therapists rarely used the supervision space to discuss observed deterioration in clients, or even a lack of progress. Possible reasons for this include time constraints, service culture, or a difficulty talking openly about perceived shortcomings. In order to ameliorate these factors, developing a team culture of learning as opposed to blame should be a priority (Farquharson, 2020). This is an approach also advised by the statutory duty of candour for all health and social care employees (Care Quality Commission, 2022), which encourages an organisational culture of openness and learning.

1.5. Scoping Literature Review

The following section will provide a description of the scoping review, which was chosen due to its use in synthesising relevant literature (Cacchione, 2016) and identifying gaps in the research base (Peters et al., 2015). The search strategy was based on the scoping review methodology developed by the Joanna Briggs Institute (JBI; Peters et al., 2015), which itself draws on a framework by Arksey and O'Malley (2005) and improvements by Levac et al. (2010).

The initial stage of the review entailed a limited search of relevant databases. This was followed by an analysis of the terms included in titles, abstracts, and index terms of relevant papers, which helped to inform the search terms selected for use in the subsequent search. A list of the selected search terms and combinations, along with a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Aromataris & Riitano, 2014) flow diagram illustrating the literature review process can be found in Appendix A. After initial database searches revealed that the inclusion of search terms relating to negative effects, such as ‘iatrogenic harm’ or ‘negative outcomes’, did not generate any additional relevant studies, a decision was made not to include these.

Stage two of the scoping review involved a literature search using the identified search terms across three databases: PsychInfo, EBSCO Academic Search Complete, and SCOPUS. In terms of inclusion criteria, given that DBT was created in the late 1970s, the decision was made to only review research published since 1975. In addition, searches were limited to items that had versions available in English. The SCOPUS search identified 389 records, and a search of EBSCO Academic Search Complete and SCOUPS generated a further 130. The third stage of the JBI methodology involved searching the citations and reference lists of the identified items for any relevant studies. This process generated a further 10 items for consideration.

After all duplicates were removed, 473 items were identified for further screening. Any studies that included the experiences of either clients or staff of DBT, were considered if the focus was not too specific. For example, papers which looked at client experiences of only one particular DBT skill were not included. A total of 36 items met these criteria and were eligible for full-text consideration. After a full text review of these items, 30 were excluded given that they did not meet the inclusion criterion of containing information relating to either negative effects from or negative experiences of DBT. A table summarising the key aspects of included items can be found in Appendix B.

1.5.1. Descriptions of Individual Items

The first four items to be presented all focus on client experiences of DBT and entail some mention of negative effects from DBT. These will be followed by one paper, which focuses on the experiences of staff delivering DBT, some of whom identified potential negative effects. The final item to be presented is a paper that looks at both client and staff experiences of DBT in a forensic learning disability service, and in doing so identifies some negative effects.

1.5.1.1. Hodgetts et al., 2007: This first study interviewed five participants who had been given a diagnosis of ‘BPD’, about their experiences of DBT in an NHS setting. The interviews were analysed using Interpretative Phenomenological Analysis (IPA), with an emphasis on interpreting emotional states that might underlie participants’ conversations. The researchers identified three key themes, which addressed the process of joining DBT, the experience of DBT itself, and evaluations of the intervention. Although participants were not asked explicitly about their experiences of negative effects from DBT, several discussed aspects of the programme that they found difficult. Indeed, when discussing the helpfulness of specific components of DBT, one participant mentioned that they struggled with mindfulness, and another described finding the process of chain analysis to be “rubbish”, and “horrible” (p. 3). In addition, one participant described how they felt unable to utilise alternative coping strategies or skills, which felt particularly challenging given that they felt they were “not allowed to self-harm” (p. 4) and so could not rely on this as a way of managing distress.

More generally, clients reflected on how the group aspect of DBT could be difficult, with one participant describing this as a “bad experience” (p. 3), and how the DBT programme could be “too rigid” (p. 4). Finally, participants touched on things that they felt DBT was missing as an approach. Indeed, one participant mentioned that there was more they wanted to explore from their childhood, relating to their experiences of trauma.

In addition to describing difficult experiences within DBT, some participants mentioned the effect that this had had on them. One participant for example described the impact that engaging in DBT had on their ability to access support from other services. They explained that since starting DBT, the crisis team would no longer offer them support. The reason given for this withholding of support was that the person was already accessing support via DBT.

Overall, this study generated valuable implications for clinical practice. Indeed, the researchers discussed how, in response to the criticism of DBT being overly structured, there might be potential for a more bespoke approach to DBT. They emphasised the role that client choice should play in service provision, whilst simultaneously acknowledging that improving access to psychological therapy has had to rely on more manualised approaches.

In terms of critique, although one participant mentioned DBT negatively impacting their access to support, the study did not describe any other ways in which the aspects clients found difficult about DBT might have had negative effects on them. In addition, the findings of the study are of limited generalisability due to the relatively small sample size of participants, all of whom were White. Finally, the participants were aware that one of the interviewers had previously facilitated DBT groups, which may have resulted in overly positive accounts from clients.

1.5.1.2. McSherry et al., 2012: This study involved semi-structured interviews and focus groups with eight participants in the UK between the ages of 32 and 55, who had been given a diagnosis of 'BPD'. The aim was to investigate their perspectives on how effective the adapted DBT programme they participated in was. The researchers used inductive thematic analysis to identify two overarching themes from the transcripts, which pertained to evaluation of therapy and the impact of treatment respectively.

Although negative effects from DBT were not specifically asked about in interviews or focus groups, one topic that was used to guide interviews was considering both helpful and unhelpful aspects of the programme. Perhaps in part due to this guidance, participants did discuss both negative experiences of DBT. Some participants for example mentioned that the use of DBT jargon was experienced as "intimidating" (p. 6) and negatively impacted their ability to engage with therapy tasks at home. Furthermore, similarly to the findings by Hodgetts et al. (2007), some participants described how difficult it was to engage in a therapy that was so highly structured. Indeed, one participant described the way in which they were not permitted to discuss their current problems as "dehumanising" (p. 6) and as having a negative impact on their sense of belonging. In addition, some participants explained how the rigid nature of the therapy meant that they could not talk about their past experiences, which was described as a frustrating experience.

The researchers concluded that although participants had reported some negative experiences stemming from the adapted DBT programme, overall, there was value in the intervention, particularly where it increased clients' coping strategies. With regards to implications for further research based on the findings, it was suggested that investigation into other methods for skills teaching, which used less jargon would be of use. In addition, further exploration of the impact of negative experiences would be beneficial in developing an understanding of the negative effects of DBT. For example, the study mentioned that participants found some of the language used to be intimidating but did not explore what the impact of this was on clients.

Finally, the findings from this study are of limited generalisability given that the programme being researched was not fully adherent to DBT protocol, and rather was an adapted intervention. Indeed, not all staff involved in delivering the programme had been DBT trained, and weekly individual sessions for clients were focused on support rather than psychotherapy.

1.5.1.3. Barnicot et al., 2022: The third identified research item aimed to examine both the common and unique treatment processes underlying DBT and mentalization-based therapy (MBT), and to investigate whether these were helpful or unhelpful. Seventy-three participants who had been given a diagnosis of a 'personality disorder' were interviewed about their experiences and given two self-report quantitative measures to complete: The Borderline Evaluation of Severity over Time (Pfohl et al., 2009) and The Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004).

Unlike the papers by Hodgetts et al. (2007) and McSherry et al. (2012), this study did focus explicitly on negative effects from therapeutic interventions. Indeed, one of the three research questions used to guide the study focused on what aspects of interventions the participants had experienced as negatively affecting them. In addition, one of the questions used in the interview schedule asked participants whether therapy had had a negative effect on them.

The researchers found that only one participant reported purely positive experiences of therapy, whereas 14 reported only negative experiences, and 58 reported a combination of the two. Thematic analysis of the interview transcripts identified three themes relating to negative experiences, the first of which was difficulties in the therapeutic relationship. Both participants who had recieved MBT and DBT described experiences of their therapists not understanding them, as well as feeling anxious because of rigid rules being set. However, differences between those with experience of MBT and DBT arose when discussing therapist hostility. Whilst some who had experienced DBT reported therapists being “actively hostile”, “critical” and “belittling” (p. 11), very few participants who had engaged with MBT reported such concerns. Regarding the impact of these negative experiences from DBT, participants described emotional distress, a decline in mental health, and a worsening of self-harm. The second theme generated was difficulties interacting with group members, with participants describing ways in which it was hard to share personal experiences in such a context. The final theme related to painful introspection, with participants explaining that discussing their thoughts and emotions could result in experiences of shame and anxiety.

Regarding implications for practice, the researchers emphasised the importance of therapists being able to recognise and repair ruptures in the therapeutic relationship, particularly given that reports of difficulties in the therapeutic alliance were associated with worse treatment outcomes. One conclusion drawn by Barnicot et al. (2022) was that difficulties in the therapeutic relationship have the potential to cause iatrogenic harm.

A key strength of this research was the involvement of people with lived experience, particularly at the stage of data analysis. Additional strengths of the paper include the relatively large sample size of 73, and its mixed methods design. However, the study is limited by its participant inclusion criteria. Indeed, the fact that clients could only participate if they had been given a diagnosis of a personality disorder potentially excluded several valuable accounts.

1.5.1.4. Lomani, 2022: The fourth identified item is a report written by a collective of survivors of childhood sexual abuse and sexual violence, in response to the conceptualisation of and provision for those given a label of a personality disorder. The aim of the report was to describe the ways in which people given this label have been harmed by services, and to make recommendations for alternative understandings and service provisions.

Although the focus of the report is not explicitly on negative effects from DBT, through the process of describing the current harmful practices in place, the collective refers to various negative experiences of DBT. Firstly, the report describes how DBT services are structured around the concept of a 'personality disorder' and thus, despite some potentially helpful aspects of the intervention, many have experienced them as "pathologizing" and "blaming" (p. 7). The report goes on to discuss DBT as a behavioural approach, which some clients experienced as "silencing" and "dismissive" (p. 12), given that it is not trauma specific. This point is illustrated by quotes from survivors detailing the ways in which they were prevented from discussing their trauma whilst in DBT. One survivor said,

> We weren't allowed to discuss any kind of trauma or abuse at all, in any detail. So I was implementing strategies that were 'inappropriate' but I wasn't allowed to talk about why I was doing what I was doing. Just had to be trained out of them like a dog. (p. 12).

Key recommendations made by the authors of the report include not labelling people with a personality disorder unless they explicitly ask, and the provision of trauma-specific services separate from so-called personality disorder pathways. The most relevant recommendation is the request for survivors of sexual abuse never to be referred to or given psychological interventions which are behaviour based, without first having been offered the option for a treatment related to trauma. The collective specifically named DBT as one such intervention that survivors should not be referred to.

Perhaps the main strength of this report is that it is authored by those who have so often been excluded from research and consultation processes, whether due to their views on the label of personality disorder or due to finding the process too traumatising. However, the paper did not conduct any new structured research, which is warranted in order to guarantee that the voices of those harmed by therapeutic services can be heard by those in positions of power.

1.5.1.5. Kannan et al., 2021: Whilst the first four identified items have focused on client experiences, this paper by Kannan et al. (2021) carried out interviews with 15 staff members who facilitated DBT in order to better understand the process of its implementation in a college counselling centre. Although the focus of the paper was not on negative effects from DBT, several staff members discussed difficult or negative experiences within their interviews.

Thematic analysis of the interview transcripts identified four themes pertaining to resources, serving needs, skills training, and clinician satisfaction. Within the scope of the first theme, several participants outlined organisational factors that interfered with the ability to deliver an effective DBT programme, including limited space and time, as well as insufficient funding. Within the fourth theme, some participants discussed the ways in which the DBT programme was overly rigid. One participant in particular mentioned that DBT did not adequately consider cultural factors, explaining that their client group was culturally diverse and that the skills they were teaching did not reflect this. The participant in question described this as a “missing piece of DBT” (p. 11).

In terms of future research implications, the paper recommended further investigation into which factors could increase DBT acceptability amongst the clinicians involved. The researchers concluded that time, training, and other limited resources were the key barriers in implementing an effective DBT programme. However, the findings from this study are limited due to the specific context that the

DBT service was set within, and the fact that the programme was not fully DBT adherent. Finally, although the research identified some potential criticisms of DBT, such as a lack of consideration of the role of culture, it did not investigate what the impact of this was on clients.

1.5.1.6. Johnson and Thomson, 2016: Whilst all items so far have focused either on client or staff experiences of DBT, this paper by Johnson and Thomson (2016) aimed to explore both staff and client experiences of DBT within the context of a forensic learning disability service. The researchers used a case-oriented approach to explore the accounts of seven staff members and seven clients.

Although the focus of the research was not explicitly on negative effects from DBT, nor were any such questions included in the interview schedules, there were several mentions throughout the paper of ways in which DBT was not an easy experience. Indeed, one of the key commonalities in experience between clients and staff was the experience of DBT as intense. Some staff participants reported questioning their ability to manage the training, and the researchers described the atmosphere of intensity as “palpable” (p. 8) when conducting the staff interviews. Similarly, some of the client participants reflected on how hard it was to concurrently engage with group therapy, individual therapy, and understanding new concepts. In addition, some clients initially found it difficult to engage in the group aspect of the intervention. Participants described finding it hard to trust other group members and not feeling safe as a group, particularly when engaging in mindfulness exercises. Despite these difficult experiences, several participants from both the staff and client groups described the experience of engaging with DBT as worthwhile.

The researchers concluded that DBT was not an easy experience for either staff or clients, and that the similarities in experiences between the two groups had not been fully appreciated by members of the staff participant group. With regards to implications for practice, the researchers hoped that the descriptions of shared experiences between clients and staff would prompt reflection and empathy. In terms of critique of the paper, the findings are limited given the specific setting in which the DBT programme was set and given that all client participants were women. Finally, further research into the impact of the difficult experiences mentioned, and whether these resulted in any negative effects, would be of value.

1.5.2. Summary of Papers

The items identified in the scoping review provide a valuable insight into the qualitative research surrounding negative experiences of DBT. From the five items focusing on client experiences, several common concepts were identified. Firstly, three of the studies found that clients had difficulties with the group setting of DBT (Barnicot et al., 2022; Hodgetts et al., 2007; Johnson and Thomson, 2016). Secondly, there were multiple reports that DBT was not a trauma-focused intervention (Lomani, 2022) and thus was missing a key aspect that several clients were hoping for in therapy (Hodgetts et al., 2007). Furthermore, there were findings that clients were not permitted to discuss their past experiences in therapy (McSherry et al., 2012), which was experienced by some as silencing (Lomani, 2022). Another common finding was that clients experienced DBT as overly structured or rigid (Hodgetts et al., 2007; McSherry et al., 2012), and thus did not experience it as a personalised or bespoke therapeutic approach.

In addition to these overlapping findings, there were several other negative experiences of DBT raised by clients that were unique to each paper. These included finding the jargon intimidating (McSherry et al., 2012), difficulties with specific skills such as mindfulness (Hodgetts et al., 2007), therapists being overly hostile or critical (Barnicot et al., 2022) and finding the focus on diagnoses to be pathologizing (Lomani, 2022). However, the findings from these studies are limited, given that the participant inclusion criteria tended to necessitate having been given a diagnosis of a personality disorder.

In terms of staff perceptions of negative experiences in DBT, the research was more limited. However, some relevant findings were identified, for example an observation by clinicians that DBT did not adequately take into consideration cultural factors, and that organisational constraints often interfered with the quality of service that was delivered (Kannan et al., 2021). Only one paper was identified which looked at both client and staff experiences of DBT. This paper identified several similarities in the experiences of clients and staff, for example both groups finding it to be an intense journey (Johnson & Thomson, 2016).

Although all these findings provide a useful starting point for understanding negative experiences of DBT, there was very limited exploration of what the impact of these experiences might be, or whether they may lead to any negative effects. Indeed, the paper by Barnicot et al. (2022) was the only identified piece of research to explicitly ask participants whether they had noticed any negative effects from DBT, and to identify an increase in self-harm and emotional distress as examples of this. However, the research did not focus exclusively on negative effects from DBT in depth, rather explored similarities and differences between helpful and unhelpful treatment aspects in DBT and MBT. In addition, the research by Barnicot et al. (2022) focused only on client experiences of DBT not staff, thereby potentially omitting key insights into the ways in which the two groups' understandings of negative effects compare.

1.6. Clinical Relevance and Research Rationale

Given that DBT is recommended by the NICE (2009) guidelines and is thus widely practiced within the NHS, an understanding of its potential negative effects is important. In providing an account of client and staff experiences and understandings of these effects, the goal is to create the foundations of an evidence base available to DBT facilitators regarding the risks inherent in the approach. With regards to clinical relevance, the hope is that once these findings and relevant recommendations are disseminated to DBT teams, they will prompt critical reflection and change-oriented action. This would be in keeping with the practice guidelines for psychologists, which state that practitioners should reflect on the limits of their practice, even where this prompts fear of criticism (BPS, 2017).

Regarding further rationale for this research, there is a clear gap in the literature. Indeed, from the scoping review detailed above, no papers were identified which explicitly investigated both staff and client experiences of negative effects from DBT. This is perhaps unexpected given the prevalence of negative effects, which as mentioned previously, are suspected to occur in between five and ten percent of clients (Hansen et al., 2002; Hatfield et al., 2010; Lambert, 2013). The lack of research in this area is also surprising given the numerous negative effects from DBT detailed by clients both in the existing research (Barnicot et al., 2022; Hodgetts et al., 2007; Johnson & Thomson, 2016; Lomani, 2022; McSherry et al., 2012; Simon et al., 2022) and in the grey literature (Berrigan, 2022; Donaldson, 2022; Ostara, 2019). The fact that this client group are at an increased risk of iatrogenic harm from psychological therapies (Fonagy & Bateman, 2006), further demonstrates the importance of such research.

The rationale for exploring both staff and client understandings of negative effects from DBT, is in part based on the research by Barnicot et al. (2022), which found that clients regularly faced difficulties in the therapeutic relationship. The paper did not explore staff experiences of the therapeutic relationship, and so further research in this area is indicated. Wider exploration and comparisons of staff and client understandings of negative effects from DBT are clearly warranted given the absence of research in this area.

This research aims to address this gap in the literature, investigate potential negative effects from DBT, and explore both staff and client experiences and understandings of these effects, by answering the following three research questions:

- What, if any, negative effects of DBT do clients report?
- What, if any, negative effects of DBT do staff observe? How are these addressed?
- How do client and staff understandings of these negative effects compare?

2.0. METHODOLOGY

2.1. Chapter Overview

This chapter begins by outlining the epistemological approach and design of the research. This is followed by a description of the ethical issues inherent in the study and how these were addressed, an outline of the procedure, and an overview of the analysis process. Given the value of subjectivity as a resource both in reflexive qualitative research (Luttrell, 2019) and reflexive thematic analysis (Braun & Clarke, 2022), the chapter concludes with a researcher reflexivity statement.

2.2. Epistemology

This research adopts and is underpinned by a critical realist epistemological approach. Critical realism can be conceptualised as a combination of ontologically realist and epistemologically relativist approaches. Ontology is concerned with theories as to the nature of reality, whereas epistemology refers to theories as to how knowledge is understood and produced (Burr, 2015). Thus, whilst critical realism holds that ontologically speaking, there are realist entities and processes that exist independently of human perception (Pilgrim & Bentall, 1999), it simultaneously holds that reality is culturally mediated and that many perspectives of these realist processes are possible (Al-Amoudi & Willmott, 2011). Given the assertion that truths are socially located (Pilgrim, 2014), critical realism acknowledges that in conducting research one cannot access a direct representation of reality. Rather, researchers explore a particular representation of reality (Willig, 2016) shaped by participants’ cultural contexts. Furthermore, the influence of the researcher themselves is acknowledged (Willig, 2016), given that they observe findings through the lens of their own context.

A critical realist epistemology was deemed appropriate for this research since it recognises the existence of negative effects from therapy as a reality that exists and causes actual harm, whilst simultaneously acknowledging that such negative effects can only be understood and explored through the perceptions of those who experience and observe them. The approach values perspectives, recognising that each client who has experienced DBT and each staff member who has delivered it will have different understandings of the therapy's negative effects, based on their idiosyncratic social and cultural context. Critical realism also acknowledges that the researcher brings their own contextual representation of the reality of negative effects from therapy, and that this is a lens through which the findings are analysed. It is important to note here that whilst subjectivity can be of value, it is not inherently an asset. Indeed, subjectivity without sufficient reflexivity can result in false claims of objectivity, research that is not appropriately situated, or the reproduction of prevailing cultural prejudices (Olmos-Vega et al., 2022).

2.3. Design

In order to ensure conceptual coherence or 'fit' (Willig, 2013) between research questions, theoretical, and methodological assumptions, this research adopted a qualitative approach. Qualitative approaches are broadly focused on meaning and understanding rather than absolute truth, and as such are suited for exploring client and staff understandings of negative effects of DBT.

