

Abstract

Purpose: To identify, appraise and synthesise findings from qualitative studies of individuals diagnosed with Borderline Personality Disorder who have experienced Dialectical Behaviour Therapy, to gain further understanding of their perceptions of the process and impact of therapy.

Methods: We conducted a comprehensive systematic search of the literature from several online databases, and appraised them using an adapted version of the Critical Appraisal Skills Programme tool. A meta-ethnographic approach was used to synthesise the data.

Results: Seven studies met the criteria to be included and their quality subsequently appraised. Four main themes were identified through the synthesis process: Life before DBT; the relationships that support change; developing self-efficacy; a shift in perspectives.

Conclusions: The findings of the synthesis highlight the importance of a number of key factors in the process of DBT, and the impact that the therapy has both on day to day life and on individuals' identity.

Practitioner points:

- Existing outcome measures may not capture the complexity and magnitude of impact of DBT on individuals with BPD

- Exploring first-hand accounts of individuals undertaking DBT can offer unique insight into the processes of therapy

Background

Borderline Personality Disorder

Borderline Personality Disorder (BPD) is a diagnosis given to individuals who experience difficulties with emotional regulation, impulse control, interpersonal relationships and self-image. Despite an estimate of between 0.3 and 3% of the population meeting criteria for BPD (Lenzenweger et al., 2007), individuals with the diagnosis account for a far greater proportion of mental health service users (Sansone & Sansone, 2007), often presenting in crisis (Moran, 2002).

Treatment for BPD

Historically, professionals have viewed those with the diagnosis as difficult to treat (National Institute for Mental Health in England, 2003). Key challenges are risk management, with suicide attempts and/or self-harm common in 69-80% of those diagnosed (Frances, Dyer & Clarkin, 1986; Zanarini et al., 2008), frequent hospitalisation (Moran, 2002) and high rates of treatment failure (Choi-Kain & Gunderson, 2008). The diagnosis has in some cases been a barrier to individuals accessing services (Fanaian, Lewis, & Grenyer, 2013).

There is recent evidence that BPD is treatable, with psychotherapy regarded as the first-line treatment (Stoffers, Völlm, Rucker, Timmer, Huband & Lieb, 2012).

Various psychological therapies have demonstrated BPD symptom reduction (Brazier et al., 2006; Biksin & Paris, 2012; NICE, 2009), including Dialectical Behaviour Therapy (DBT) (Comtois, Elwood, Hodcraft, Smith & Simpson, 2007), Cognitive Therapy (Davidson, Tyrer, Norrie, Palmer & Tyrer, 2010) and Mentalization-Based Treatment (Bateman & Fonagy, 2009). Current National Institute for Health and Care Excellence (NICE, 2009) guidelines advocate psychological intervention for BPD, which is structured and based on an explicit and integrated theoretical approach.

No evidence supports one psychotherapy as more effective than others in treating BPD (Leichsenring, Leibing, Kruse, New & Leweke, 2011). However, the majority of randomised control trials have been of DBT (NICE, 2009) (e.g. Carter, Willcox, Lewin, Conrad & Bendit, 2009; McMain, Guimond, Streiner, Cardish & Links, 2012). Despite widespread popularity, concerns have been raised regarding the robustness of the evidence base (Feigenbaum, 2007). The existing evidence base also largely neglects the experience of individuals receiving DBT. Client perspectives have traditionally been neglected in psychotherapy research, but there are evidential, political, and conceptual arguments for their inclusion (McMaran, Ross, Hardy & Shapiro, 1999). The NICE (2009) guidelines refer to two qualitative studies of experience of individuals who had DBT, but offer no synthesis of the findings. Since the publication of the guidelines, further studies of the experience of DBT have been published.

Dialectical Behaviour Therapy

Dialectical Behaviour Therapy (DBT) (Linehan, 1993a; 2015) is a

cognitive-behavioural treatment for BPD, intended primarily to reduce rates of suicidality and self-harm. The structured treatment consists of four components: individual therapy, group skills training, consultation with therapist, and therapist consultation meetings. Typically conducted over a 12-month period, it has five key aims (Linehan, 1993a; 1993b; 2015), to:

- increase motivation to change and use skills provided
- teach skills for more effective emotional and behavioural regulation
- support the individual to generalise these skills to the wider environment
- help shape an environment that reinforces the use of the skills
- increase the therapist's own skills and motivation to keep working with the client.

Theoretical background to DBT

DBT is based on a biosocial theory of BPD, which posits that the core difficulties seen in this diagnosis stem from the relationship between two factors. Firstly, those diagnosed have a biological dysfunction of the emotion regulation system; and secondly, their environment is invalidating, inhibiting the use of positive behavioural skills and reinforcing the use of less helpful ones (Linehan and Kehrer, 1993; Feigenbaum, 2007). Behaviours that constitute criteria for a diagnosis have been reinforced over time, so DBT aims to teach clients new behavioural skills and support the replacement of unhelpful behaviours with more adaptive ones.

In trialling different therapeutic techniques, Linehan (1993a) found that a therapeutic stance grounded purely in either change or acceptance techniques was experienced as invalidating by clients. Resulting from this conflict, DBT is *grounded in a 'dialectical philosophy that encourages the balance and synthesis of both acceptance and change'* (Lynch et al., 2006, p.461).