More specifically, this research adopts a 'Big Q' experiential orientation. The term 'Big Q' (Kidder & Fine, 1987) refers to 'fully qualitative' research, as opposed to 'small q' research which adopts qualitative tools within a quantitative paradigm. For research to be 'Big Q', it must embrace a degree of uncertainty, and acknowledge that researcher subjectivity, when paired with reflexivity, is an asset (Braun & Clarke, 2022). 'Big Q' itself has been differentiated into experiential and critical orientations (Willig, 2013), where the former centres participant meaning, and the latter prioritises interrogation of meaning. This research seeks to capture and stay close to participants' meanings and understandings, and as such adopts an experiential orientation informed by a hermeneutics of empathy (Braun & Clarke, 2022).

Finally, this research used semi-structured interviews as a method of data collection over focus groups, in part due to existing research which suggests that a prominent theme of client negative experiences of DBT pertains to difficulties interacting in a group setting (Barnicot et al., 2022).

2.4. Justification for Thematic Analysis

Thematic analysis is a method used to develop, analyse, and interpret patterns within qualitative data (Braun & Clarke, 2022). By focusing on themes across the data set, thematic analysis facilitates an exploration of shared meanings, and as such was seen as an appropriate analysis technique for addressing the research questions of this study. Furthermore, thematic analysis has been indicated as appropriate for exploring participant's lived experiences, perspectives, and the factors that influence and shape certain phenomena (Braun and Clarke, 2013). In the present research, this was achieved by exploring staff and client lived experiences of the negative effects of DBT, and the factors that may have contributed to these. The fact that thematic analysis is theoretically flexible (Willig, 2013), and fits well with a critical realist epistemological approach (Braun & Clarke, 2006), also makes it suitable for this research.

Although interpretative phenomenological analysis (IPA) was considered, thematic analysis was selected for this research in part based on the suggestion by Braun and Clarke (2021) not to use IPA in research where the total sample exceeds ten.

2.5. Participants

2.5.1. Inclusion Criteria

The inclusion criteria for clients were as follows:

- Over the age of 18
- Contact with a DBT service within the last five years
- English speaking

Having been given a label of ‘BPD’ was not listed as an inclusion criterion for clients, given the established difficulties with this diagnostic label as outlined in the introduction. There were no exclusion criteria.

The inclusion criteria for staff were as follows:

- Over the age of 18
- Experience of facilitating DBT within the last five years
- English speaking

There were no exclusion criteria.

2.5.2. Client Participant Demographics

Eight participants who had received DBT took part in the study. Their self-reported demographic information is outlined below in Table 1. To minimise potentially identifiable information, pseudonyms have been used, and ages have been presented in categories. One participant (Imogen) had experience of DBT in an inpatient setting, and seven participants within a community setting. Overall, the participant ages ranged from 20 to 34, and the majority identified as female (n=7) and White British (n=7).

Table 1

Client Participant Demographics

Name	Age	Ethnicity	Gender	Sexuality
Hallie	20-24	White British	Female	Asexual
Bea	20-24	White British	Female	Heterosexual
Harry	25-29	White British	Male	Other
Em	30-34	Black Grenadian and White British	Female	Heterosexual
Layla	30-34	White British	Female	N/A
Imogen	25-29	White British	Female	Bisexual
Amanda	30-34	White British	Female	Heterosexual
Sophie	25-29	White British	Female	Heterosexual

2.5.3. Staff Participant Demographics

Seven staff members with experience of delivering DBT took part in the study. Their self-reported demographic information is displayed below in Table 2, with pseudonyms used and ages presented in categories to maintain confidentiality. Overall, the participant ages ranged from 30 to 64, and the majority identified as female (n=5) and heterosexual (n=6).

Table 2

Staff Participant Demographics

Name	Age	Ethnicity	Gender	Sexuality
Benny	55-59	White British	Female	Lesbian
Nadia	35-39	White European	Female	Heterosexual
Paul	60-64	African Caribbean / British	Male	Heterosexual
Claire	35-39	White British	Female	Heterosexual
Ayah	30-34	Afghan - British	Female	Heterosexual
Oscar	40-44	White Irish	Male	Heterosexual
Eleni	30-34	White Other - Greek	Female	Heterosexual

One participant had experience within an inpatient setting, and six in community settings. One participant had experience of both receiving and delivering DBT. The job titles of participants included Social Worker, Clinical Psychologist, Lived Experience Practitioner, and Psychotherapist.

2.6. Participant Involvement

In keeping with the National Survivor User Network (NSUN) motto ‘nothing about us without us’ (Wynter, 2021), two organisations involved in survivor research were contacted to ask if any members would be interested in consulting on the draft client interview schedule. One member with personal experience of DBT expressed interest and provided invaluable feedback on the interview schedule, for example a suggestion to include an exploration of the impact of diagnosis on identity. In accordance with one of the National Institute for Health Research INVOLVE's (Farr et al., 2020) guiding principles for co-producing research, there was an emphasis on respecting and valuing the knowledge brought. As such, suggestions raised were incorporated into the interview schedule, and remuneration for time and expertise was provided. Regarding the staff interview schedule, two DBT facilitators agreed to review the draft and provided useful written feedback (Appendix C), which was used to update the document.

Additional consultation with the UEL People's Committee took place regarding the best way to allocate available funds. Given the limited resources available and the number of participants required, the People's Committee advised that all funds should be allocated to clients who had experience of DBT rather than staff participants who had delivered DBT. A copy of the People's Committee Proforma can be seen in Appendix D.

2.7. Procedure

2.7.1. Interview Schedule Development

A draft interview schedule for clients, was partially informed by the Negative Effects Questionnaire (Rozental et al., 2016), and a draft interview schedule for staff was created drawing on information from the Unwanted Event to Adverse Treatment Reaction checklist (Linden, 2013). These draft schedules were further discussed and developed both in supervision, and in accordance with participant consultation as described above.

2.7.2. Recruitment

Convenience and snowball sampling approaches were used, with the intention of accessing participants from a variety of DBT services. To ensure a balance between a sample large enough to facilitate a rich understanding and small enough to be able to manage the material (Sandelowski, 1995), eight clients with experience of DBT, and seven staff members who had delivered DBT were recruited. Recruitment took place via a combination of word of mouth and online advertisements, with recruitment materials (Appendices E and F) being posted on both Instagram and Twitter, and subsequently shared by organisations involved in mental health research. To minimise the established risk within psychological research of the majority of research participants being White (Yancey et al., 2006), recruitment materials were also sent directly to organisations involved with the mental and emotional wellbeing of racially minoritized adults.

Given that both the advertisements and the information sheets specified that the research was regarding negative effects, it is both likely, and intended, that the final sample consisted of participants who had either experienced or witnessed negative experiences related to DBT. In addition, it is acknowledged that by using Twitter and Instagram as key modes of recruitment, the sample may not be representative of the populations who access or facilitate DBT, given that they are unlikely to all use social media.

2.7.3. Initial Contact

Participants indicated their interest in taking part by contacting the researcher via their e-mail. The researcher responded to each email by seeking consent to share the participant information sheet (PIS; Appendices G and H). A copy of either the client or staff PIS was sent, as appropriate, with an explicit invitation to ask any questions, take as much time as needed to review the information, and to respond if they wished. A copy of the consent form (Appendices I and J) and demographics form (Appendix K) were e-mailed to all participants who responded. Once these had been returned to the researcher, a mutually convenient time and date for the interview was arranged. All interviews took place via Microsoft Teams.

2.7.4. Semi-Structured Interview

The finalised interview schedules (Appendices L and M) were used as guides to facilitate each interview, with the pre-developed probes being used to expand on certain topics (Fylan, 2005). Each interview took approximately 45 – 60 minutes, and began with a brief check-in, orientation to the interview setting, and the opportunity for participants to ask questions. Space was made at the end of each interview to ask participants if there was anything else they felt was important to say, summarise what had been discussed, and debrief. Given the sensitive nature of the topic, there was the potential for participants to disclose things that elicited strong emotions. Where this occurred, the researcher acknowledged (Fylan, 2005) and validated the emotion, before asking if it was alright to continue, and reminding participants they could take a break or choose not to answer a question at any point.

2.7.5. Data Governance

As outlined in the PIS, all data were treated in accordance with the Data Protection Act (HM Government, 2018). All files containing personal information, including consent forms, demographics forms, and video recordings of interviews were stored separately in password protected files on a secure device that only the researcher could access. Transcriptions of video recordings were stored in password-protected files, with all identifying information removed. For example, pseudonyms were used and other identifiable information such as geographical locations or job titles were replaced with meaningful descriptive terms (Thompson & Chambers, 2011). Only the researcher, their supervisor and if necessary, the examiner, will have access to these files. All data containing personal information will be destroyed following examination of this research. Data with identifying information removed will be stored securely by the researcher's supervisor for three years from the point of submission, before being erased.

2.7.6. Transcription

When conducting research using thematic analysis, there is no advantage in using a full Jefferson transcription, rather an 'orthographic' or verbatim approach is indicated (Howitt, 2019), and so was used in this research. A simple transcription scheme (Appendix N) based on conventions outlined by Banister et al. (2011) was used to guide the transcription process. Pseudonyms were used, identifying information was replaced by words within [ ], and any inaudible sections of the transcript were indicated in order to minimise the risk of transcription errors (Poland, 2002). An orthographic approach aims to produce a complete record of spoken word, as well as some non-verbal features such as laughter. As such slang, abbreviations and grammar were not 'corrected'. It is important to acknowledge that transcription is not a neutral process (Banister et al., 2011), rather an active one, which transforms ‘raw’ data into ‘partially cooked’ data (Sandelowski, 1994), and as such represents the early stages of analysis.

2.8. Ethics

Ethical approval was sought by applying to the University of East London (UEL) (Appendix O). Approval was granted subject to minor amendments (Appendix P), which were completed before the research commenced. Both the ethics application and research itself were guided by the BPS’s Code of Ethics and Conduct (BPS, 2021), as well as a Code of Practice for Research Ethics and Research Data Management Policy specific to UEL.

2.8.1. Informed Consent

All clients were given a PIS prior to engaging in the research. These were sent via an e-mail, in which it was emphasised that there was no time pressure to respond, and that any questions were welcomed. The PIS outlined the purpose of the research, what participating would involve, potential benefits and disadvantages to participation, how to withdraw from the research, and potential research dissemination plans. The PIS for clients also emphasised that involvement in the study would not affect their care in any way. Once participants had been given plentiful time to read and discuss the PIS, they were provided with a consent form.

2.8.2. Confidentiality

Clients were informed within the PIS that all identifiable information would be removed from final transcripts. The PIS also included information on the limits of confidentiality, for example what would occur if risk were to be disclosed. Finally, the PIS outlined information on data protection, explaining that all data would be held and processed in accordance with the Data Protection Act (2018) and General Data Protection Regulations.

2.8.3. Remuneration

In alignment with advice from the UEL People's Committee as described above, each client participant was offered a £10 Amazon voucher for their time. The researcher was clear that the intention of providing vouchers was not to incentivise participation, rather to remunerate participants for their time, and not rely on free emotional labour (Faulkner & Thompson, 2020).

2.8.4. Possible Distress

The PIS explicitly acknowledged that due to the sensitive nature of the topic, there was a risk of distress. At the beginning of each semi-structured interview, the researcher reiterated that participants could take a break at any time, decline to answer questions, or discontinue the interview. The researcher also adopted a process consent approach (Polit & Beck, 2010), whereby consent is continuously re-established in a collaborative way. Contact details for external support organisations were included both in the PIS and in the debrief sheet.

2.8.5. Debrief

At the end of each interview, time was allocated to check in with participants regarding their experiences of taking part in the study and any concerns that may have arisen. During this time, participants were also informed that they could contact the researcher to discuss options for further support if they wished. Following participation in the study, all participants were given a debrief sheet (Appendices Q and R), which contained information on what would happen to the research results, how to make contact if any concerns were to arise, as well as a list of contact details for relevant support organisations.

2.9. Analytic Approach

Thematic analysis itself can be understood as an umbrella term covering a variety of differing approaches, including coding reliability (Boyatzis, 1998), template analysis (King, 2012), and reflexive (Braun and Clarke, 2006). This research uses a reflexive thematic analysis approach, given that this is the most 'fully qualitative' and therefore most appropriate for exploring meanings and understandings (Braun and Clarke, 2022). There are ten core assumptions of reflexive thematic analysis, one of which is that researcher subjectivity is not a flaw, rather a resource to draw on in analysis (Gough and Madill, 2012) if researchers are able to critically interrogate their own perspectives (Elliot et al., 1999). In line with a critical realist epistemological approach, the researcher acknowledges that their own perspective is only one of several possible.

One of the strengths of reflexive thematic analysis is its flexibility. On the spectrum of inductive to deductive reflexive thematic analysis, this research is situated more towards the inductive end, in recognition of the ethical importance of representing participant understandings (Swauger, 2011) and experiences. In keeping with this, codes and themes were generated by staying close to the raw data. However, it is acknowledged that a purely inductive approach is not possible, given that the researcher brings to the data their own perspectives, both theoretical and personal. Finally, to avoid interpreting data in a ‘contextual vacuum’ (Braun and Clarke, 2022), which is a common criticism of thematic analysis (Bryman, 2001), the researcher contextualised data within its historical, social, and political settings (Joffe, 2012).

2.9.1. Analytic and Interpretive Process

Analysis was guided by Braun and Clarke’s (2006) six-phase process. These phases are intentionally not referred to as ‘steps’, since the process is recursive, rather than linear, and the phases are not sharply delineated (Braun and Clarke, 2022). In addition, the chapter outlining the findings from this process is entitled ‘analysis’ rather than ‘results’, in order to emphasise the interpretive work and subjective role of the researcher (Braun and Clarke, 2022).

2.9.1.1. Familiarisation with the dataset: This phase involved the researcher becoming deeply immersed in the dataset, via the process of transcribing interviews, as well as actively reading and re-reading each transcript. Throughout this phase the researcher also critically engaged with the data by making brief notes to capture preliminary analytic ideas and reflections.

2.9.1.2. Coding: The researcher adopted a manual coding process rather than using software, to facilitate deep engagement, as well as time for reflection and insight (Braun and Clarke, 2013). Segments of data that were potentially relevant to the research questions were given analytically meaningful code labels. On the spectrum from explicit semantic to implicit latent levels of coding, the researcher adopted an approach more towards the semantic end, staying close to the language of the dataset. A list of initial codes and an example transcript can be seen in Appendices S and T respectively.

2.9.1.3. Generating initial themes: Clusters of codes that shared a central organising concept (Braun et al., 2014) were compiled. Visual thematic maps were used to develop candidate themes that were constructed based on the data, research questions, and researcher's knowledge. Versions of this process can be found in Appendix U.

2.9.1.4. Developing and reviewing themes: This phase involved assessing the fit of candidate themes by ensuring they related both to the coded data extracts and, more broadly, to the full dataset and research questions. Supported by discussions with their supervisor, the researcher also checked whether each theme had firm boundaries and could be evidenced by sufficient meaningful data.

2.9.1.5. Refining, defining, and naming themes: Key aspects of this phase included writing brief synopses of every theme and sub-theme, as well as outlining the scope, boundaries, and core concept of each. Concise, informative names for each theme and sub-theme were also developed.

2.9.1.6. Writing up: A coherent analytic narrative was interspersed with illustrative data extracts to address the research questions of this study. Consideration was given to the order in which the themes and sub-themes were presented, to ensure a clear account (Braun and Clarke, 2006). Occasionally, to enhance readability, words were removed from quotes, and ellipses were used to indicate this. In order to abide by American Psychological Association (APA) style and grammar guidelines, research participant quotations of fewer than 40 words were presented within the text, and those of 40 or more words were presented in block and indented below the text (APA, 2020).

2.9.2. Reflexivity: Researcher’s Position

Researcher subjectivity and reflexivity is the key to conducting a successful reflective thematic analysis (Braun and Clarke, 2022), as well as being an essential component of a critical realist epistemological approach. Reflexivity itself can be defined as identifying and taking responsibility for the researcher’s own situatedness within the research, and the impact this can have on research questions, data, and its interpretation (Berger, 2015). Given that reflexivity is never final, rather an ongoing process, the researcher kept a reflexive journal (Ortlipp, 2008) to reflect on each stage of the research process.

Personal reflexivity in particular refers to the researcher’s intersecting social positionings (Wilkinson, 1988) and where they occupy positions of social privilege or marginality. Functional and disciplinary reflexivity (Wilkinson, 1988) on the other hand, refer to the research and training experiences of the researcher. Reflexivity related to the specific research topic is also important, and pertains to the researcher’s personal experiences, assumptions about the topic, and how they may be perceived by participants.

What follows is a summary of the personal, functional, and disciplinary aspects of the researcher’s identity that are relevant to this research topic, and which they continue to reflect upon:

- Middle-class background, White British, and as such holds certain positions of social privilege. Non-binary, queer, disabled, and as such holds certain positions of social marginality.
- Holds left-wing political views and is committed to social justice and equity.
- Through working in a service-user research enterprise, and training as a clinical psychologist at the University of East London, the researcher is drawn to methods that prioritise participant voices, is critical of the medical

model, and emphasises the role of social context when understanding distress.

- Experience of receiving DBT, as an adolescent and as an adult. The researcher has lived experience of both positive and negative effects from this, and so holds the belief that DBT can be harmful as an approach.
- Experience of providing cover for DBT groups and conducting research into client experiences of DBT. Through these experiences, the researcher witnessed both positive and negative effects of DBT on clients, which contributed to their critical approach to DBT.

Given the researcher's experiences of both receiving and delivering DBT, they occupied a complex mix of both 'insider' and 'outsider' researcher roles, which shifted depending on which dataset or participant group was being interacted with (Obasi, 2014; Paechter, 2013). Given the risk that self-disclosure too early in an interaction can remove the focus from the participant (Dunlop et al., 2021), it was not felt appropriate to actively disclose these roles. However, given that insider research can bring an increase in openness to research interviews (Keval, 2009; Watts 2006), if directly asked about their inspiration for the research, the researcher named their lived experiences.

3.0. ANALYSIS

3.1. Chapter Overview

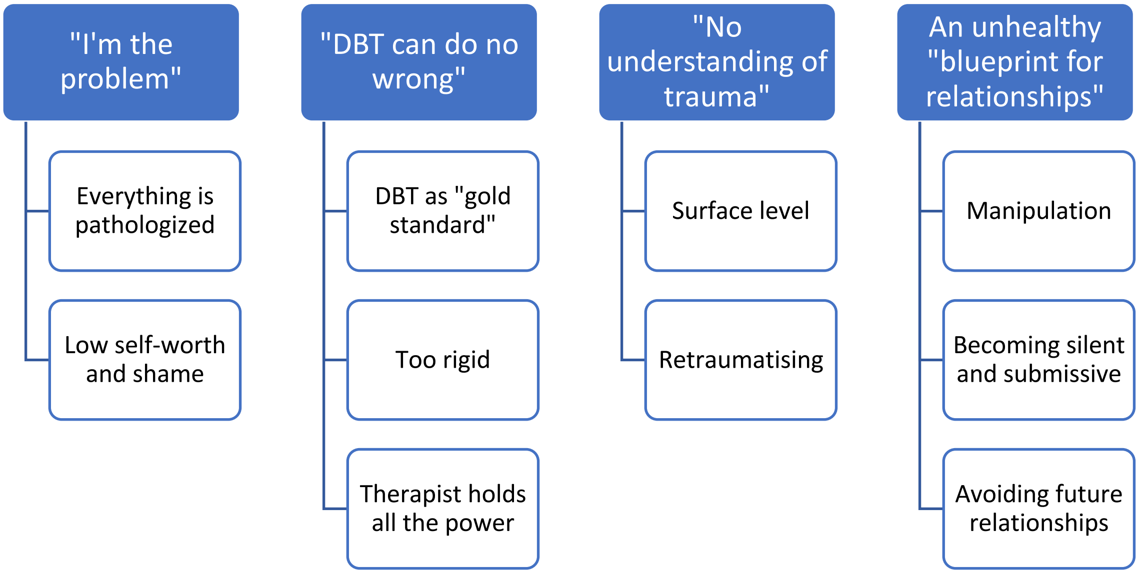
This chapter presents the results of the analysis. Thematic maps are used to illustrate themes and subthemes, each of which are discussed and illustrated with data extracts. The thematic map and findings relating to clients are presented first, followed by the map and findings of staff participants.

3.2. Client Themes

During phases two, three and four of Braun and Clarke's (2006) reflexive thematic analysis process, the researcher developed and refined thematic maps. The final client thematic map is illustrated below in Figure 1. Four themes were generated, each of which contained a number of sub-themes.

Figure 1

Client Thematic Map



3.2.1 Client Theme 1: “I’m the Problem”

The first theme relates to clients’ experiences of having had ‘the problem’ placed within them, rather than within the systems around them or events they had experienced. As Em said when reflecting on her DBT experience, “It assumed that everything about you is wrong, basically and everything needs redoing.” This approach was experienced by some as having connotations of blame, with several participants feeling as though DBT staff were implying that being in distress was their fault. Bea for example, described how as a result of taking part in DBT, “I genuinely was still in … the head space that all of it was my fault. And it was reinforced on a weekly basis.”

This locating of ‘the problem’ often left participants experiencing low self-esteem, decreased confidence, and feelings of shame. Often, when ‘the problem’ was placed within clients, it was related to assumptions about the diagnostic category of a ‘personality disorder’.

3.2.1.1. Everything is pathologized: When discussing the idea of ‘the problem’ being placed within the client, several participants reflected that their distress had often been pathologized, rather than explored in context. In particular, the concept of ‘therapy interfering behaviour’ was discussed. Participants recounted times at which their distress was labelled as a therapy interfering behaviour, rather than as something to be explored or validated. Bea recalled that “my crying was a therapy interfering behaviour”, Amanda that “emetophobia was … expressed as a therapy interfering behaviour”, and Hallie summarised: “any resistance is categorized as a therapy interfering behaviour when actually any sane person would be resistant to this right now”.

Although one participant appreciated receiving a diagnosis because it meant that “it wasn’t all in my head” (Imogen), several others whilst on the topic of pathologization, spoke about the negative impact of having been given a label of ‘BPD’ whilst under the care of a DBT service. Sophie explained, “I’ve always struggled with my diagnosis because I don’t 100% agree with it … so I think then being put in a treatment that is just for that. It was just a bit …”, and then spent some time in silence. The stigma associated with this label was also discussed, with Imogen saying, “there’s still that stigma around it now” and Amanda explaining the negative effect that the diagnosis had had on “appointments with my general health … work … and welfare services”. In her experience, being labelled with ‘BPD’ meant that “if I had any problems with the therapy, it was very much just thrown in as a symptom. ... So, I'm being inappropriately aggressive or difficult was a big one, or I'm being challenging.”

3.2.1.2. Low self-worth and shame: Almost all participants described an experience whereby engaging in DBT had left them feeling “ashamed” (Amanda) or had reduced their self-esteem. When reflecting on the negative effects of DBT, Bea said, “I completely lost any self-esteem and confidence I had because I thought I was a terrible person … I don’t even know how to describe myself positively anymore.” When considering what may have precipitated these experiences of shame, several participants referenced the way in which DBT facilitators used shame as a negative reinforcer for behaviour. For example, Hallie shared:

> They seem to think that shame can be motivating. Like I remember sometimes I did things, and my therapist would be like, “yeah your shame fits the facts”. In fact, at one point I had criticised her … and I said I’m feeling really ashamed and guilty, and she said “good – I’m glad you are”. And just this idea that they think shame can be helpful when actually it’s really paralyzing. And it feels like a lot of the stuff that they do with the punishments makes you feel shame … I experience way more shame now … it just felt like I was being shamed all the time.

Some participants also reflected on the way in which they felt problematised, which led to feelings of shame. For example, Harry shared that “I was seen as a sort of troublemaker” and Em recalled how the DBT team were “making it out like it was me … I thought there was something wrong with me”.

In some cases, experiences of low self-esteem stemming from DBT had a negative effect on participants' futures. For example, in response to a question about how the negative effects of DBT impacted upon her life, Bea shared, "I wanted to apply for jobs, but I thought like nobody would want to employ me … I remember writing the application and thinking I don't even know how to describe myself positively anymore."

3.2.2. Client Theme 2: "DBT Can do no Wrong"

The second theme captures the ways in which clients felt that DBT was often marketed to them as an infallible protocol, which would solve all difficulties and "give you everything you need" (Amanda). This left clients with concerns about what would happen if DBT didn't 'work'. Although some clients reported that the structure of DBT was "helpful at the time" (Sophie), participants also discussed the ways in which DBT therapists' beliefs around the merits of DBT would lead them to stick rigidly to the protocol, with little room for personalised care. This idea that DBT could "do no wrong" (Hallie) often resulted in a power imbalance, whereby clients felt that the DBT therapist was placed in the position of expert.

3.2.2.1. DBT as "gold standard": When asked about what information was given ahead of starting DBT, several participants mentioned that the approach was described as the "gold standard" (Em), or "the only thing that's going to be effective" (Layla). On occasion, this left clients with a sense that they should feel fortunate for having been offered DBT, and therefore feeling unable to report any concerns regarding the approach. As Sophie reported, "I didn't want to come across like I was just moaning when I'd waited so long to have this DBT". The marketing of DBT as such an effective treatment also left some participants concerned that if they did not progress within the therapy or if they wanted to leave, there would be nothing else for them. As Hallie reflected, when considering what would happen if she left DBT, "where does that leave you? Does that mean you're un-helpable? Does that mean you're like too messed up for therapy?" These concerns were exacerbated by staff stating similar views, for example telling clients "We've done DBT … there kind of isn't anything else for you" (Layla). Furthermore, Imogen described how having had DBT often led healthcare providers to assume that she needs no further help, reporting that “consultants … will say … well you had DBT so you should already be able to do them skills … and I’m like yeah but it doesn’t mean I don’t need the help”.

The emphasis on DBT as being better than other therapeutic approaches left some participants with the impression that it was “cult-like” (Bea). Indeed, Bea recalled that in every group session, all members would have to repeat the phrase “DBT is life”. Em spoke at length about DBT feeling “culty [sic]” and explained that this had fed into her tendency to be perfectionistic, leaving her “obsessing” and trying to fulfil every demand that DBT placed upon her and in doing so becoming “less myself and more of a … perfect person”.

3.2.2.2. Too rigid: Several clients discussed the ways in which facilitators’ beliefs that DBT is “always right, infallibly” (Harry), led them to rigidly adhere to the manual as if it was a “Bible” (Em). As Sophie articulated:

> It was like she was just reading a script and … we used to, like, joke about it in the group that she sounded like she swallowed the book because she was just like, she literally just spieled off the book.

Although one participant reported that some level of “structure” was helpful (Em), there was also an acknowledgment that the rigidity within DBT took this a step too far and was “not sustainable” (Em). The negative effect stemming from this was that clients felt as though their therapy was not person-centred. Indeed, when reflecting on the skills teaching, Sophie said, “it’s not tailored to you”.

Hallie described how the “emphasis on adherence” left facilitators without the ability to “be more flexible and listen to people and take people’s views into consideration”. Sophie added that because in each session, the priority was on covering material in the DBT manual, “there was still just never enough time to talk through the things that I wanted to talk about”. Layla had a similar experience whereby repeatedly completing a chain-analysis was always prioritised over “so many other things that I would want to talk about”.

Participants also discussed the ways in which the “rules-based nature” (Harry) of DBT put them under a great deal of pressure. As Harry said, the view of the facilitators was: “well it may not work for everyone, but you absolutely will fail if you don’t follow every single rule”. Harry went on to explain that he would have appreciated a more personalised approach, explaining that “if you’re gonna [sic] find a way of existing that is more harmonious, that’s gonna [sic] come from inside and not following this, you know, religious level set of commandments about how to act in every situation.”

3.2.2.3. Therapist holds all the power: The belief that DBT is the ‘gold standard’ of therapy that facilitators should rigidly adhere to, often led to a dynamic between therapist and client that participants described as “parent – child, or teacher – student” (Em). Bea described feeling as though she had to “put my therapist on a pedestal”, and that because her therapist held the knowledge of DBT she had to “bow down to him”. This set up a potentially dangerous power dynamic whereby client feedback was not welcomed or taken on board. As Hallie described, “there’s no scope for collaboration, and the therapist is always expert, and they always know best, and you always have to do what they say.” For example, when Hallie asked for some reasonable adaptations, she recalls being told “no – this is the way we do things … we know best.”

Several participants described their experience of DBT as being less like therapy and more like “school” (Sophie). Indeed, Harry described his experience of DBT as a “very primary school-like environment” consisting of “constant control”. The impact of this was that clients often felt patronised and chastised. Amanda described this by saying, “I felt like I was this bad kid … the whole language and approach just feels very patronising, very punishment based”. Hallie also recalled that her therapist was “talking to me like I was a naughty child”. This environment was triggering for some clients who had negative experiences at school, for example Harry, who reported, “I just had this visceral sense: I’m back in school … I was transported straight back to being eight or ten". It also fostered conditions where clients, some of whom already struggled with voicing their needs, felt "frightened to talk" (Harry).

3.2.3. Client Theme 3: "No Understanding of Trauma"

This theme references clients' reports that DBT staff did not appear to understand how to work in a trauma informed way. As Layla stated, "it really doesn't validate anything that they labelled traumatic". There was a sense of frustration that the focus was on behaviour rather than what may be underlying this behaviour; "in DBT they just extinguish behaviour – they don't think about why it's there" (Hallie). The impact of this was that clients were often still incredibly distressed but had their coping mechanisms removed. In addition, the regular experiences of invalidation combined with therapists being positioned as expert often mirrored clients' difficult childhood experiences. Some participants emphasised how shocking it was that DBT was not, in their experience, trauma informed, especially given that "most people with so called 'BPD' do have trauma in their background" (Bea). Indeed, Hallie spoke about how distressing it was that there is a wealth of "new research about trauma and attachment … and nobody cares about adding that research into DBT."

3.2.3.1. Surface level: Whilst some participants found the skills taught in DBT to be "all well and good" (Em), almost all reported that this focus on behaviour was insufficient. As Imogen articulated "I had these skills … it's just when I'm in that crisis moment they're the last thing I think of". Sophie added, "I think DBT is really good, but I think there are things missing from it", and Layla echoed "DBT tools are helpful to some extent, but they are also not helpful for a lot of things". A common theme was participants feeling that DBT was not sufficient in addressing their trauma. Looking back on her time in DBT Imogen reflected that although DBT "helped me understand how my brain worked", she also felt that "if some aspects of my life were touched on back then … it would give me a better perspective now. … I needed a bit of … childhood trauma therapy".

Some participants even recalled being “forbidden” (Harry) from talking about their past, apparently out of concern that they were “not emotionally strong enough” (Em). Layla shared that her childhood trauma was put “in a box and <u>not</u> to be spoken about”. Several participants recalled being told that once they had reduced their so-called life-interfering behaviours (Swales, 2009), then they could potentially be referred for trauma therapy. However, this was felt by many to be the wrong order in which to approach things. As Amanda explained, “to purely base everything on distraction when you're not dealing with the root of the problem … all you're doing is just sticking a plaster on and no wonder people are gonna [sic] bleed out”.

One negative effect of this surface-level focus was that many felt they had wasted time which they could otherwise have spent in “actual real therapy” (Em). In addition, several participants felt that the focus on skills which emphasised distraction had led them to become “avoidant” (Amanda), and “repress emotion” (Harry), rather than acknowledging distress and moving through it. Furthermore, two participants described feeling as though their coping strategies had been “ripped from me” (Bea), without any attention paid to the reasons these strategies existed. Indeed, as Hallie stated, “they just want to take all of your coping mechanisms away and leave you to be in horrific pain”. Finally, the emphasis on behaviour led one client to believe that if she stopped harming herself, the DBT facilitators would “think I’m all sorted and … discharge me” (Layla), which she believed led to an increase in self-harm.

3.2.3.2. Retraumatising: Several participants conveyed that the DBT facilitators “had no understanding of trauma at all” (Hallie), and that this led to several harmful practices, with the potential to retraumatise clients. For example, Bea recalled that despite asking for a female therapist due to her trauma history, she was told that she had to “radically accept” having a male. This therapist then “told me he didn’t believe I had trauma”, and accused her of being “sexist”, which left her feeling unsafe and invalidated. More generally, Bea felt that “the whole process mimicked my childhood … it mimicked not being believed, it mimicked the invalidation.” Amanda, who at the time of engaging in DBT was living in an abusive home environment felt that the therapeutic “approaches and language felt the very same approach than what I was dealing with in the outside”. Sophie also found that the experience of support being withdrawn following self-harm was potentially retraumatising. She recalled how being told to wait 24 hours to contact the team was experienced as “a rejection” which she “took personally” and ultimately “escalated” her self-injury.

Several participants also described how damaging the mindfulness module had been for them. Layla explained that given how much trauma she had survived, “I hated mindfulness … I just found that sometimes it would actually lead to me feeling quite distressed, especially the visualisation ones … I guess I just couldn’t visualise a safe space, like nowhere felt safe you know?”

Towards the end of their interviews, some clients discussed ways in which they felt DBT could be improved by becoming more trauma informed. Harry reflected on how, rather than being encouraged to ignore signs of trauma, it could have been helpful to have a space to discuss the past, given that “this stuff has to be let out”.

3.2.4. Client Theme 4: An Unhealthy “Blueprint for Relationships”

The final client theme captures participants’ experiences of the therapeutic relationship, and the impact of DBT on other relationships in their lives. There were several references to feeling manipulated by the therapeutic relationship, and this leading to a negative impact on clients’ sense of self. Two participants compared their interactions with DBT services to an abusive relationship in which “you don’t know how damaging it is until you’re out of it” (Amanda). Participants also outlined the ways in which their DBT experiences had impacted the way in which they navigated future relationships, with many reporting they now felt unable to be assertive. Finally, there were reports that the negative experiences of DBT had a detrimental impact on clients being able to seek future therapeutic support.

3.2.4.1. Manipulation: Participants spoke both about feeling manipulated by DBT facilitators and feeling as though the interpersonal effectiveness module was teaching them how to be manipulative. Regarding the latter, Amanda mentioned in particular the DEAR MAN skill, which is described by Linehan and Wilks (2018) as teaching individuals how to make requests effectively. However, Amanda described the reality of the skill as “teaching manipulation”, explaining that she was being “taught to pretend to be interested” in order to “get what you want”. Em also felt as though she was being taught to manipulate people, which did not sit well with her because “it’s not being honest and it’s not being yourself”. Several participants reflected on the irony of this alongside the common misconception that people given a label of ‘BPD’ are manipulative. As Bea said, “you’re telling me I’m manipulative and you’re getting me to manipulate people”.

In terms of feeling manipulated by DBT, almost all participants touched on this in their interviews. Harry described DBT as “coercive” and “just totally losing your skin and being manipulated by something outside”. Bea, when referring to the ways in which rewards were used to reinforce behaviour, stated that DBT staff “blackmailed me into so many situations that … were never actually for my own good”. Some participants also reflected on the way in which they were taught how to behave and interact with people. Hallie described feeling “violated” by this process because “they’ve put things into me and taken things out of me and used all these techniques on me”. Unsurprisingly, these experiences had an impact on the way in which participants then interacted with people in their daily lives.

3.2.4.2. Becoming silent and submissive: Several participants spoke about the impact that experiences of manipulation, and other aspects of DBT had had on their sense of self and in turn how this impacted the way in which they related to others. Layla reflected on how facilitators “closing people down” when they wanted to talk about certain things had made both her and other group members “cautious” about sharing. Almost all participants mentioned that they had felt silenced by their DBT experience. Indeed, Amanda shared how “I was afraid to discuss concerns and I just became quite silent”, and Bea described DBT as “a very good way to silence people”.

Several participants also reflected on the way in which DBT had made them unsure of themselves. As Hallie described:

> This sense of knowing my own mind has been affected. … Constantly being told that you're wrong and that … your emotions don't fit the facts or they're too intense or whatever. You just become so confused about what emotions you should be having and … what feelings are right and what's your intuition and what's not. Yeah, it's like that epistemic injustice kind of thing. ... You're not believed and then you start to think … I can't even trust myself to know anything about myself.

Em described a similar process whereby a “culmination of things … made me not trust myself”. This distressing experience of becoming “unsure of yourself” (Amanda), also impacted upon clients’ relationships. Em described how “I didn’t stand up for myself as much”, and Amanda described how she was “afraid to be assertive”. There was a sense that after having spent a length of time questioning their emotional responses in therapy and trying to please therapists, that clients then became “people pleasing and … compliant” (Hallie) in other relationships.

3.2.4.3. Avoiding future relationships: Perhaps as a result of the difficult relationships within DBT, several participants became deterred from entering any new relationships, or engaging with existing ones. As Harry articulated when describing the therapeutic relationship, “I didn’t have a lot of trust to start with, but I think I can see that was a really damaged relationship”. Harry then identified that this was then “taking it out of me” in terms of his relationships with others. Bea described how since engaging in DBT, “I didn’t wanna [sic] make new friends. Didn’t even want to see my old friends … I just became very isolated”. Hallie reflected that if the therapeutic relationship in DBT was the “blueprint for future relationships”, the blueprint she has now is a “relationship where I was essentially bullied into doing whatever they told me”. This had left Hallie feeling as though “I could never be in a relationship again” and that she should never show her emotions because they could be “used against me”.

This avoidance of future relationships extended beyond the personal. Indeed, almost all participants described a negative impact on their relationship to help. Imogen described feeling concerned that if she were to attempt to engage in future therapy, they would say “well you’ve done all this DBT therapy in the past” and assume that she did not warrant support. Several clients felt unable to engage with healthcare services at all. Indeed, Bea stated, “I completely disengaged from all services because I just couldn’t trust them”, and Amanda reported that “I tend to … not call things like the duty lines. Now I don’t speak out when I do feel bad”. Participants who had gone on to engage in future therapy reported that it had taken them a long time to be able to trust their new therapist. Em reported, “I’m still kind of … undoing it with my current therapist” and Bea explained that since starting a new therapy, “it’s taken a year and a half to get to the point where … we can actually work on the problem because I’ve had to deal with this services stuff first”.

3.3. Staff Themes

A thematic map for staff was also developed during the reflexive thematic analysis process. Five themes were generated, each of which contained a number of sub-themes. The final map is illustrated below in Figure 2.

Figure 2

Staff Thematic Map

3.3.1. Staff Theme 1: “It’s Not Me, It’s the Client”

The first theme references instances in which staff saw members of their team placing ‘the problem’ within the client, either by acting in ways that could be construed as punitive, or by the language used when discussing client cases. As Ayah reported, whenever there was a difficulty or progress was not being made in therapy, there was often a view within the DBT team that “it’s not me, it’s the client and maybe they’re not ready for that kind of intervention”. Staff also discussed the concept of diagnostic labels, how enmeshed with DBT these were, and how this could “run the risk of maybe pathologizing stuff that’s quite normal human” (Oscar). The impact of this was discussed, with some staff hypothesising that people may feel that they were “a bad client” (Eleni).

*3.3.1.1. Problematising clients***:** Several staff participants raised concerns that DBT had the potential to place blame with the clients. Oscar outlined his worry that clients could be “labelled as the problem because of their behaviour” and that if clients were struggling to use DBT skills this could be framed as “on you” rather than the responsibility of the DBT team. Oscar also described the risk that clients may be positioned as “systemically carrying the madness for the family” if they were facing a difficult home environment and were then problematised in DBT.

Similar to the client sub-theme regarding pathologization, several staff members observed negative effects stemming from the label of ‘BPD’ being given. Benny mentioned how one of her clients was “furious about being given another label”, and Claire noticed how the diagnosis could act as a “council of despair” that professionals interpreted as “unworkable with”. Paul reflected on the interaction between this diagnostic label and ethnicity. Having noticed that the majority of the clients in his DBT service were White, Paul wondered whether the inclusion of the ‘BPD’ label as an eligibility criterion was excluding racialised people. Paul noticed that the label of ‘BPD’ was “predominantly” given to White people, whilst Black people were viewed by staff as “not being psychologically minded enough” and given “psychotic diagnoses”. In this way, not only were people with the label problematised within the service, but Black people were further problematised to the extent that they could not even access the DBT programme.

Another group that several staff noticed were becoming problematised during DBT were those who were neurodivergent. As Nadia summarised:

> I've noticed that particularly with clients who came into the programme with a diagnosis or a query of neurodiversity … found it really difficult not to feel like a bad client … because they couldn't apply the skills for example or be as consistent as the DBT programme often demands.

3.3.1.2. Punitive practice: One of the ways in which clients were problematised was via "punitive ways" (Oscar) of working. For example, Ayah described how if a client missed three sessions, instead of exploring the reasons why this might be happening, the protocol was: "you're off the programme". Ayah grappled with the ethics of this practice, questioning:

> What is the desired effect and where does that stop and punitive practice start? ... my concern is that some of the interventions can seem like <u>school</u> actually … that authoritarian authoritative power dynamic of just being told what to do – being told you're wrong.

This way of working did not sit well with Benny either, who said "it feels quite hard to exclude people and penalise people". In addition, Claire reported that one of her clients had told her, "I hope you leave the team because I don't want to think of you still working in this model that I consider to be very punitive". Claire further reflected on the ways in which self-harming had been an effective coping mechanism for many clients, but that in DBT they had to abandon these strategies leading to, in one client's opinion, "enforced stability due to threat of punishment".

Whilst some of these punitive practices appeared to be related to the DBT protocol, in particular strategies such as "irreverence, extending, creating cognitive dissonance and creating some kind of dysregulation to teach skills" (Ayah), others seemed more linked to individual facilitators. As Ayah reported, "I've seen some of the interventions be used really, really effectively ... and equally I've seen some of the interventions in certain hands be used in a not helpful way."

Staff also discussed the negative impact that punitive practice could have on clients, with Nadia explaining, "the narrative that then can develop out of that is: I'm really trying but … I'm just a bad client … somehow it must be my fault" and Ayah adding that it could reinforce the idea that "there's something wrong with me".

3.3.2. Staff Theme 2: DBT or Nothing

This theme refers to the descriptions of DBT being viewed as a gold standard protocol to be upheld rigidly. Indeed, Eleni outlined how although DBT has some helpful skills, "some aspects of it … makes it very rigid" and Nadia stated that, "essentially the main method of the DBT practice was sticking to the structure". Staff reflected on the ways in which this rigidity could invite problematic power imbalances and lead to DBT being practiced by facilitators "in a glass house" (Paul), removed from the clients it intends to support. Staff also hypothesised about the negative effects that may ensue if clients feel that even the 'best' treatment isn't working for them. Finally, some participants described the systematic oppression that has occurred when DBT is delivered rigidly without consideration of minoritized groups. For example, mindfulness exercises not being accessible for those living in inner city areas, and dialectical dilemmas being ingrained with Western norms.

3.3.2.1. DBT as 'gold standard': Several staff described the ways in which DBT was viewed by teams as a "fix all" (Ayah). As Benny explained, although DBT can be "powerful", it is often placed in a "white ivory tower" and conceptualised as "the best thing". The dangers of this were explored, with some staff touching on how discouraging it could be for clients if a therapy lauded as incredibly successful was not effective for them. As Nadia summarised, "to feel like the bad client in … a therapy that works for seemingly everybody else but for you is a really disheartening experience". Claire touched on a similar phenomenon, stating:

> People had said DBT will be the thing, so then it feels worse if things are the same … you've drank the magic potion that was supposed to make things better and things are objectively and subjectively worse, even if the kind of symptoms are the same.

Many participants also disclosed how DBT was often viewed by staff as a "last chance saloon" (Benny), with the implication that if this therapy was not effective, there would be nothing else available. Ayah reflected on one client she worked with who was finding DBT difficult to engage with. She recalls thinking, "where else was he going to access support if this type of therapy wasn't effective or working for him?". The risk inherent in this is that if clients adopt this view after being exposed to it in staff, it could engender feelings of hopelessness. Furthermore, some participants described how the idea that it had to be DBT or "nothing else" (Benny) had led to clients being offered DBT when another therapeutic approach may have been more appropriate. As Ayah recalled, "we were getting referrals that actually maybe a different type of therapy would be helpful for this person".

3.3.2.2. Too rigid: All participants referenced the tendency for DBT to be "inherently a bit more rigid" (Claire) than other therapeutic approaches. Indeed, Oscar outlined his concern that DBT could be used in a "one size fits all" way. Reflecting on the irony of this, given the emphasis within DBT on finding a middle path between 'black and white thinking' (Choudhary & Thapa, 2012), Claire said, "for a therapy that is so much about, let's move from black and white into shades of grey, I think it struggles to hold shades of grey much of the time".

Whilst it was noted that some clients found the structure helpful, it was equally acknowledged that for others this was not the case. As Nadia said, "the very strictness … that for some of my clients has become a real positive, for others that's not been so easy". Claire also reflected on the "risk of not being able to be flexible" and the negative impact that this could have on clients. She gave the example of if a client were to harm themselves after coming across "someone who's previously abused them". Claire explained that the DBT protocol would be to say, "you did the behaviours that we said you weren't allowed to do" and to cut contact with the client for 24 hours, rather than provide support following such a difficult experience.

When reflecting on the tendency for DBT to be practiced in a rigid way, Paul held the view that this was a misinterpretation of the therapeutic approach, and therefore a criticism not of DBT itself but rather of the facilitators who apply it in a strict manner. He explained: "you're being too absolute with something which is saying you can't be absolute … Marsha Linehan acknowledged that that was never intended to be universal". Paul further encouraged DBT facilitators to "critically reflect on what's making you hold on to this thing so absolute when it's a thing that … says nothing is absolute".

3.3.2.3. Exclusionary: Both the idea of DBT as a 'gold standard' and the rigid adherence to its protocol, led to occasions on which it was not adapted for clients' needs and was therefore practiced in a way that could be viewed as exclusionary. One form that this took was "bombarding" (Ayah) clients with skills. Indeed, Ayah described how, "sometimes I struggle to even teach the skills let alone expect people to grasp it". Paul also mentioned how inaccessible DBT terminology was for his clients and emphasised the importance of being able to "break it down and deliver it in a language that people can understand".

Another form that exclusionary practice took was in failing to account for clients' social contexts. As Oscar summarised when reflecting on DBT skills, "they're quite socially constructed ideas of how one behaves … and what implicit assumptions are behind that? Class, power, culture, gender?" Paul discussed the impact that these assumptions had on clients. For example, when discussing mindfulness, he said:

> The mindfulness exercises always seem to have a kind of leaning towards the country … but I don't see why inner-city experiences cannot be used … for example hearing police sirens … hearing lots of noise … that's the lives that many of our people live, and how you then do your mindfulness may have an inadvertent effect of excluding them.

Paul went on to describe how one client had said to him about a mindfulness exercise:

> I really don't think they fucking get me … because they was [sic] talking about … being able to sit in their house and you see the trees and … I live in a high-rise block. How does that relate to me?

Finally, Paul reflected on how the three dialectical dilemmas (Granato et al., 2021) are rooted in Western norms and that in his experience of working with people of South Asian heritage, "some of this didn't fit … it's not so individualistic ... so therefore if you're working with them, you can't just use those dilemmas."

3.3.3. Staff Theme 3: "We Don't do 'Why' in DBT"

The third theme references the many ways in which staff described DBT as not addressing trauma. These descriptions ranged from statements that DBT was not concerned with the "why" but more focused on "how and what" (Ayah), to some members of staff who were concerned that DBT was mirroring clients' trauma histories. There were also concerns raised that DBT could encourage detaching from emotions or mirror dissociation, rather than addressing underlying causes. In particular, several staff participants reflected on the potential for mindfulness exercises to induce dissociation in clients with trauma.

3.3.3.1. Unaddressed and exacerbated trauma: Many staff participants reflected on how DBT was more focused on the present than the past, and the implications of this on clients with trauma histories. As Eleni neatly summarised, “I think some people needed more work on trauma”. Claire also touched on this when describing a client she worked with who “had really severe, crippling, untreated PTSD” which led to her leaving the DBT programme. Claire also mentioned the “catch 22 situation”, which in her opinion was that this client’s trauma prevented her from engaging with DBT, but “she needed to do DBT before she’d be ready to do the trauma work”. Oscar mentioned the importance of giving clients a “choice” of DBT or “trauma related treatment” and “transparency” in describing DBT to ensure clients are aware that it is not primarily a trauma-based intervention.

Beyond the reports that DBT did not touch on trauma, there were also some participants who felt that it actively retraumatised clients. As Ayah explained, “actually it reinforced a lot of the messages that they would have had previously about … their emotions are too much”. Two staff participants also mentioned the danger of the power imbalance between therapist and client and how this might trigger past traumatic memories. Indeed, Claire stated that “particularly where people have had threatening or abusive relationships … that’s one of the interpersonal bits that DBT doesn’t potentially recognise … perhaps we will do things that … will be experienced as threatening and punitive”. Similarly, Ayah reflected that:

> For services users that have had experiences of abuse that have involved power dynamics … with regards to some of the interventions that are used then, where does that start mirroring some of their experiences of abuse and power dynamics? Where does that begin and end?

3.3.3.2. Detached and dissociated: One potentially negative implication of focusing on the present rather than the past is that it could lead to clients feeling detached from their histories and emotions. Or, as Benny described it, as feeding into the “detached protector” mode where clients become “slightly detached” from their experiences. Oscar shared similar concerns, stating, “That’s always my worry about stuff that's not very embodied, that I think ... it replicates the problem … if avoidance of what you're feeling in here is part of the problem". Oscar went on to describe how some clients he had worked with coped by "when difficulty comes in to view over the horizon, they just start pushing it away". Oscar worried that some aspects of DBT could exacerbate this by encouraging "cognitive avoidance".

When considering whether DBT could encourage avoidance, several participants mentioned how mindfulness may contribute to this. Indeed, Eleni mentioned that almost all of her clients "hated mindfulness". Similarly, Oscar stated, "some of them do dissociate and that's what makes mindfulness difficult … particularly if you're doing … body scan or relaxing or anything". Oscar acknowledged that "in more modern DBT literature" it is addressed that "mindfulness is not this dissociated state", but equally noted that many clients will already "probably have had negative experiences of how mindfulness has been taught or used". Given these potential difficulties and the risk of mindfulness triggering dissociation, Paul emphasised the importance of having "an open discussion about mindfulness" with all clients, in which the risks are outlined. However, from staff reports, it did not seem as though this happened often. Indeed, Eleni described how mindfulness exercises were often delivered as "a tick box task".

3.3.4. Staff Theme 4: "We Did Make Some Changes"

This theme entails the ways in which staff attempted to address some of the potential negative effects of DBT. Although most staff participants were passionate about DBT, they also all acknowledged its limitations, and generated potential ways of mitigating negative effects. For example, consult was named as a key place to be able to reflect on what might need to change, and pre-treatment sessions were regularly referred to as a place to manage clients' expectations of DBT. Finally, being able to incorporate flexibility within the structure of DBT was described by all staff as a key strategy in alleviating any potential negative effects. As Ayah summarised, "we did make some changes".

3.3.4.1. Value of consult: Almost all staff mentioned consult as a valued space in which any concerns about DBT could be discussed, and ideas for change could be generated. Indeed, when discussing what would happen if staff had concerns that DBT was not suited to a client, Nadia said:

> I’m aware that my colleagues do bring clients to consult where that has happened and we … then focus on really … trying to think through together as a community what would be helpful and what might need to change or what to hold in mind, and that feels quite nice.

Eleni discussed how helpful consult had been when she had started using other therapeutic techniques with clients for whom DBT seemed inappropriate. She explained that “the consult helped … bring me back into the main principles but also gave me … the freedom … validated my tendency to go … into other interventions”.

Three participants discussed the concept of therapist interfering behaviours; a DBT concept, which states that just as clients can exhibit therapy interfering behaviours, so too can facilitators. Examples include being late to appointments, interrupting the client, or being distracted within sessions (Vaughn, 2022). Participants discussed how helpful consult was in monitoring and reducing these behaviours. As Ayah summarised, “one part of DBT is looking at therapist interfering behaviours as well. And again, if the consult is strong enough … it can be a helpful tool to manage some of that.” Similarly, Nadia described, “it’s something that we all need to sign up to when we sign up to attending consult weekly … that we’re willing to look within ourselves and … have the same expectations of ourselves as we would of our clients”.

Finally, Ayah outlined her concerns about what would happen if consult was not run in an effective way, explaining that “if consult is strong enough … then great, but I guess my concern is what if it’s not, and some of these practices are just sort of going on and not being checked”.

3.3.4.2. Managing expectations: Four staff participants mentioned the importance of managing clients' expectations of DBT and not "putting it on a pedestal" (Oscar). Ideas for how to make changes to the pre-treatment sessions in order to ensure this were outlined. For example, Benny explained, "this pre-treatment and this … preparation for people is so key" and went on to describe how during these sessions she tells her clients, "It's just one more therapy. If it works, it works. If it doesn't, it doesn't." Similarly, Nadia reported, "I try to make it really clear … what we do offer … where our limits are … and what we can and can't do".

Claire described how in her pre-treatment sessions with clients, she would try to "kibosh a bit that idea that this is going to be an external fix". In order to achieve this, she would acknowledge with clients that there were often unrealistic expectations placed on DBT and would tell them, "I know people are told that sometimes. No. It's really hard work and it's not going to fix you. It's going to help you manage the symptoms … [but] things are still going to be really hard". Finally, Claire acknowledged that whilst as a model "DBT is really clear" on not marketing itself as a gold standard, equally she does not know whether all DBT facilitators were acknowledging this in their pre-treatment sessions. She summarised, "I'm only in my own pre-treatment sessions, so … you never really completely know … how much of that gets communicated by everybody".

3.3.4.3. Flexibility within structure: All staff mentioned ways in which they incorporated flexibility to ameliorate the tendency for DBT to be rigid. As Eleni summarised, "adherence – yes … but not getting … stuck into this idea and restricting yourself". For example, Benny recalled how she had provided a client with an appointment time outside of regular hours. Although her manager was not happy with this, Benny stated, "we don't live in the utopian world where you can take off two bloody hours on a Monday morning". Benny also described ways in which she had introduced flexibility into the way her service viewed diagnostic categories, stating, ""after the first couple of months we changed from 'personality disorder' service to 'complex emotional needs'".

Also touching on the importance of flexibility, Paul mentioned, “there are times that I’m going to be working with somebody, and if I feel that what’s emerging means that I drift, then I’m going to drift”. For example, he explained that he tends to use telephone coaching “not so rigidly”, describing how instead of clients only being permitted to call when in crisis, he also encourages them to call “when you’ve got a question … when you’ve done something successful”. Paul acknowledged that in doing so, “I’m not considered as DBT adherent”, but emphasised that even “Marsha Linehan … said she never intended for things to be used universally … which tells me and should tell others … use them as a guide, but not as an absolute”.

Finally, several participants described ways in which they had incorporated other therapeutic approaches into their practice when DBT had not seemed sufficient. Indeed, Claire recalled, “I drew a CAT [cognitive analytic therapy] map because … something more is needed to contain what’s going on relationally here”. Similarly, Eleni reported that with some clients she would start “exploring schemas and interpersonal dynamics” and Oscar would work on “incorporating the body”.

3.3.5. Staff Theme 5: Organisational “Restrictions”

The final staff theme captures the ways in which the context surrounding the DBT team can contribute to negative effects. Several staff spoke about funding and resource constraints and the detrimental impact of this, for example on waiting lists, and staffing. Participants also described the ways in which funding limitations meant that some services were unable to deliver a full DBT programme, instead being forced to omit key factors such as telephone coaching. Other participants referenced organisational identities and how difficult it can be to navigate this. Indeed, Paul touched on the difficulties of “working with a DBT service within the … restrictions and the parameters of being an organisation”.

3.3.5.1. The wider system: Several participants discussed the impact of the wider system that the DBT team sat within. As Eleni emphasised, “in terms of the team, it needs to be understood that … it’s an organisation within an organisation”. She went on to discuss the implications of this both on staff and clients. Firstly, Eleni named “the organisation side of things, on how it operates, money and all this”, and how this environment often had “an impact on staff leaving”, which inevitably impacted client experiences of DBT. Secondly, Eleni mentioned that the wider system did not provide adequate staff support, which left her wondering, “who contains the container?” Oscar similarly touched on the concept of insufficient staff support from the wider organisation and the impact of this, saying:

> People who are … dealing with distressed people in the frontline … without clinical training and support, it is difficult. It is going to evoke strong emotions. It's going to evolve ultimately, empathy burnout. And then … good people get burnt out because they care and people who've stopped caring stay in their posts and I think that's the systemic risk.

Oscar also described his concerns regarding the lack of training for DBT facilitators, saying:

> You can do a really minimal training. You can do like a three-day group training and off you go. I wonder whether they have the opportunity to reflect on what’s being mobilised in them … and that can have an effect on their overall care.

Finally, Paul mentioned the impact of service identity, and the difficulties that can arise when the views of the wider organisation do not match those of the DBT team or individual staff members. He reported that, “as an organisation … you have other interests … but for me … well, I’m not going to compromise how I believe”.

3.3.5.2. Lack of resources: All staff participants mentioned a lack of resources within their DBT team, and the negative effects of this. Insufficient physical resources were often mentioned, with Benny explaining:

> We don’t have the funds to send out people the book, so we’ve got the eBook and I’ve managed to convert it, although it’s a bit higgledy piggledy [sic]. … I’d like more money to be able to give everyone a book.

Also referring to the lack of physical resources, Nadia explained that she could not provide her clients with telephone coaching, “simply because the Trust doesn’t give me a telephone”. Three further participants stated that their services did not have the provision to provide telephone coaching. Indeed, Oscar stated that in his service, “phone support won’t quite be 24 hour and wrap around”, and Ayah reported, “I think that’s what the model was missing. A lot of them didn’t have the one-to-one and the phone coaching”.

Several participants also mentioned the impact that a lack of resources had on waiting times and amount of support available. For example, Benny stated, “people were waiting up to two years for DBT, which is like … you’ve got a brain haemorrhage, let’s wait three years”. Similarly, Paul expressed his frustration with the limited number of sessions per client that were funded, saying “it’s a complete contradiction … you’re saying that we are working with people with these entrenched difficulties … but you’re only gonna [sic] offer them 20, up to 23 sessions”. Benny also experienced frustration regarding the regularity with which individual therapy could be provided, recalling, “that’s another thing I need to scream at my manager about: fortnightly one to ones … if it’s only six months, can we at least have bloody weekly meetings?”

4.0. DISCUSSION

4.1. Chapter Overview

The final chapter summarises the findings in relation to the initial research questions and existing literature. Implications for both research and clinical practice will then be considered, followed by a critical review of this research. Finally, researcher reflexivity will be discussed, and conclusions drawn.

4.2. Summary of Findings in Relation to Research Questions

This research aimed to address the gap in the literature regarding client and staff experiences of negative effects from DBT. As such, and due to the dearth of research in this area, recruitment for this research prioritised the hearing of negative experiences of DBT. Therefore, it should be noted that this study does not represent the voices of all DBT clients, many of whom have reported positive experiences (Calderon, 2016; Little et al., 2017; Mader, 2017).

This summary section will begin by discussing findings relating to negative effects reported by clients in order of the four themes were generated. Following this, negative effects observed by staff will be discussed in order of the five themes generated. The fourth of these themes will be discussed in relation to the research question regarding how negative effects are addressed by staff. Finally, the third research question regarding comparisons between staff and client understandings of negative effects will be discussed.

4.2.1. What, if any, Negative Effects of DBT do Clients Report?

4.2.1.1. "I'm the problem"': In keeping with an existing report by Lomani (2022), which suggested that clients had found DBT to be "pathologizing" and "blaming" (p. 7), participants in this research described DBT as having connotations of blame and outlined experiences of their distress having been pathologized. More general research on negative effects from psychological therapy has outlined the risk of clients experiencing blame and hypothesised that this could result from therapist factors, such as a misuse of power (Curran et al., 2019). However, other than the Lomani (2022) report, no other research investigating client experiences of DBT has identified the negative experience of blame. This could in part be because participants were concerned that researchers would perpetuate their prior experiences of blame. This would be particularly likely in studies where clients were aware that the interviewers had previously been DBT facilitators, as was the case in the research conducted by Hodgetts et al. (2007).

The negative effects reported, which appeared to stem from these experiences of blame and pathologization, were low self-worth and feelings of shame. Indeed, participants described decreases in confidence and self-esteem, as well as an increase in shame, following engaging with DBT. In one case, this also had a negative effect on a participant's ability to apply for jobs. When considering which aspects of DBT as an approach may have contributed to these negative effects, it is worth exploring one of the emotion regulation skills called 'Check the Facts'. According to this skill, clients are advised that if their emotion, for example shame, does fit the facts then they do not need to change said emotion (Linehan, 2014). Indeed, in a YouTube video on the topic of shame, Linehan stated: "many of our clients have shame that is justified" (BorderlinerNotes, 2017). She goes on to provide examples of this, one of which is gay people experiencing shame historically in the United States. Perhaps then, it is no wonder that participants reported increased experiences of shame following time spent in DBT.

4.2.1.2. "DBT can do no wrong": Similarly to clients in the research by Hodgetts et al. (2007), McSherry et al. (2012), and Barnicot et al. (2022), participants in this study described the ways in which DBT was overly structured and rigid as an approach. In addition to the negative experience of taking part in such an inflexible psychological therapy, participants outlined other negative effects that they experienced as having been caused by this rigidity. Some participants found that due to strict adherence to protocol, they were unable to discuss the difficulties that they wanted to and found that their views were not listened to. This echoes an experience of one participant in the research by McSherry et al. (2012), who found that within the structure of DBT they were not able to discuss their current problems. In addition, many participants in this study found that the number of rules being set in DBT left them feeling under pressure to fulfil demands, as well as increasing obsessive and perfectionistic tendencies. A similar finding was present in research by Barnicot et al. (2022), in which participants described feelings of anxiety in response to rules.

There were also some findings regarding the negative effects of rigidity that were unique to this research. For example, some participants explained that staff adhering strictly to a protocol resulted in a power imbalance whereby the therapist held all the knowledge and could never be wrong. This is an important finding, given existing research which has identified that a power imbalance between therapist and client can result in negative effects (Berk & Parker, 2009; Linden & Schermuly-Haupt, 2014; Parry et al., 2016).

When considering which factors might contribute to the aforementioned rigidity, it is worth revisiting the context within which DBT was created, and the inspiration that Linehan drew from the Catholic Church. It could be that a certain amount of the strict rule-based nature of Catholicism (Rost & Graetzer, 2014) seeped into the development of DBT. Indeed, several participants in this research made religious references when discussing their experiences of DBT, with one participant even comparing the DBT manual to a Bible.

4.2.1.3. “No understanding of trauma”: Perhaps in part due to the rigidity mentioned above, several participants found that there was no time or space to discuss trauma. Similar experiences were cited by participants in research by McSherry et al. (2012), who described not being able to discuss their past experiences, and by one participant in research by Hodgetts et al. (2007) who described wanting to explore more from their childhood.

Beyond being unable to talk about trauma, some participants in this research found DBT to be actively retraumatising, for example by mirroring abusive relational dynamics. These findings echo a statement from the report by Lomani (2022), that

DBT is not a trauma-specific approach and is harmful for clients with “unaddressed trauma needs” (p. 16). Perhaps then, DBT is a poor fit for clients with a trauma history. Indeed, there is plenty of research to suggest that a poor fit of therapeutic approach can result in negative effects (Duggan et al., 2014; Parry et al., 2016).

When reflecting on the topic of trauma and DBT, several clients described how mindfulness had contributed to negative effects. For example, one participant described feeling distressed after engaging in mindfulness exercises. This is in keeping with research by Hodgetts et al. (2007), in which one participant reported struggling with mindfulness. Interestingly, there is literature available describing the ways in which mindfulness or meditation could be damaging for those with trauma. Van Der Kolk (2014) for example described the ways in which clients who are experiencing their trauma as happening in the present may experience dissociation, flashbacks, or emotional dysregulation in response to engaging in meditation. Furthermore, research by Baer et al. (2019) found that having a trauma history was a key factor relating to difficult experiences with meditation.

4.2.1.4. An unhealthy “blueprint for relationships”: Similarly to research by Barnicot et al. (2022), in which clients reported DBT therapists to be hostile and critical, participants in this research compared their interactions with DBT facilitators to abusive relationships. It is important to consider which aspects of DBT may contribute to this. One possible factor is the DBT technique of irreverence, which encourages therapists to behave in unexpected ways with the aim of shifting clients’ thought processes. Examples of this include adapting a deadpan or intense style of interaction, directly addressing sensitive topics, or even directly confronting clients’ behaviour (Linehan, 1993). Despite Linehan’s (2020) warning that such techniques should be used in a warm and validating way, it is not hard to see how in the wrong hands or with insufficient training, these strategies could easily become damaging. Indeed, several participants in this research described feeling as though they had been manipulated by staff.

Regarding negative effects resulting from these difficult therapeutic relationships, participants in Barnicot et al.’s (2022) research described emotional distress and worsening mental health. More specifically, participants in this research described becoming more submissive, less assertive, and losing their sense of self. Unsurprisingly, this had a subsequent impact on clients' relationships outside of therapy. Indeed, participants explained that they found it harder to trust others, began avoiding friendships, and as a result became increasingly isolated.

It is important to highlight that the negative effects on relationships were not limited to those of a personal nature. Indeed, several participants described the ways in which their relationship to help had been damaged. One participant for example, explained that she disengaged from all services because she could not trust them. In addition, some participants explained that other sources of help were withheld from them because they had engaged in DBT. A similar finding was present in research by Hodgetts et al. (2007), in which a participant explained that the crisis team would not support them since they had engaged in DBT.

4.2.2. What, if any, Negative Effects of DBT do Staff Observe? How are These Addressed?

4.2.2.1. "It's not me, it's the client": In keeping with client experiences of feeling blamed and pathologized, many staff participants in this research observed team members locating 'the problem' within clients. This took several forms, including the use of pathologizing language, and the problematising of neurodivergent clients. The latter of these is particularly concerning given that autistic people are so frequently misdiagnosed with 'BPD' (Dell'Osso & Carpita, 2022) and can then be referred to DBT.

These findings regarding staff observations of placing the problem with the client in DBT are the first of their kind, and so are worth exploring in more depth. One negative effect that staff observed to be originating from this problematisation was the use of punitive practice, whereby instead of working to understand what might underly a certain behaviour, clients were instead chastised for it. For example, instead of working to understand how self-harm might be a useful coping mechanism for someone who has experienced trauma, staff instead would withdraw contact for 24 hours following self-injuring behaviour. One staff member also observed the impact that this punitive practice had, explaining that clients had on occasion believed that they were ‘bad’ or that there was something wrong with them. Broadly speaking, the question staff seemed to be asking was ‘what is wrong with you?’, rather than a less blaming question such as ‘what has happened to you?’, as is suggested by the Power Threat Meaning Framework (Johnstone & Boyle, 2018).

When invited to consider which aspects of DBT might contribute to these practices, one staff participant mentioned the technique of irreverence. This corresponds with existing research, which suggests that in some instances the use of irreverence can increase clients’ distress (Swales & Heard, 2016). More generally, the existence of punitive practice within DBT can be understood within the wider context of the NHS approach to clients given diagnoses of ‘personality disorders’ or labelled as ‘high intensity service users’. Indeed, although now suspended, the Serenity Integrated Mentoring approach, which encouraged the use of police involvement and coercive measures for those in mental health crisis, was widely used by the NHS for clients given a label of ‘BPD’ (House, 2022). Furthermore, research has found that mental health practitioners have more negative views of clients given a diagnosis of ‘BPD’ than they do clients given other diagnostic labels (McKenzie et al., 2022).

4.2.2.2. DBT or nothing: Similarly to the client theme regarding the rigidity of DBT, several staff participants in this research referred to the inflexible nature of DBT and the negative effects that resulted from this. More specifically, participants described the ways in which rigidity led to power imbalances and exclusionary practice. These observations correspond with research by Curran et al. (2019), which outlined a causal relationship between therapist rigidity and clients feeling disempowered. Staff participants helpfully gave examples of times when rigidity led to exclusionary practice, such as when inaccessible jargon or culturally insensitive exercises were used. This finding regarding inaccessible language is in keeping with previous research by McSherry et al. (2012), which found that clients viewed DBT jargon to be “intimidating” (p. 6) and that this acted as a barrier to them engaging with certain tasks. The finding regarding cultural insensitivity has also been touched upon in previous research by Kannan et al. (2021), who found that DBT facilitators felt that the missing factor in DBT was the consideration of cultural factors.

A unique finding to this research was that rigidity was also present in the prescribing of DBT. Indeed, several staff participants described how DBT was framed as the only appropriate intervention. They went on to explain how, as a result of this, they had observed how clients who did not find DBT helpful were often left feeling hopeless. In terms of factors contributing to the rigidity, it may be that the ‘Layard hypothesis’ is at play. This hypothesis suggests that there are both economic and logical grounds to support an increase in access to psychological therapies (Layard & Clark, 2014). However, the therapies that this popular approach resulted in were often single-model treatments, which are not easily personalised. Interestingly, one of the staff participants in this research felt that the rigid practice of DBT was a fundamental misunderstanding of the therapeutic approach, and thus was a problem not with DBT as an approach, but rather with facilitators who practice it in that way.

4.2.2.3. “We don’t do ‘why’ in DBT”: Many staff in this research referred to the ways in which DBT was not a trauma-specific approach. Previous research into staff experiences of DBT has not identified any such observations by facilitators, however the theme does correspond with client experiences regarding a lack of understanding of trauma in DBT. When reflecting on the negative effects stemming from the lack of a trauma-specific approach, staff described therapeutic relationships mirroring abusive histories, as well as clients becoming more detached from their emotions. Perhaps then, it is no surprise that the dropout rates for DBT are higher for those who have experienced childhood trauma (Euler et al., 2021), and that DBT clients with a diagnosis of Post-Traumatic Stress Disorder (PTSD) have shown slower reductions in self-harm (Barnicot & Priebe, 2013).

Interestingly, one exercise mentioned by staff participants as being difficult for clients with trauma was mindfulness. This corresponds with client experiences mentioned previously regarding negative experiences of mindfulness. Two staff participants hypothesised that the reason mindfulness could be damaging for clients with trauma histories related to its potential to trigger dissociation (something that clients with trauma may already struggle with). This is in keeping with research by Barnicot and Crawford (2018), which suggested that dissociation may mediate the relationship between PTSD and DBT treatment outcomes.

When considering what it is about DBT as an approach that leads to unaddressed trauma, it is again worth considering the context within which it was created. More specifically, it is worth reflecting on Linehan's behaviourist roots, and in what ways this focus on behaviour may overlook clients' histories. One example of this can be seen in research by Hodgetts et al. (2007), in which one participant described how DBT had focused on behaviour and taken away their coping skill of self-harm, without exploring the potential reasons for this, thereby leaving them without a way to manage distress.

4.2.2.4. "We did make some changes": All staff interviewed recognised the limitations of DBT and accordingly made valuable suggestions for amendments that could be made, or aspects of DBT that could be better utilised. These strategies broadly fell into three sub-themes: the use of consult, managing expectations, and introducing flexibility. They can be conceptualised as answering the latter part of this study's second research question regarding how observed negative effects were addressed by staff.

The first sub-theme described the value of consult in being able to address negative effects. This is in keeping with previous research which found that DBT facilitators viewed consult meetings as playing a key role in providing opportunities to reflect on therapeutic work, develop new insights, and draw awareness to potential 'blind spots' (Walsh et al., 2018). Unfortunately, there is also research to suggest that approximately 10% of DBT teams do not use team consultation (Dubose et al., 2013). In addition, it is worth noting that the idea of consult can be distressing for clients. Indeed, in a podcast on DBT, Hollie Berrigan, a Consultant Lived Experience Practitioner, described consult as many people in power talking about her, and experienced this as “intimidating” and “uncomfortable” (Harding & Berrigan, 2020 – 2022).

The second sub-theme described the ways staff attempted to counteract the narrative that DBT was the gold-standard of treatment. Staff gave examples of how they went about doing this, such as being transparent with clients in pre-treatment about the limitations of DBT. Finally, participants described some of the ways they attempted to introduce some flexibility into DBT in order to address the negative effects stemming from rigidity. These strategies included using the DBT manual as a guide not an absolute, which fits well with research that suggests therapy protocols are not intended to be used as ‘cookbooks’ (Kendall & Frank, 2018), rather that facilitators should use flexibility within the fidelity of the model (Kendall et al., 2008).

4.2.2.5. Organisational “restrictions”: The final staff theme comprised the ways in which staff observed organisational restrictions contributing to negative effects. Interestingly this theme was not generated from client participant interviews, however it does correspond with previous research into staff experiences of DBT. Indeed, the study by Kannan et al. (2021), found that several DBT facilitators felt that organisational factors, particularly insufficient funding, interfered with the ability to deliver an effective form of DBT.

Organisational factors that staff participants in this study mentioned included high staff turnover rates, empathy burnout, insufficient staff training, long waiting lists, limited availability of sessions, and inadequate physical resources. Participants also outlined some of the negative effects that could stem from these factors, including a decline in empathetic practice, reduced levels of support for clients, and clients receiving less than the recommended frequency of input. These findings correlate with research by Hardy et al. (2019), which suggested that organisational factors such as insufficient funding for training or resources, had the potential to contribute to negative effects from psychological therapies.

Although this link was not made in staff interviews, it is possible that the lack of funding for training and resources could be contributing to rigid practice. Indeed, if staff are not trained sufficiently, they may feel less confident to use their own therapeutic judgement in adapting DBT resources or exercises. In addition, the impact of insufficient funding on waitlist lengths and the subsequent high demand on services could mean that therapists do not have enough time to personalise approaches. Indeed, research by Swenson et al. (2002) found that competing demands on staff time can interfere with their ability to practice DBT.

4.2.3. How do Client and Staff Understandings of These Negative Effects Compare?

The first three themes generated from both staff and client interviews can be broadly mapped onto one another and cover similar negative effects, including those stemming from the problematisation of clients, the rigidity of DBT, and the lack of a trauma-specific approach. In this way, staff and client understandings of negative effects can be viewed as similar. Indeed, both staff and client participants discussed the difficulties with pathologization and how they understood this to result in a decline in clients' self-worth. In addition, both participant groups mentioned the way DBT is often viewed as a gold standard therapy and understood that this could then leave clients feeling hopeless if the approach was not effective. Finally, both staff and clients regularly mentioned the ways in which DBT did not take trauma histories into account and understood that this could unfortunately result in the re-traumatisation of clients.

However, whilst several clients mentioned negative effects relating to the therapeutic relationship, this theme was not generated from staff interviews. In addition, staff participants regularly discussed organisational factors, which may have contributed to negative effects, and this was not a theme which was identified from client transcripts. In these ways, client and staff understandings of negative effects differed. The absence of clients mentioning wider organisational factors is perhaps understandable, given that when receiving DBT, they were likely not directly exposed to discussions around funding and service provision. However, the fact that staff did not often discuss relationships is particularly interesting, given the amount of existing research to suggest that difficulties within the therapeutic relationship are a key contributing factor to negative effects (Berk & Parker, 2009; Linden & Schermuly-Haupt, 2014; Parry et al., 2016), and given that an entire module of DBT is dedicated to interpersonal effectiveness.

All the above findings regarding the comparisons between staff and client understandings of negative effects from DBT are the first of their kind. Indeed, only one study to date has investigated both groups' experiences of DBT, and the sole negative effect reported by both staff and clients was that DBT was intense (Johnson & Thomson, 2016).

4.3. Implications

4.3.1. Clinical

The following section will outline some amendments that could be made to DBT in order to minimise negative effects as far as is possible. These will include general recommendations, as well as more specific alterations regarding problematisation, rigidity, trauma, relationships, and organisational factors.

Firstly, and more generally, the findings from this research indicate the importance of employing methods to recognise negative effects. All DBT clinicians should be asking themselves what harm looks like, what they might be doing that contributes to this, and what they can do to address any negative effects. In practice however, despite all efforts to counteract this, it is likely that staff will regularly overlook certain negative effects (McGlanaghy et al. 2021). It is therefore of the utmost importance that clients have as many opportunities as possible to report experiences of negative effects. Methods to facilitate this could include regular reviews with therapists, in which clients are explicitly invited to reflect on any negative experiences (Curran et al., 2019), as well as opportunities for anonymous feedback.

Secondly, given the regularity with which both clients and staff mentioned problematisation as a negative effect, it would be warranted for DBT services not to label clients as having a ‘personality disorder’, unless they explicitly request this (Lomani, 2022). In addition, DBT services could address the wider problematisation of clients by adopting a more systemic perspective, which conceptualises problems as existing in an interpersonal context (Vetere & Dallos, 2019), rather than locating them within an individual. In response to the findings from this study regarding the ways in which neurodivergent clients became problematised, DBT would do well to adapt its protocols and exercises for neurodivergent people. Fortunately, Wise (2022) has recently published *The Neurodivergent Friendly Workbook of DBT Skills*, which could be an essential resource for DBT teams. The book, which is written by a neurodivergent person, acknowledges that DBT skills are not always accessible for other neurodivergent people, and so has reframed certain skills to be more affirming. For example, the ‘opposite action’ skill, is renamed using the more affirming language of ‘act intentionally’ and emphasises the importance of behaving in accordance with one’s values.

Thirdly, when considering both client and staff reports regarding the rigidity of DBT and resulting power imbalances, perhaps strict adherence to a protocol is not as important as was once thought. Indeed, guidelines now state that the NHS should provide care that is tailored to the personal preferences of service users (NICE, 2019). Perhaps then, DBT practitioners should, as suggested by one of the staff participants, use the DBT protocol as a guide rather than an absolute. This should be navigated in such a way that clients have opportunities to tell DBT facilitators which aspects of the approach do not work well for them, and that these preferences would be responded to with necessary alterations in the intervention, rather than labelling the client as non-compliant.

Fourthly, with regards to findings in this study regarding experiences of DBT as re-traumatising, facilitators should have more training on trauma-informed approaches. In addition, given the staff concerns in this study that DBT could be causing clients to become more detached or dissociated, DBT services as a whole should be informed by the International Study of Trauma and Dissociation (ISSTD) guidelines (ISSTD, 2011). This is particularly important given that if clients are dissociated or otherwise outside their window of tolerance (Corrigan et al., 2010) during sessions, they are unlikely to benefit from any therapeutic techniques. In addition, given that unmet client expectations are a contributing factor to negative effects (Curran et al., 2019), all clients should be made aware in advance of starting DBT that it is not a trauma-specific approach. Interestingly, an adapted form of DBT for PTSD (DBT-PTSD) has been designed, and initial trials showed improvements in primary outcome measures (Bohus et al., 2020). However, the research was not conducted by independent investigators and so allegiance effects are probable. In addition, the dropout rate was high (32%), meaning that attrition bias was also likely.

Fifthly, given the findings from both previous research (Barnicot et al., 2022) and this study, setting out the negative effects stemming from the therapeutic relationship, attention should be paid to the potential for this to cause harm. Irreverence, manipulation, or any form of ‘withdrawal of warmth’ (Green, 2022) should not be used. In addition, particular attention should be paid to identifying and addressing the power imbalance inherent in the relationship, given its role in contributing to negative effects (Curran et al., 2019).

Sixthly, when addressing negative effects, a multi-level response is key (Parry et al., 2016). The importance of responding at an organisational level is emphasised by findings from this research, which outlined the role staff observed organisational factors to be playing in contributing to negative effects. One recommended organisational level response would be for teaching on negative effects to be included in the DBT accreditation training, as was recommended by Castonguay et al. (2010) to be the case for all therapies. In addition, in order to avoid empathy burnout, DBT facilitators should receive sufficient organisational support and opportunities for reflection.

Finally, the findings from this study indicated that rigidity was also present in the prescribing of DBT, where perhaps an informed consent procedure would be more appropriate. Information based both on this research and previous research concerning negative effects of DBT should be made widely available to all, and especially to those being referred to DBT, who should then be able to choose if they feel that the intervention is suited to them. Such information should include transparent descriptions of any potential negative effects or experiences, including, among others, withdrawal of warmth, pathologization, re-traumatisation, and rigidity.

Indeed, the NHS guidelines on consent to treatment (NHS, 2022) state that for consent to treatment to be valid it must be voluntary and informed. Furthermore, the guidelines state that for this consent to be informed, a person must be given all information about a potential treatment, including any risks. Given both the importance of this information, and the NHS Health Research Authority (HRA) guidance to include plain language summaries of research findings (NHS HRA, 2023), an accessible summary of this study's findings can be found in Appendix V. The hope is that this will also support clients currently in DBT who may be having difficult experiences.

4.3.2. Research

This research outlined some of the negative effects from DBT that had been experienced by clients or observed by staff. However, the study did not explore whether these negative effects were particular to DBT, implying that the intervention itself carries an inherent risk of harm (Lilienfeld, 2007), or whether they exist across other therapeutic modalities. Further research regarding whether negative effects from DBT share commonalities with those from other types of psychological therapies, would be beneficial. In particular, it would be interesting to investigate the extent to which negative effects from DBT are due to a specific intervention risk (Parry et al., 2016), and the extent to which they stem from other factors that may be present across other interventions, such as organisational factors.

To the researcher's knowledge, this study was the first to explicitly investigate staff experiences of negative effects. Staff participants described many ways in which the DBT had resulted in negative effects, which raised the question of how these staff managed the knowledge that they had been part of teams that perpetrated harm. In particular, the question arose as to whether these participants encountered moral distress; an experience that arises when staff act in ways that they perceive to violate their professional integrity or are constrained from acting in ethically appropriate ways (Epstein & Hamric, 2009). Indeed, several staff participants in this study described ways in which organisational restrictions prevented them from practicing in the ways they would have wanted to. Existing research has found that the ways psychologists respond to moral distress include support seeking, becoming silent, and taking a stand against perceived injustices (Austin et al., 2010). Qualitative research to explore the ways that DBT facilitators respond to occasions on which they recognise the negative effects stemming from their practice would be of value.

Future quantitative research into this area would also be beneficial. In particular, a study with a larger and more representative sample of those who have experienced DBT, would be of value in providing an estimate of the prevalence of negative effects. Existing measures for identifying negative effects, such as the NEQ (Rozental et al., 2016) could be used here, although there is also a need for something more tailored to DBT that is created in full partnership with experts by experience.

Finally, whilst existing research has found that those who are marginalised are more likely to experience negative effects from therapy (Crawford et al., 2016), this research did not explore whether this was the case in DBT. However, given the findings both in previous research (Kannan et al., 2021) and in this study which indicated that DBT did not adequately consider cultural and social factors, further investigation into this is clearly warranted. In particular, future research into whether the negative effects of DBT are more likely to be experienced by those who are racially minoritized, members of the LGBTQIA+ community, disabled, or hold any other marginalised identity, would be of value.

4.4. Critical Review

Yardley's (2015) flexible principles for assessing the quality of qualitative research are used below as a guide for critically reviewing this research, alongside a broader discussion of strengths and limitations.

4.4.1. Sensitivity to Context

The review of the development of DBT and a description of its practice within the UK, alongside an expansive literature review included in the introduction of this thesis, enabled the research to be located within its relevant historic and current context. With regards to the processes of analysis and reporting, the researcher endeavoured to be as sensitive as possible to the interactions between their own context and those of the participants. This included keeping a regular reflective diary and creating a list of the relevant contextual aspects of the researcher's identity.

Attempts were made to address the power imbalance in the relationship between researcher and participant, by focusing on marginalized experiences (O'Connor & O'Neill, 2004). However, the dynamic between interviewee and interviewer is inherently hierarchical (Whitmore, 1994) and as such some clients may not have felt safe to be critical of services they had received. In addition, there was no specific question or prompt regarding the social GGRRAAACCEEESSS (Burnham, 2013) included in the interview protocols, which may have resulted in contextual information being overlooked.

4.4.2. Commitment and Rigour

The researcher demonstrated commitment to the topic through "prolonged engagement" (Yardley, 2000, p. 7), both as someone with lived experience of DBT, and through thorough and lengthy immersion with the data and literature. This was combined with time for the researcher to distance themselves from the data, allowing space for reflection. This dual process of immersion and distance contributed to rigour in the processes of coding and theme generation (Braun & Clarke, 2022).

Rigour was also demonstrated through the inclusion of direct participant quotations, the utilisation of supervision, and participant involvement with the development of the interview schedules. Ideally, a greater degree of participant involvement would have been undertaken, in order to move from a model of consultation to one of citizen control (Arnstein, 1969), in which the participants have a greater degree of power with regards to planning and management. However, given the limited funding available, and the desire to avoid service users being involved in a tokenistic way without being remunerated for their work, this was not possible.

Finally, rigour was demonstrated in the use of multiple prompts within the semi-structured interviews, which enabled the collection of rich, nuanced data, and avoided surface-level interviewing (Connelly & Peltzer, 2016).

4.4.3. Transparency and Coherence

Transparency is said to be achieved through a thorough explanation of the data collection and coding process (Peräkylä, 1997). Accordingly, this research explicitly and clearly detailed these processes in the methodology chapter. Furthermore, copies of the transcription key, initial codes, a transcript example, and the process of theme generation can be found in appendices N, S, T, and U respectively. Transparency in qualitative research can also be enhanced by reflexivity, particularly into the ways in which the researcher’s status and experiences may interact with those of the participants. Correspondingly, a reflexive account on the researcher’s position was included in the methodology chapter. In addition, a plain language summary of this research has been made available.

Coherence is a key principle across all qualitative research (Braun & Clarke, 2013; Willig, 2013). Accordingly, this research ensured that there was a good fit between the research questions, epistemological approach, design, and analytic approach. Indeed, the research questions aimed to investigate participant understandings, which the epistemological approach of critical realism prioritises through its assertion that realist entities can only be accessed via particular interpretations.

Similarly, reflexive thematic analysis, the approach used in this research, has been indicated as an appropriate method for exploring participants' perspectives and experiences (Braun and Clarke, 2013). Also key to ensuring coherence was an awareness that thematic analysis is a cluster of methods, each underpinned by idiosyncratic concepts and theoretical contexts (Yardley, 2015). This research used reflexive thematic analysis rather than coding reliability or codebook, and as such prioritised extensive reflexivity into the researcher's assumptions and practice (Trainor & Bundon, 2021).

4.4.4. Impact and Importance

In terms of theoretical impact, this research succeeded in exploring both staff and client experiences and understandings of the negative effects of DBT, an area of research which until now has been largely unexplored. The findings from this research also have the potential to create a valuable socio-cultural impact, given that these understandings of DBT as holding the potential to cause harm are relatively novel, and challenge the predominate view of DBT. The hope is that this will serve a social purpose (van Dijk, 1997) by platforming the voices of those who have so often been silenced and disempowered (Curran et al., 2019).

Finally, the findings from this research indicate a series of potential avenues for further research and changes in both policy and practice, which would aim to reduce the occurrence of negative effects from DBT. A full overview of these recommendations for changes can be found in the implications section above.

4.4.5. Strengths and Limitations

The use of a qualitative approach to investigate both client and staff understandings of the negative effects of DBT was a key strength of this research. It enabled the collection of rich data, which provided opportunities for previously untold stories (Pearce, 2007) to be shared, and a more nuanced understanding of experiences to be described. However, it is possible that the use of semi-structured interviews with pre-prepared protocols may have resulted in areas that were important to participants being overlooked (Potter & Hepburn, 2005).

Another strength related to the qualitative method taken was the rigorous approach to transparency, which included two reflexive accounts. The aim of continuous reflection throughout the process was to avoid analytic tourism in which the researcher is biased towards only finding information within the data that correlates with their own assumptions and experiences. Another way to safeguard against this occurring is to send the analysis to participants for their input, otherwise known as the member checking of themes. Although the researcher did send a summary of the analysis to participants, there were no responses to this before the deadline for submission, and as such this was a limitation of the research.

Another potential limitation of this research is that it was not clarified whether the negative effects identified were specific DBT intervention risks, or whether they were in part related organisational factors. Indeed, one of the staff participant themes, ‘Organisational “restrictions”’ could potentially apply to any NHS therapeutic intervention. Furthermore, it is likely that some of the reported negative effects were related more to therapist variables. Indeed, one staff participant even named that they felt some negative effects were “a problem not with DBT as an approach, but rather with facilitators”.

With regards to the recruitment process, one strength of this research was the attempt to recruit participants who were racially minoritized, by making contact with relevant charities. However, despite this, the client participant sample was not representative of the UK population with regards to ethnicity, according to the latest census (Office for National Statistics, 2021). Also in relation to recruitment, seven out of the eight client participants identified as female, mirroring an existing limitation within DBT research whereby those identifying as female are disproportionately represented (Wupperman & Edwards, 2017).

Finally, it is possible that a self-selection bias occurred, whereby those who responded to a recruitment poster on the potential for DBT to do harm may have been more likely to have experienced or witnessed negative effects. Equally, a non-response bias may have been present, whereby those who had particularly difficult or traumatic experiences with DBT may not have felt able or ready to participate.

4.5. Researcher Reflexivity

As implied in the reflexivity statement in the methodology chapter, I was drawn to this research topic due to my own experiences of DBT, first as a client and later as a trainee clinical psychologist providing cover for a DBT group and conducting research into client experiences of said group. Given the design of the research, which involved interviewing both clients and staff, I spent time reflecting on my identity as a “partial insider” (Chavez, 2008, p. 4) who shared certain aspects of identity with each group of participants but differed in other aspects. After bringing this to supervision and discussing the impact that holding these roles may have, both on interactions with participants, and the analysis process, I chose to engage in a reflective exercise. This involved writing out the positives and negatives of DBT I had experienced first as a client, and then as a practitioner.

Throughout this exercise, I reflected on the impact that my own experiences with DBT and subsequent preconceptions may have had on the process of writing up this research. For example, I wondered whether I was more drawn to include negative experiences, and whether I needed to give more space to positive experience. However, it is notable that even after explicitly inviting examples of positive effects, and coding these, there were not enough codes to develop a theme relating to positive experience of DBT that was evidenced by sufficient meaningful data. Of course, this itself is in the context of the selection bias and that the recruitment materials encouraged participants who had experienced negative effects.

Relatedly, I reflected on how I felt more aligned with my identity as a service-user than provider. For example, I continue to feel drawn to recommend that DBT should no longer be practised, given that clients in this study recognised its negative effects, that the “Stop Dialectical Behavioral Therapy” Facebook group continues to grow, and that other survivor groups have recommended that those with histories of sexual trauma should never be referred to any behaviour-based interventions, including DBT (Lomani, 2022). At the same time, I recognised how damaging it could be if, by identifying more with my service-user identity, I became unable to acknowledge my relative position of power. This process also contributed significantly to my journey of embracing my identity as a lived experience practitioner.

I also spent time reflecting on the interview process. I was aware that there was a delicate balance to be held in validating participant's experiences without introducing my own views into the process. The ongoing process of keeping a reflective diary helped me to conduct interviews in a way that was authentic without imposing my own perspectives. Through keeping this diary, I was also prompted to reflect on my tendency to conceptualise harm from DBT as a dichotomy (either harmful or not) rather than as existing on a continuum. I spent time considering the potentially damaging implications of conceptualising harm in this way, including overlooking less easily observable instances of harm or discounting peoples' positive experiences of DBT. Entries in my reflective diary regarding this at all stages of the research were key in working towards ethical qualitative research, which is recommended to involve both prospective and retrospective reflexivity (Attia & Edge, 2017).

Overall, I was continuously inspired both by the resistance of the client participants, and the honesty of the staff participants. I was also incredibly touched to receive feedback from some participants, which indicated that taking part in the research had played a role in their healing journey.

4.6. Conclusion

This thesis sought to investigate and compare both client and staff experiences and understandings of negative effects from DBT. Four themes were generated from client participant interviews, and five from staff participants. The findings indicated that both staff and clients understood negative effects from DBT to partially stem from rigidity, and to include blame, pathologization and re-traumatisation. In addition, clients understood negative effects to be related to the therapeutic relationship, and staff understood them to be in part caused by organisational restrictions.

It is likely that many of the negative effects identified in this research result from a combination of factors, including therapist factors, organisational factors, and poor fit (Parry et al., 2016). As such, it is also likely that other therapeutic interventions may cause similar negative effects. Indeed, research suggests that clients who have experienced MBT also found it to be too rigid (Barnicot et al., 2022), and clients who have experienced Cognitive Behavioural Therapy have also found it to be pathologizing (Ratnayake, 2022). Nevertheless, there are some features of DBT that may set it apart from other therapies with regards to negative effects, for example the explicit suggestion for therapists to use ‘withdrawal of warmth’ as a therapeutic technique.

Based both on the findings from this research, and existing research, there are several adaptations that could be made to DBT, in true collaboration with service-users, to reduce the likelihood of negative effects occurring. Central to these changes should be the implementation of meaningful informed consent procedures so that no client is referred to DBT without being aware of the potential for both positive and negative effects.

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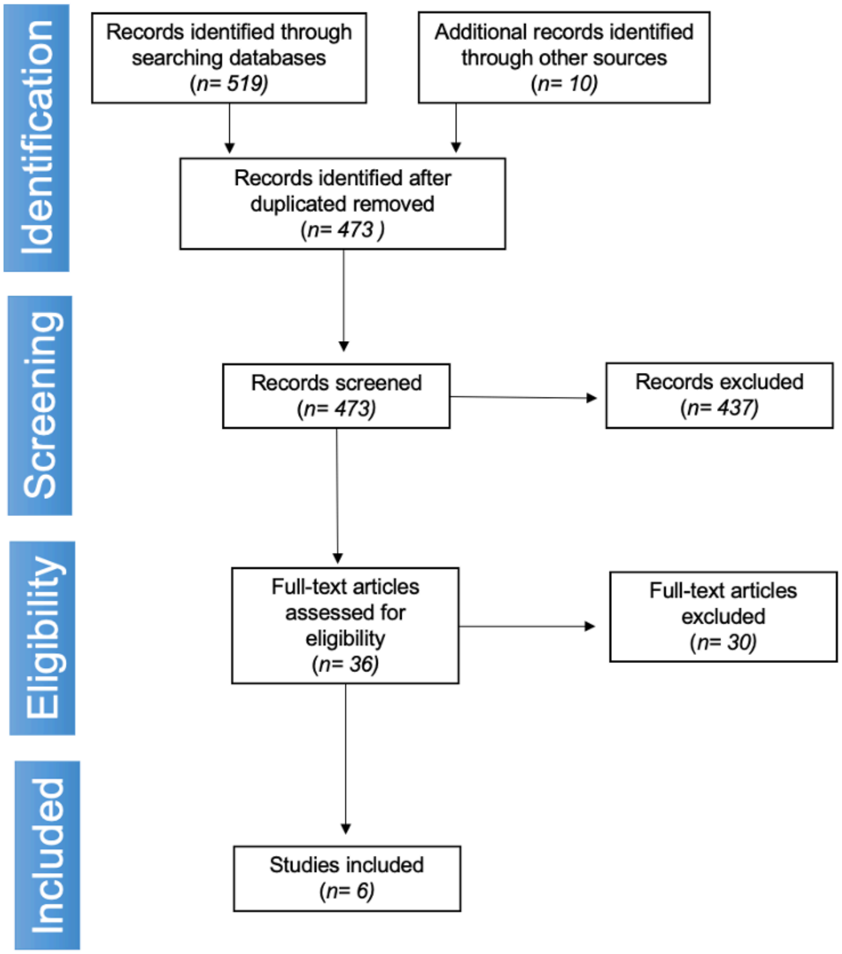
APPENDICES

Appendix A: Literature Review

Search: PsychInfo, EBSCO Academic Search Complete, and SCOPUS

01/01/1975 – 28/02/2023

Search terms: ("DBT" OR "DIALECTICAL BEHAVIOUR THERAPY" OR "DIALECTICAL BEHAVIOR THERAPY") AND ("EXPERIENCES" OR "VIEW" OR "PERCEPTION") AND ("STAFF" OR "CLIENT" OR "PATIENT")



Appendix B: Table Summary of Papers

Study	Aims	Participants	Location	Methodology	Relevant Findings	Limitations
1. Hodgetts et al. (2007)	To provide an insight into client experiences of DBT	• 5 clients given a diagnosis of 'BPD' • 3 female, 2 male • Between the ages of 24 and 48 • All participants White British	South West of England	Interpretative Phenomenological Analysis	• DBT experienced as overly structured • Lack of exploration of past traumas • Difficulty with the group setting	• Limited generalisability given participant demographics • Potential for overly positive accounts, given one interviewer had facilitated DBT groups
2. McSherry et al. (2012)	To examine client views on the effectiveness of a community DBT programme	• 8 clients given a diagnosis of 'BPD' • 6 females, 2 males • Between the ages of 32 and 55	UK: Semi-rural setting	Thematic Analysis	• Inaccessible terminology • DBT experienced as overly structured • DBT experienced as de-humanising	• The DBT that clients experienced was adapted and staff were relatively inexperienced
3. Barnicot et al. (2022)	To establish common and unique, and helpful and unhelpful, treatment processes in DBT and MBT	• 73 clients given a diagnosis of a 'personality disorder' • 17 male, 56 female • 42 experienced DBT, 31 experienced MBT • 42 White British, 5 White Other, 7 Black,	UK	• Mixed methods • Thematic analysis • Chi-squared tests • Generalized linear regression	• Difficulties with the therapeutic relationship, e.g., therapist being hostile or critical • Difficulty with the group setting • Some exercises triggered painful memories	• Limited to those give given a diagnosis of a 'personality disorder' • Unable to interview whole sample, potentially omitting different experiences.

		8 South Asian, 10 Mixed				
4. Lomani et al. (2022)	To share experiences and propose less harmful approaches to future service provision	Collective of survivors of child sexual abuse and sexual violence	UK	N/A	• Experiences of DBT as pathologizing, blaming, dismissive, silencing, and harmful	No new research generated
5. Kannan et al. (2021)	To develop a richer understanding of the process of developing and implementing DBT	• 15 mental health professionals • 12 women, 3 men • 93.3% Caucasian and 6.7% Asian	USA	Thematic Analysis	• Organisational barriers to implementing DBT • Insufficient attention paid to multicultural issues	• Limited generalisability given specific context • No mention of limitations
6. Johnson & Thomson (2016)	To explore the lived experiences of staff and service-users of DBT in an NHS forensic learning disability service	• 7 members of staff • 7 women with learning disabilities	UK	• Interpretative Phenomenological Analysis • Case orientation approach	• Clients expressed difficulty with the group setting • Staff and clients described the experience as intense	• Limited generalisability given specific context • No mention of limitations

APPENDIX C: Staff Consultation Feedback

Staff Feedback on Draft Interview Schedule (their comments in red)

1. Could you tell me a little about the DBT that you've provided? Could you tell me a bit about your experience as a DBT facilitator providing DBT? OR do you mean Could you tell me a bit more about the DBT programme you offer in your service?

   Prompts:
   - How was the therapeutic process? What does your programme offer? Was there a DBT assessment? Did you provide pre-treatment sessions? What was discussed in these sessions? Do you offer a full DBT programme, including the 4 modalities? How did you find the therapeutic process?
   - Were clients given any information ahead of starting DBT? If so, what kind of information? Was there any mention of the potential for negative effects?

2. Have you ever observed any negative effects of DBT at all?

   Prompts:
   - If so, what kind of negative effects? E.g., emergence of new distress / deterioration/increase access of emergency services/duty?
   - Have clients discussed with you any negative effects of DBT?
   - How long did they last?
   - Can you give me an example?
   - Were any measures or methods for identifying negative effects used?

3. What is your understanding of these negative effects?

   Prompts:
   - How did these negative effects develop?
   - Do you think that they might be related to any aspects of DBT? What aspects of DBT may have contributed to them? E.g., formulation, groups, structure, DBT contract, certain exercises, endings, therapeutic relationship.
   - Were there any organisational factors that may have contributed? E.g., time, resources, team dynamics

4. How did you address any negative effects?

   Prompts:
   - Did you discuss them with anyone? E.g., in supervision, in consult or with clients (did you offer a review session?). If not, what were the reasons for this?
   - Were any changes made?
   - Can you give me an example?

5. Is there anything else that you think is important to mention about the (potential) negative effects of DBT?

6. Is there anything else that you would like to ask me?

APPENDIX D: People's Committee Proforma and Feedback

Brief summary of research proposal for People's Committee

Your name:
Zazie Lawson
Proposed title of research:
First do no harm: Client and staff experiences of Negative Effects from Dialectical Behaviour Therapy (DBT)
What is known about this topic (3-4 sentences max.)?
There has been one paper looking at client experiences of negative effects of DBT. Three themes of negative experiences were found: difficulties interacting with other group members, difficulties within the therapeutic relationship, and having to engage in painful introspection. There is no research about staff experiences of DBT and negative effects.
What do you want to find out (3-4 sentences max.)?
What, if any, negative effects of DBT do clients experience and staff observe? How are these negative effects addressed? How do client and staff understandings of these negative effects compare?
What is the relevance to clinical practice/policy (3-4 sentences max.)?
Being able to consider the risks of therapy is in the professional guidance for clinical psychologists but there is a lack of research into negative effects of therapies. This research aims to provide clients of DBT services with the opportunity to express their experiences of iatrogenic harm and in doing so add to the evidence base available to clinical psychologists regarding the risk factors inherent in therapeutic approaches. The research also aims to gather staff views on iatrogenic harm and DBT and address the literature gap in this area.
Who will the participants be or what materials/resources (such as reports, discussion forums) will you use?
Semi-structured interviews with between 5 and 10 people who have had DBT, and between 5 and 10 members of staff who have facilitated DBT.
How will you recruit/access them?
Snowball sampling using online adverts
What are the main points that you took away from the session?
Whole group agreement that, due to limited resources, vouchers for participation should all be allocated to clients who have experienced DBT rather that staff participants who have facilitated DBT.
What will you do next?
Allocate resources according to the agreements from the discussion during this session.

APPENDIX E: Client Recruitment Poster

University of East London

Invitation to participate in research: for those with experience of Dialectical Behaviour Therapy (DBT)

Are you over the age of 18, with experience of DBT within the last 5 years?

I am looking into peoples' experiences of DBT, both helpful and unhelpful and am aiming to research which aspects of DBT, if any, can cause harm.

I would love to speak to you about your experiences.

Participation will involve a one-hour interview over Microsoft Teams, where I will ask you some questions about your experiences of DBT.

You will be reimbursed for your time in the form of a £10 voucher

For more information or to take part, please contact: Zazie Lawson at u2075210@uel.ac.uk

APPENDIX F: Staff Recruitment Poster

University of East London

Dialectical Behaviour Therapy facilitators needed for a research study

Existing research has found both that DBT can be an effective intervention, and that some aspects of DBT can result in negative effects. However, there is no research investigating staff experiences of any potential negative effects.

We hope that your participation can help us to understand more about this and increase awareness of the potential negative effects of therapies.

Who is eligible?

- Clinicians who have facilitated a DBT program within the last 5 years

What will taking part involve?

- An interview about your experiences of DBT, lasting up to 1 hour, online via Microsoft Teams

For more information or to take part, please contact:

Zazie Lawson at u2075210@uel.ac.uk

APPENDIX G: Client Participant Information Sheet

Version: 1
Date: 21.01.2022

PARTICIPANT INFORMATION SHEET

First Do No Harm: Client and Staff Experiences of Negative Effects from Dialectical Behaviour Therapy

Contact person: Zazie Lawson
Email: u2075210@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Zazie Lawson. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Doctorate in Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into both client and staff experiences of Dialectical Behaviour Therapy (DBT). Existing research has shown that DBT can be effective, however less is known about whether there are any potential negative effects. The aim of this research is to investigate which aspects of DBT, if any, can cause harm and what form this harm takes. This research also aims to explore how staff address any instances of harm, as well as to compare client and staff experiences surrounding any negative effects of DBT. In doing so, the longer-term aim of this research is to add to the evidence base regarding the risk factors of therapeutic approaches, with the hope that this will prompt critical reflection, and action within services.

Why have I been invited to take part?

To address the study aims, I am inviting people who have had experience of DBT to take part in my research. If you are over the age of 18 and have had contact with a DBT service within the last five years, you are eligible to take part in the study. Involvement in this study will not affect your care in any way. It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?

If you agree to take part, you will be asked to attend an interview, which will take place over Microsoft Teams and be both audio and video recorded. The interview will not last more than one hour. It will be like having an informal chat and you will be asked questions about your experiences of DBT. After the interview, you will be reimbursed for your time in the form of a £10 voucher.

Can I change my mind?

Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw from the interview you can do so by letting the researcher (Zazie Lawson) know. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

Due to the sensitive nature of the topic, there is a potential risk of emotional distress for participants. The researcher will monitor for any signs of distress, and you can take a break at any time during the interview. You do not have to answer all of the questions and you may ask to discontinue the interview at any point. If you do become distressed during the interview, you may wish to contact one of the following sources of support:

- Rethink Mental Illness Advice Line

Telephone: 0300 5000 927 (9.30am - 4pm Monday to Friday)
Email: advice@rethink.org
Website: http://www.rethink.org/about-us/our-mental-health-advice

- Saneline

Telephone: 0300 304 7000 (4:30pm-10:30pm)
Website: www.sane.org.uk/what_we_do/support/helpline

- Samaritans

Telephone: 116 123 (24 hours a day, free to call)
Email: jo@samaritans.org
Website: https://www.samaritans.org

You can also contact the researcher to discuss options for further support if you wish.

How will the information I provide be kept secure and confidential?

Your basic contact details that I will use to get in touch with you will be saved on a password protected word document. When you have finished your interview, I will save the recording on a password protected laptop that only I have access to. I will then transcribe (type up) the interview and to protect your identity, I will assign you a different name. In addition, all identifiable information, for example names of other people involved, will be removed. Therefore, you will not be identifiable by any data collected or any material resulting this, such as the write-up of the research. I will be discussing anonymous information from the interviews with my supervisor. Any data that is transferred will be done so using secure UEL emails.

Once your interview has been transcribed, the interview recording will be deleted. If you wish to receive a copy of the results of this research, your contact details will be stored until these have been sent to you, and then destroyed. If you do not wish to receive a copy of results, your contact details will be destroyed after your participation in the interview. Anonymised research data, for example the interview transcripts, will be securely stored for a maximum of 3 years, following which all data will be deleted.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the ‘public task’ condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as ‘special category data’ in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

Will everything I say be kept confidential?

As mentioned above, all identifiable information will be removed from the typed-up copies of your interviews. However, my role as a researcher also includes a responsibility to the safety of the participants in my research. Therefore, if I am concerned about your safety or the safety of anyone else, I may be required to inform someone who can help. If this does happen, I will discuss this with you first. I will then discuss the situation with my supervisor, so that they can advise me on how to proceed.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Research Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations or talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Who has reviewed the research?

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me: Zazie Lawson (Email: u2075210@uel.ac.uk).

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor: Dr Lorna Farquharson. School of Psychology, University of East London, Water Lane, London E15 4LZ,
(Email: l.farquharson@uel.ac.uk)

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

APPENDIX H: Staff Participant Information Sheet

Version: 1
Date: 21.01.2022

PARTICIPANT INFORMATION SHEET

First Do No Harm: Client and Staff Experiences of Negative Effects from Dialectical Behaviour Therapy
Contact person: Zazie Lawson
Email: u2075210@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Zazie Lawson. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Doctorate in Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into both client and staff experiences of Dialectical Behaviour Therapy (DBT). Existing research has shown that DBT can be effective, however less is known about whether there are any potential negative effects The aim is to investigate which aspects of DBT, if any, can cause harm and what form this harm takes. This research also aims to explore how staff address any instances of harm, as well as to compare client and staff experiences surrounding any negative effects of DBT. In doing so, the longer-term aim of this research is to add to the evidence base regarding the risk factors of therapeutic approaches, with the hope that this will prompt critical reflection, and action within services.

Why have I been invited to take part?

To address the study aims, I am inviting staff members with experience of facilitating DBT to take part in my research. If you are over the age of 18 and have facilitated DBT within the last five years, you are eligible to take part in the study. It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?

If you agree to take part, you will be asked to attend an interview, which will take place over Microsoft Teams and be both audio and video recorded. The interview will not last more than one hour. You will be asked questions about your experiences of DBT.

Can I change my mind?

Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw from the interview you can do so by letting the researcher (Zazie Lawson) know. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

Due to the sensitive nature of the topic, there is a potential risk of emotional distress for participants. The researcher will monitor for any signs of distress, and you can take a break at any time during the interview. You do not have to answer all of the questions and you may ask to discontinue the interview at any point. You can also contact the researcher to discuss options for further support if you wish. If you do become distressed during the interview, you may wish to contact one of the following sources of support:

- Your clinical supervisor
- Staff wellbeing services relevant to your workplace
- NHS Staff Support Line, operated by the Samaritans, daily from 7:00am – 11:00pm.
  Call: 0800 069 6222
  Text: FRONTLINE to 85258

How will the information I provide be kept secure and confidential?

Your basic contact details that I will use to get in touch with you will be saved on a password protected word document. When you have finished your interview, I will save the recording on a password protected laptop that only I have access to. I will then transcribe (type up) the interview and to protect your identity, I will assign you a different name. In addition, all identifiable information, for example names of other people involved, will be removed. Therefore, you will not be identifiable by any data collected or any material resulting this, such as the write-up of the research. I will be discussing anonymous information from the interviews with my supervisor. Any data that is transferred will be done so using secure UEL emails.

Once your interview has been transcribed, the interview recording will be deleted. If you wish to receive a copy of the results of this research, your contact details will be stored until these have been sent to you, and then destroyed. If you do not wish to receive a copy of results, your contact details will be destroyed after your participation in the interview. Anonymised research data, for example the interview transcripts, will be securely stored for a maximum of 3 years, following which all data will be deleted.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

Will everything I say be kept confidential?
As mentioned above, all identifiable information will be removed from the typed-up copies of your interviews. However, my role as a researcher also includes a responsibility to the safety of the participants in my research. Therefore, if I am concerned about your safety or the safety of anyone else, I may be required to inform someone who can help. If this does happen, I will discuss this with you first. I will then discuss the situation with my supervisor, so that they can advise me on how to proceed.

What will happen to the results of the research?
The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Research Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference

presentations or talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Who has reviewed the research?

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me: Zazie Lawson (Email: u2075210@uel.ac.uk).

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor: Dr Lorna Farquharson. School of Psychology, University of East London, Water Lane, London E15 4LZ,
(Email: l.farquharson@uel.ac.uk)

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

APPENDIX I: Client Consent Form

University of East London

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

First Do No Harm: Client and Staff Experiences of Negative Effects from Dialectical Behaviour Therapy
Contact person: Zazie Lawson
Email: u2075210@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 21.01.2022 (version 1) for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using Microsoft Teams.	
I understand that my personal information and data, including audio/video recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant’s Name (BLOCK CAPITALS)

……

Participant’s Signature

……

Researcher’s Name (BLOCK CAPITALS)

……

Researcher’s Signature

……

Date

……………………..……

APPENDIX J: Staff Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

First Do No Harm: Client and Staff Experiences of Negative Effects from Dialectical Behaviour Therapy
Contact person: Zazie Lawson
Email: u2075210@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 21.01.2022 (version 1) for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using Microsoft Teams.	
I understand that my personal information and data, including audio/video recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant’s Name (BLOCK CAPITALS)

…………………………………………………………………………………………………
……………………………………

Participant’s Signature

…………………………………………………………………………………………………
……………………………………

Researcher’s Name (BLOCK CAPITALS)

…………………………………………………………………………………………………
……………………………………

Researcher’s Signature

…………………………………………………………………………………………………
……………………………………

Date

…………………….………………………………………………………………………
……………………………………

APPENDIX K: Demographics Collection Form

Demographic Information

First Do No Harm: Client and Staff Experiences of Negative Effects from Dialectical Behaviour Therapy

Contact person: Zazie Lawson
Email: u2075210@uel.ac.uk

Please answer the following questions:

1. **How old are you?**

2. **How do you describe your gender?**

3. **How do you describe your sexual orientation?**

4. **How do you describe your ethnicity?**

APPENDIX L: Client Interview Schedule

1. Could you tell me a bit about the DBT that you've received?
   Prompts:
   - How was it decided that DBT would be most suitable for you?
   - To what extent did DBT feel like a good 'fit' for you?
   - What information, if any, were you given ahead of starting DBT? Was there any mention of potential negative effects?

2. What effects did DBT have on you, considering both positive and negative aspects?
   Prompts:
   - What kind of positive effects? E.g., learning particular skills
   - What kind of negative effects? E.g., more unpleasant feelings, somatic effects, practical burden, impact on relationships or sense of self.
   - How long did they last?
   - Can you give me an example?
   - What impact did this have?

3. What is your understanding of these negative effects?
   Prompts:
   - How did these negative effects develop?
   - What aspects of DBT may have contributed to them? E.g., formulation, groups, structure, DBT contract, certain exercises or skills, endings, therapeutic relationship, language used
   - Was there anything else that may have contributed to them? E.g., service waiting times, identity, diagnosis.

4. How were these negative effects managed?
   Prompts:
   - Did you ever discuss any of these negative effects with staff? If not, what were the reasons for this?
   - If so, how did this go?
   - What was the response?
   - Were there any changes made?

5. Is there anything else that you think is important to mention about the potential negative effects of DBT?
   Prompts:
   - Was there anything you think that could have been done or included to improve the DBT you received?

6. Is there anything else that you would like to ask me?

7. Would you like to receive a copy of the research findings?

8. How are you feeling about the conversation we’ve just had?

APPENDIX M: Staff Interview Schedule

1. Could you tell me a bit about your experience as a DBT facilitator providing DBT?

   Prompts:
   - Could you tell me a bit about the programme that was offered? E.g., pre-treatment sessions, full DBT programme, telephone coaching, service setting.
   - What outcomes have there been?
   - How did you find the therapeutic process?
   - What kind of information, if any, were clients given ahead of starting DBT? Was there any mention of the potential for negative effects?

2. What positive effects of DBT have you observed?

   Prompts:
   - How long did they last?
   - Can you give an example?

3. What negative effects of DBT have you observed?

   Prompts:
   - Examples of potential negative effects? E.g., emergence of new distress / deterioration/ increase in use of emergency services?
   - How long did they last?
   - Can you give me an example?
   - Were any measures or methods for identifying negative effects used?
   - Have clients discussed any negative effects of DBT with you?

4. What is your understanding of these negative effects?

   Prompts:
   - How did these negative effects develop?
   - Do you think they may have been related to any aspects of DBT? E.g., formulation, groups, structure, certain exercises, endings, therapeutic relationship, DBT contract.
   - Were there any organisational factors that may have contributed? E.g., time, resources, team dynamics

5. How did you address any negative effects?

   Prompts:
   - Did you discuss them with anyone? E.g., in supervision, in consult, or with clients. If not, what were the reasons for this?
   - Were any changes made?
   - Did you offer a review session?
   - Can you give me an example?

6. Is there anything else that you think is important to mention about the potential negative effects of DBT?

7. Is there anything else that you would like to ask me?
8. Would you like to receive a copy of the research findings?
9. How are you feeling about the conversation we’ve just had?

APPENDIX N: Transcription Key

Transcription Key (adapted from Banister et al., 2011)

(.)	Pause
(2)	2 second pause
[inaudible]	Inaudible section of transcript
<u>Emphasis</u>	Word spoken with more emphasis than others
[laughter]	Laughter during the interview

Where an interruption by another speaker is brief it is placed in parentheses <>

Words in brackets () replace potentially identifiable information

Pseudonyms are used in place of names

APPENDIX O: UEL Ethics Application

University of East London

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2021)

FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form
(please read carefully)

1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: ▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx

	https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details

2.1	**Your name:**	Zazie Lawson
2.2	**Your supervisor's name:**	Dr Lorna Farquharson
2.3	**Name(s) of additional UEL supervisors:**	Dr Matthew Jones Chesters
		3rd supervisor (if applicable)
2.4	**Title of your programme:**	Professional Doctorate in Clinical Psychology
2.5	**UEL assignment submission date:**	01/05/2023

		Re-sit date (if applicable)

Section 3 – Project Details

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.

3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	First Do No Harm: Client and Staff Experiences of Negative Effects from Dialectical Behaviour Therapy
3.2	**Summary of study background and aims (using lay language):**	Existing research has found that some aspects of Dialectical Behavioural Therapy (DBT) have resulted in negative effects. However, there is less research available looking at what these negative effects were and no research investigating staff experiences of negative effects of DBT. This proposed study will interview both clients who have had DBT and staff who have facilitated it, to explore and compare their experiences and understandings of its negative effects. The proposed research aims to investigate which aspects of DBT, if any, cause harm, and what form this harm takes. The research also aims to explore how staff address any instances of iatrogenic harm, as well as to compare staff and client experiences surrounding negative effects of DBT. In doing so, the aim is to add to the evidence base available to clinical psychologists regarding the risk factors inherent in therapeutic approaches, with the hope that this may prompt critical reflection, and action.
3.3	**Research question(s):**	What, if any, negative effects of DBT do clients report? What, if any, negative effects of DBT do staff observe? How are these addressed? How do client and staff understandings of these negative effects compare?
3.4	**Research design:**	This study will use adopt a qualitative design, to explore the experiences of those who have either delivered or received DBT in depth. There will be no relationship between the clients and facilitators interviewed. Semi-structured interviews will be utilised to collect this data.
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	This research aims to interview between five and ten staff members who have delivered DBT and between five and ten clients who have experienced DBT. All participants will be over the age of 18 and have had contact with a DBT service within the last five years.

3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	Convenience and snowball sampling approaches will be used with the intention to access participants from a variety of DBT services. Recruitment will take place via advertisements online and word of mouth.	
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	This research will require access to Microsoft Teams, a password-protected laptop and UEL OneDrive. In addition, vouchers will be needed for reimbursing participants. Coding will be conducted manually.	
3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	Clients will be given an information sheet and consent form. Completed forms will be stored in password protected documents. For those who consent to participate, interviews will take place via Microsoft Teams. Each interview is expected to last approximately 1 hour and will be recorded and transcribed using Microsoft Teams auto-transcription. These transcribed interviews will be reviewed, edited, and stored in password-protected documents, with all identifying information removed. Original transcripts with identifying information will be destroyed following the anonymisation process. Following participation, all participants will be given a debrief form.	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	If you selected yes, please provide more information here	
3.10	**Will participants be reimbursed?**	**YES** ☒	**NO** ☐
	If yes, please detail why it is necessary.	As recognition for participants' time.	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	£10 voucher for each participant who has received DBT. The UEL People's Committee was consulted regarding the allocation of funds and agreed that reimbursement should be offered to participants who have received DBT, not those who have facilitated it.	
3.11	**Data analysis:**	Thematic analysis will be used in order to explore shared meanings and focus on meaning across a data set. In particular, reflective thematic analysis will be used, in recognition of the fact that researchers are not free of assumptions and that themes do not passively emerge from the data.	

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.

4.1	**Will the participants be anonymised at source?**	**YES** ☐	**NO** ☒
	If yes, please provide details of how the data will be anonymised.		
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** ☒	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	All identifiable information, for example geographic locations, will be replaced with a meaningful descriptive term. Pseudonyms will also be used. Search and replace techniques will be used, so that unintended changes are not made. In addition, an anonymisation log of all replacements or removals will be made and stored separately from the pseudonymised data files. If a participant wishes to withdraw, they will be re-identified using the anonymisation log.	
4.3	**How will you ensure participant details will be kept confidential?**	Consent forms and all other personal information, for example contact details, as well as audio and video files of interviews, will be stored separately in password protected files on the researcher's OneDrive, that only they have access to. This will be accessed only via a password-protected laptop.	
4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	All data will be stored on UEL OneDrive. In order to ensure a backup of material, transcriptions of interviews with pseudonyms used and all other identifiable information removed, will be stored in password protected files on both the researcher's and their supervisor's OneDrive accounts. Only the researcher, their supervisor and, if necessary, examiners, will have access to these files. Video recordings of the interviews will be stored on UEL OneDrive in a password protected file that only the researcher has access to. Video recordings on Teams are stored by default in the Microsoft Stream Library. Once a copy of each recording been downloaded and then uploaded to UEL OneDrive, any local copies will be deleted.	

4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	Only the researcher will have access to raw data, including consent forms and video recordings of interviews. Only the researcher, their supervisor and, if necessary, examiners, will have access to anonymised files, such as interview transcripts. Access to UEL storage is password protected and UEL storage is accessed via multi-factor authentication. Regular password changes will also be undertaken. Interview transcripts with all identifiable information removed and saved under pseudonyms will be shared with the researcher's supervisor via OneDrive using password protected files.	
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	Once the research has been examined and feedback given for the purpose of the thesis, all data on the researcher's OneDrive will be erased. Anonymised data, for example interview transcripts, will be secured securely on the supervisor's OneDrive for three years from the point of submission, before being erased. Participants will be made aware of this in the information sheet given prior to participating in the research.	
4.7	**What is the long-term retention plan for this data?**	Following the researcher's graduation from UEL, they will erase all data on their OneDrive. Anonymised data will be sent to their supervisor who will store this securely on their OneDrive for 3 years, before erasing it.	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

5.1	**Are there any potential physical or psychological risks to participants related to taking part?**	**YES** ☒	**NO** ☐

	(e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)			
	If yes, what are these, and how will they be minimised?	There are no potential physical risks to participants related to taking part. However, due to the sensitive nature of the topic, there is a potential risk of emotional distress for participants. The researcher will monitor participants for any signs of emotional distress. Contact details for external support organisations will be available in the participant debrief sheet. Participants will also be made aware that they can contact the researcher to discuss options for support if they so wish.		
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐	
	If yes, what are these, and how will they be minimised?	There are no potential physical risks to the researcher. However, due to the sensitive nature of the topic and the researcher's lived experience, there is a potential risk of emotional distress to the researcher. The researcher will discuss any such instances in supervision with their Director of Studies.		
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:**	**YES** ☒		
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐	
	If yes, where?	Online via Microsoft Teams		
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒	
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in	**YES** ☐		

	the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	
5.7	**Additional guidance:** ▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. ▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor). ▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.	

Section 6 – Disclosure and Barring Service (DBS) Clearance

6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	**YES** ☒	**NO** ☐

	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		
6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** ☒	**NO** ☐
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** ☒	**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	001703896708	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). ▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.		

Section 7 – Other Permissions

7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☐	**NO** ☒
	If yes, please provide their details.	Please provide details of organisation	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if	**YES** ☐	

	you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	
7.2	**Additional guidance:** ▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.	

Section 8 – Declarations

8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	Zazie Lawson
8.3	**Student's number:**	U2075210
8.4	**Date:**	17/02/2022
Supervisor's declaration of support is given upon their electronic submission of the application		

APPENDIX P: UEL Ethics Review Decision Letter – Approval Subject to Minor Amendments

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in blue | **Student:** Please complete/read sections in orange

Details

Reviewer:	**Julia Papworth**
Supervisor:	**Lorna Farquharson**
Student:	**Zazie Lawson**
Course:	**Prof Doc in Clinical Psychology**
Title of proposed study:	First Do No Harm: Client and Staff Experiences of Negative Effects from Dialectical Behaviour Therapy

Checklist

(Optional)

	YES	**NO**	**N/A**
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐

Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this

REQUIRED BEFORE THE RESEARCH COMMENCES	form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	**APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

Minor amendments

Please clearly detail the amendments the student is required to make

3.4 please indicate the client / therapist relationship: is it a therapist and their client? Or are the clients and therapist relationships separate. Its worth considering the pro/cons of either combination and justifying it.

3.7 will you be coding manually or use NVIVO?

3.8 transcripts need to be cleaned of identifying information. What happens to the original transcripts?

4.6 three years from point of transcription? Or after submission?

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature

Reviewer: (Typed name to act as signature)	Julia Papworth

Date:	16/03/2022

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data

Student name: (Typed name to act as signature)	Zazie Lawson
Student number:	U2075210
Date:	17/03/2022

Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required

APPENDIX Q: Client Debrief Sheet

PARTICIPANT DEBRIEF SHEET

First Do No Harm: Client and Staff Experiences of Negative Effects from Dialectical Behaviour Therapy

Thank you for participating in my research study on client and staff experiences of dialectical behaviour therapy (DBT) and its potential negative effects. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?
The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?
The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Research Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations or talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. All personally identifying information will be either removed or replaced. You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

After the completion of the study, anonymised research data will be securely stored by Lorna Farquharson for a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

- Rethink Mental Illness Advice Line
  Telephone: 0300 5000 927 (9.30am - 4pm Monday to Friday)
  Email: advice@rethink.org
  Website: http://www.rethink.org/about-us/our-mental-health-advice

- Saneline
  Telephone: 0300 304 7000 (4:30pm-10:30pm)
  Website: www.sane.org.uk/what_we_do/support/helpline

- Samaritans
  Telephone: 116 123 (24 hours a day, free to call)
  Email: jo@samaritans.org
  Website: https://www.samaritans.org

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me: Zazie Lawson (Email: u2075210@uel.ac.uk).

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor: Dr Lorna Farquharson. School of Psychology, University of East London, Water Lane, London E15 4LZ,
(Email: l.farquharson@uel.ac.uk)
or
Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

APPENDIX R: Staff Debrief Sheet

PARTICIPANT DEBRIEF SHEET

First Do No Harm: Client and Staff Experiences of Negative Effects from Dialectical Behaviour Therapy

Thank you for participating in my research study on client and staff experiences of dialectical behaviour therapy (DBT) and its potential negative effects. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Research Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations or talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. All personally identifying information will be either removed or replaced. You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

After completion of the study, anonymised research data will be securely stored by Lorna Farquharson for a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?
It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

- Your clinical supervisor
- Staff wellbeing services relevant to your workplace
- NHS Staff Support Line, operated by the Samaritans, daily from 7:00am – 11:00pm.
  Call: 0800 069 6222
  Text: FRONTLINE to 85258

Who can I contact if I have any questions/concerns?
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me: Zazie Lawson (Email: u2075210@uel.ac.uk).

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor: Dr Lorna Farquharson. School of Psychology, University of East London, Water Lane, London E15 4LZ,
(Email: l.farquharson@uel.ac.uk)
or
Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

APPENDIX S: Initial Codes

Client Initial Codes

1. Staff turnover
2. Poor resources
3. Distress seen as ‘therapy interfering’
4. Not focused on the ‘why’
5. Worsening distress
6. Avoidance rather than addressing
7. DBT as ‘gold standard’
8. Reducing sense of self
9. Teaching manipulation
10. Doubting self
11. Negative impact of diagnosis
12. Difficulties with group setting
13. Shame-inducing
14. Mirroring past trauma
15. Punitive
16. Feeling manipulated
17. Patronising
18. Mindfulness as negative
19. DBT as a last resort
20. Pathologizing
21. Lack of feedback opportunities
22. Not good for folk with trauma
23. Therapist being ‘cold’
24. DBT as ‘cult-like’
25. Feeling blamed / problematised
26. Interfering with future therapy experiences
27. Invalidating
28. Removed coping mechanisms
29. Reduced self-esteem
30. Negative impact on relationships
31. Negative impact on relationship to help
32. Silencing
33. Too rigid
34. Need for trauma-informed approach
35. Therapist as expert
36. High dropout rates
37. Limited utility of tools
38. Reliant on service
39. Increase in self-harm
40. Facilitator differences

41. Positives: community
42. Positives: structure
43. Positives: reflection
44. Positives: mindfulness
45. Usefulness of DBT
46. Difficulty with the ending
47. Not personalised
48. Feeling unable to complain
49. Suggestions for improvement
50. Stepford Wives
51. Exacerbating perfectionism
52. Language as damaging

Staff Initial Codes

1. High dropout rates.
2. Too rigid
3. Facilitator differences
4. Shame-inducing
5. Irreverence as harmful
6. Mirroring past trauma
7. Bullying
8. Addressed in consult
9. Big time commitment
10. Worsening distress
11. DBT as a last resort
12. Punitive
13. Patronising
14. Poor resources
15. Placing blame with the client
16. Addressed by changing staff roles
17. Addressed in supervision
18. Addressed by change in language
19. Addressed by increase in flexibility
20. Addressed by reflecting on mindfulness
21. Not focused on the ‘why’
22. Need for more relational work
23. DBT as ‘gold standard’
24. Avoidance rather than addressing
25. Difficulties with group setting
26. Negative impact of diagnosis
27. Not adapted for neurodiverse folk

28. Judgemental
29. Not good for folk with trauma
30. Difficulty with the ending
31. DBT as ‘cult-like’
32. Too much information
33. Not the full programme
34. Addressing DBT as gold standard
35. Usefulness of DBT
36. Addressing negative impact of diagnosis
37. Negative impact on relationship to help
38. Addressed by using other therapeutic modalities
39. Jargon
40. Who contains the container?
41. Organisational limitations
42. DBT in a glass house
43. Mindfulness as negative

APPENDIX T: Transcript Example

Hallie: Um. I definitely think the mindfulness aspect felt like it made things worse for me and since being in DBT.

*<**Zazie:** Mm-hmm>*

Hallie: I have read that there are, you know, there is literature out there about how when you're traumatized, mindfulness can be really bad for you. So it did feel like.

*<**Zazie:** Yeah>*

Hallie: Yeah, like they thought it was like the cure for everything, when actually.

*<**Zazie:** Mmm>*

Hallie: They just had no understanding of trauma at all. Like I remember at one point because a lot of the difficulties in the relationship, I think was because I was struggling to trust her and she was saying you're not trusting me, she said: "You need to write a pros and cons list of choosing to trust me versus not choosing to trust me" and it's like you have no understanding of trauma. Like, yeah. I think being made to like share things in the group and if you leave the group because you're upset after five minutes, the facilitator is gonna come out and try and manipulate you into coming back in, because they will. They'll be like "this is part of the treatment and you're missing it. It's a therapy interfering behaviour." Like. Yeah, like any resistance is categorized as a therapy interfering behaviour when actually any sane person would be like resistant to this right now. And it. Yeah, it's like. And in a way like me being so resistant, is the reason I survived my traumatic experiences. So it's like pathologizing my survival.

*<**Zazie:** Yeah>*

Hallie: Umm. Yeah, definitely the way that they work with resistance, like just. If you're not complying with them, then you're bad and you're therapy interfering and there's no scope for like collaboration, and the therapist is always the expert, and they always know best. And you always have to do what they say. And yeah.

Zazie Lawson
Mindfulness as negative

Zazie Lawson
Not good for folk with trauma
Mindfulness as negative

Zazie Lawson
DBT as 'gold standard'

Zazie Lawson
Not good for folk with trauma

Zazie Lawson
Not good for folk with trauma

Zazie Lawson
Feeling manipulated

Zazie Lawson
Distress seen as 'therapy interfering'

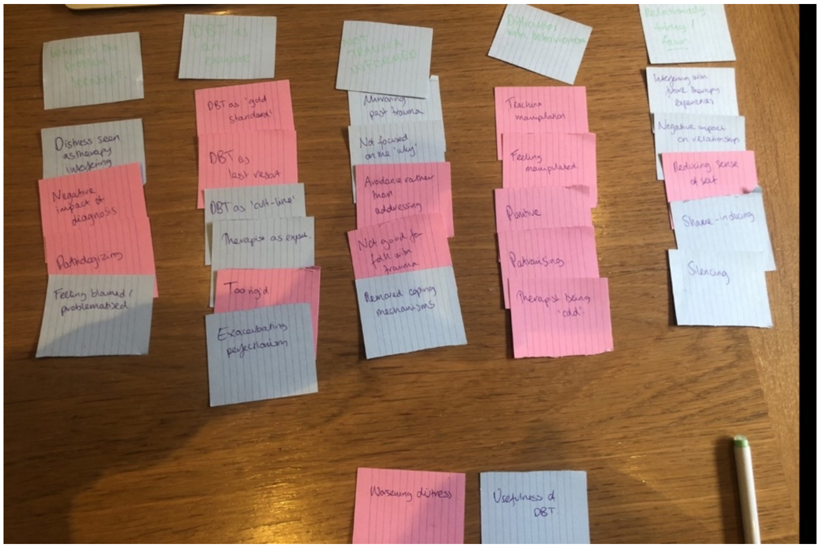
Zazie Lawson
Pathologizing

Zazie Lawson
Distress seen as 'therapy interfering'

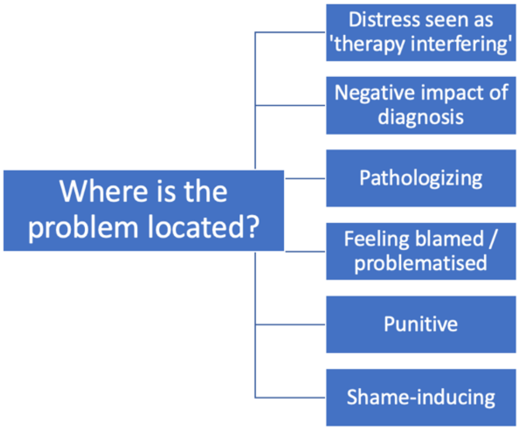
Zazie Lawson
Therapist as expert

APPENDIX U: Theme Development

Client Theme Development

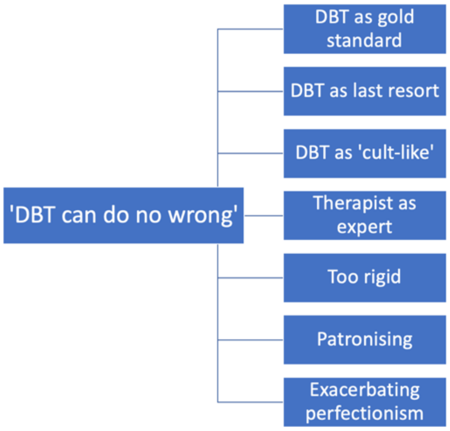


Theme 1



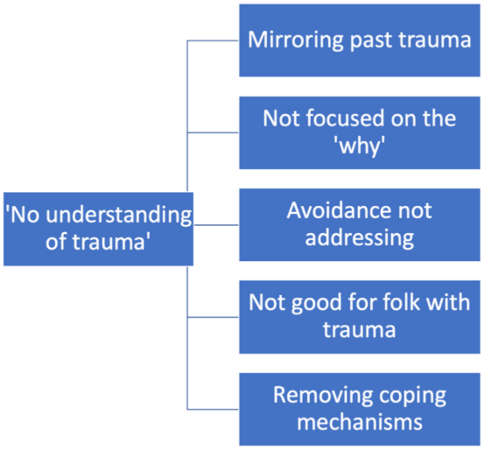
- Where is the problem located?
  - Distress seen as 'therapy interfering'
  - Negative impact of diagnosis
  - Pathologizing
  - Feeling blamed / problematised
  - Punitive
  - Shame-inducing

Theme 2



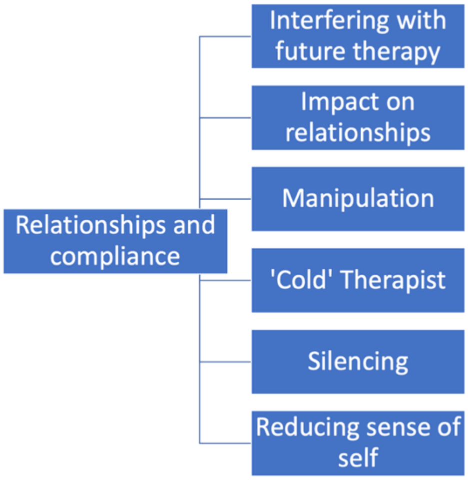
- 'DBT can do no wrong'
  - DBT as gold standard
  - DBT as last resort
  - DBT as 'cult-like'
  - Therapist as expert
  - Too rigid
  - Patronising
  - Exacerbating perfectionism

Theme 3



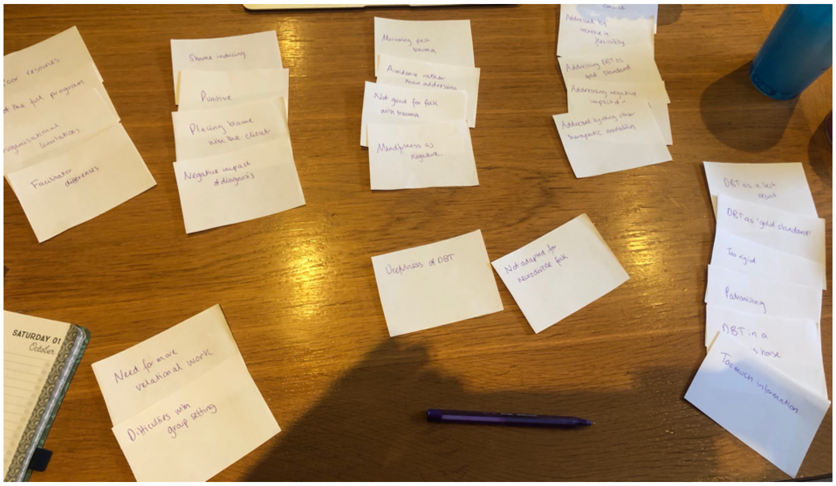
- 'No understanding of trauma'
  - Mirroring past trauma
  - Not focused on the 'why'
  - Avoidance not addressing
  - Not good for folk with trauma
  - Removing coping mechanisms

Theme 4

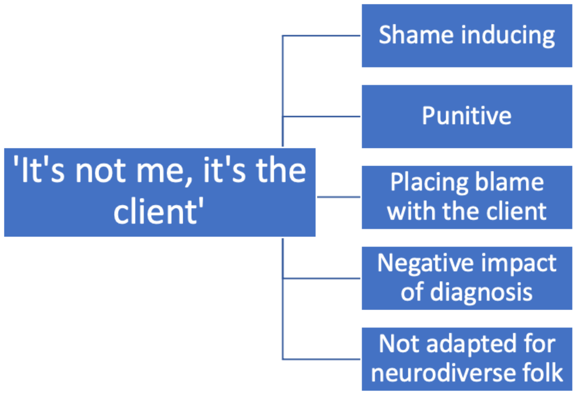


- Relationships and compliance
  - Interfering with future therapy
  - Impact on relationships
  - Manipulation
  - 'Cold' Therapist
  - Silencing
  - Reducing sense of self

Staff Theme Development

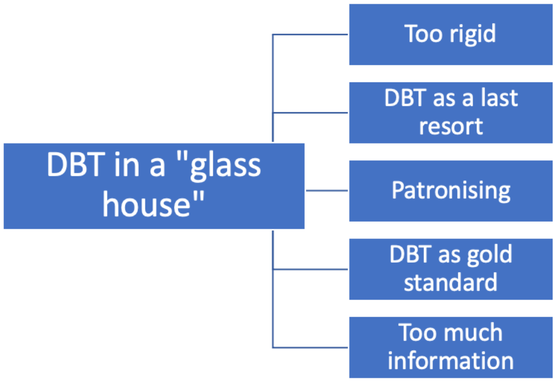


Theme 1:


'It's not me, it's the client'

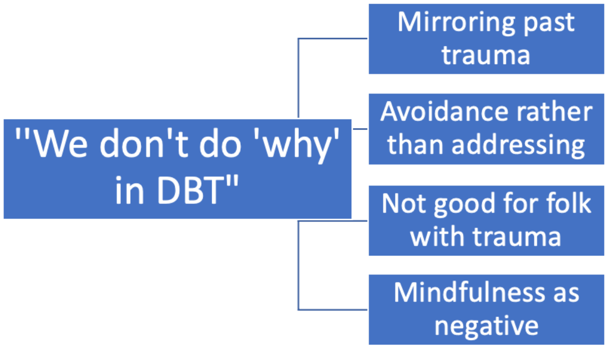
- Shame inducing
- Punitive
- Placing blame with the client
- Negative impact of diagnosis
- Not adapted for neurodiverse folk

Theme 2:


DBT in a "glass house"

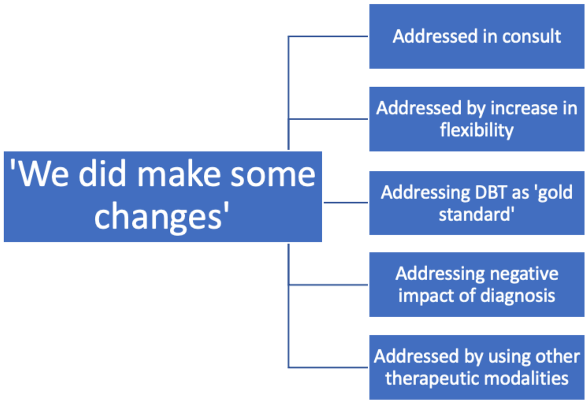
- Too rigid
- DBT as a last resort
- Patronising
- DBT as gold standard
- Too much information

Theme 3:


"We don't do 'why' in DBT"

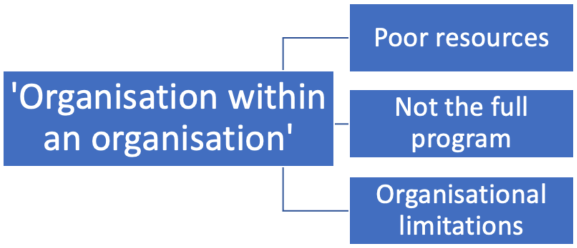
- Mirroring past trauma
- Avoidance rather than addressing
- Not good for folk with trauma
- Mindfulness as negative

Theme 4:


'We did make some changes'

- Addressed in consult
- Addressed by increase in flexibility
- Addressing DBT as 'gold standard'
- Addressing negative impact of diagnosis
- Addressed by using other therapeutic modalities

Theme 5:


'Organisation within an organisation'

- Poor resources
- Not the full program
- Organisational limitations

APPENDIX V: Plain Language Summary of Research Findings

First Do No Harm: Client and Staff Experiences of Negative Effects from Dialectical Behaviour Therapy

Thank you to all participants!

Who conducted the research?
My name is Zazie Lawson (they/them). I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Doctorate in Clinical Psychology.

Why was the research needed?
Existing research has shown that Dialectical Behaviour Therapy (DBT) can be effective, however less is known about whether there are any negative effects.

What were the research aims?
The aim of this research was to investigate which aspects of DBT, if any, can cause harm and what form this harm takes. This research also aimed to explore how staff address any instances of harm, as well as to compare client and staff experiences surrounding any negative effects of DBT.

When did the research take place?
The research began in April 2021 and finished in May 2023.

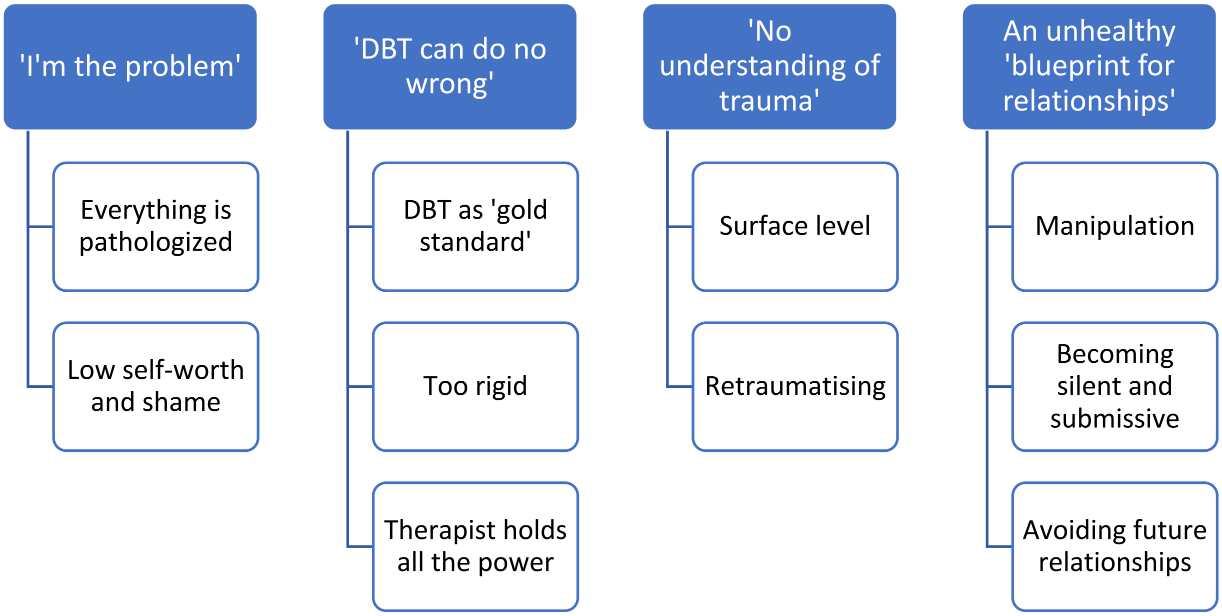
How were service users included?
One person with lived experience of DBT helped to develop the interview questions for client participants.

Who participated and what did it involve?
Eight client participants were interviewed for about one hour about their experiences of receiving DBT. They were asked about any negative effects they experienced, and their understandings of these. Seven staff participants were interviewed for about one hour about their experiences of delivering DBT. They were asked about any negative effects they observed, and how they addressed these.

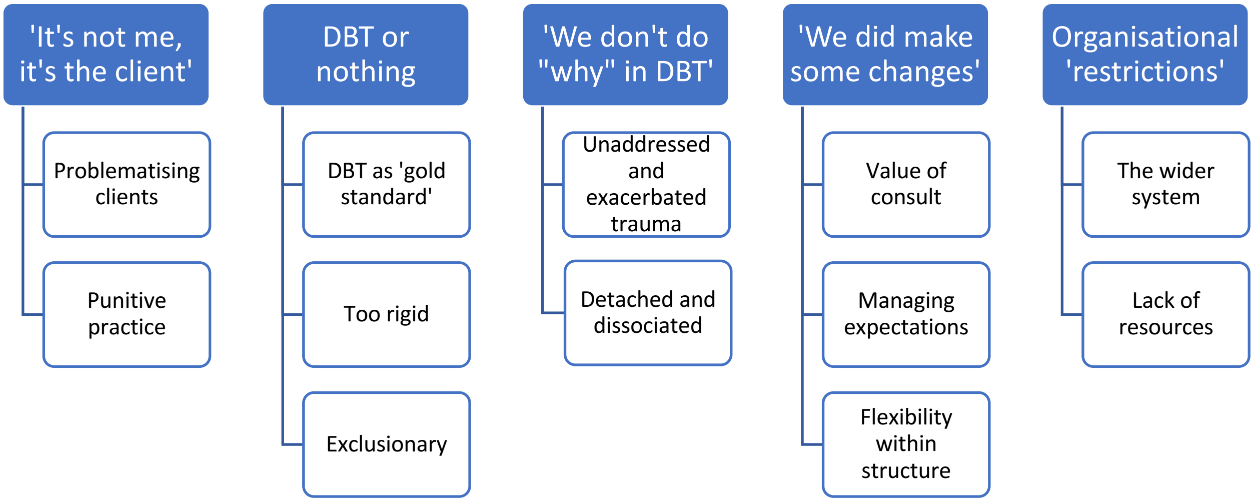
What methods were used?
Reflexive thematic analysis was used. This involved finding patterns or common ideas that came up in the interviews.

What were the results?

Four themes, each with several sub-themes, relating to negative effects from DBT were generated from client interviews. These can be seen below:



Five themes, each with several sub-themes, relating to negative effects from DBT were generated from staff interviews. These can be seen below:



Key Findings:

- Both staff and client participants described DBT as blaming towards clients, too rigid, and not trauma informed.
- Client participants described negative effects which arose from the therapeutic relationship. Staff participants did not describe this.
- Staff participants described organisational factors that may have contributed to negative effects, for example not having enough funding.
- Staff participants described some of the things they did to address negative effects. These included being more flexible in their practice and being open about the limitations of DBT.

How will the findings be used?
The research has been written up as a thesis and submitted for assessment. It will be publicly available on UEL's online Research Repository. The aim is for the findings to also be shared with clinicians, academics, and members of the public through talks and journal articles.

Where can I learn more about this research?
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me: Zazie Lawson (Email: u2075210@uel.ac.uk).