Effectiveness of DBT

DBT is an evidence-based and well-established treatment, according to the criteria outlined by Chambless and Hollon (1998). Several randomised controlled trials suggest that individuals engaged in DBT experienced statistically significant improvements compared to treatment as usual (Harned et al., 2008; Koons et al., 2001; McMain, Korman & Dimeff, 2001; Linehan et al., 1999; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 2002; Verheul et al., 2003). This includes reductions in frequency and severity of self-harm, suicidality, anger, anxiety, depression, and lengths of frequency of hospitalisation, together with improved treatment retention (Koons et al., 2001) and global functioning (Linehan et al., 1999).

When compared to more 'active' control conditions than treatment as usual, such as general management according to American Psychiatric Association (APA) guidelines (McMain et al., 2009) or community treatment by experts (CTBE), no statistically significant differences were found in terms of pathology-related outcomes. However, treatment retention in DBT was significantly superior to CTBE (Linehan et al., 2006), and some small effects were noted in favour of DBT

in relation to outcomes of suicidality and depression (Stoffers et al., 2012). While the efficacy of DBT in comparison to other treatments remains debated, it has the most comprehensive empirical support of all treatments for BPD is widely used in clinical practice.

Mechanisms of change in DBT

Mechanisms of change, that is, the 'processes by which therapeutic change occurs' (Kazdin & Nock, 2003: p. 1117), factors that mediate the relationship between treatment and outcome, are beginning to be understood. These may include factors common to all to therapies, such as those outlined by Weinberger and Rasco, (2007), as well as factors considered unique to DBT. Mechanisms of change are hypothesised based on theory and then demonstrated through quantitative investigation, although research methods often fall short of achieving this (Kazdin, 2007).

DBT can be considered a 'complex intervention' due to having several interacting components (Craig et al., 2008). There are various potential mechanisms of change that may be associated with unique aspects of DBT and underpinning theory (Lynch, Chapman, Rosenthal, Kuo & Linehan, 2006). For example, there has been investigation into the use of new behavioural skills mediating between therapy and outcomes, with a recent study reporting decreases in suicide attempts and depression and an increase in control over anger all being mediated by the reported use of skilful behaviour (Neacsiu, Rizvi, & Linehan, 2010; Kramer et al., 2016). Yet this factor does not account for every outcome of DBT. Despite

recent developments, most proposed mechanisms of change in DBT are yet to be empirically tested (Lynch et al., 2006).

The majority of research surrounding DBT's efficacy, impact and process relies on quantitative methodology. A smaller number of explorative studies using qualitative methods have aimed to understand how individuals experience DBT. Although investigating clients' perspectives may not equate to clarifying mechanisms of change, it may highlight processes and impact of DBT not considered by researchers. As qualitative research is concerned more with meaning and experience than measuring the effect of certain variables, it arguably allows for a more in depth understanding of a particular experience or phenomenon (Willig, 2001). This approach can offer an explanation for varied findings in quantitative research, and further understanding of the relationship between variables or phenomena (Harden et al., 2004).

Single qualitative studies alone have been criticised for their limited impact on policy and practice (Silverman, 1998) and each individual study should be situated within a broader context (Sandelowski & Barroso, 2002). Synthesising different primary qualitative accounts of a phenomenon can help to generate further understanding, build theory and better communicate the experiences of individuals (Campbell et al., 2003). Metasynthesis offers a way to appraise and combine the findings of such studies (Lloyd Jones, 2004).

Aims

The aims of this review were to develop understanding of the perceptions of

individuals diagnosed with BPD who have experienced DBT, about the process and impact of the therapy. The objectives were to systematically identify and critically appraise relevant qualitative studies, and synthesise the results of identified studies using meta-synthesis.

Method

Searching

We conducted a comprehensive search of the literature using the following databases from inception till 8/7/16: PsycINFO, MEDLINE (1946-present), Cumulative Index of Nursing and Allied Health Literature (CINAHL) and EMBASE. Databases were selected due to the range of literature that they cover and their inclusion of research from different disciplines.

The following search terms were used in combination, with adaptations made where necessary for the different databases: borderline personality disorder, borderline, BPD, emotionally unstable personality disorder, experience¹, attitude\$, view\$, opinion\$, perspective\$, interview\$, dialectical behaviour therapy, dialectical behavior therapy, dialectic\$, DBT. To remain inclusive, no limits were placed on the searches in terms of time or type of publication. References of eligible studies were then hand-searched for potential additional publications. Two grey literature databases, GreyLit and Ethos, were also searched for relevant unpublished research. These were searched using single search terms 'dialectical behavio(u)r therapy' and the results were hand-

¹ The symbol \$ was used in some databases to allow for truncation of search terms, ensuring a broad search of the literature.

searched to select any that appeared relevant.

Selection

Figure 1 details the process of selection using a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Liberati et al., 2009). Duplicates were removed, before the abstracts of each of the remaining articles were assessed for their eligibility. If the abstract did not provide sufficient information to determine the eligibility of the study, the full text was read. Studies were included based on the follow criteria:

Qualitative methodology (or mixed methods study with a distinct qualitative section)

Published in English

- Used data collected from first-hand accounts of service users, evidenced by direct quotations
- Participants had a diagnosis of BPD (or Emotionally Unstable Personality Disorder according to International Classification of Diseases 10th edition (ICD-10²))
- Participants had had or were having a programme of DBT³
- The DBT programme is explicitly described and consists of the key

² This review will use the term Borderline Personality Disorder (BPD) as it is a more widely recognised term in clinical practice and research, and is also the terminology used in the literature surrounding Dialectical Behaviour Therapy.

³ Whilst it is recognised that individuals currently partaking in DBT may not be able to comment on the full impact of the treatment, it was acknowledged that their experiences may provide further insight into the process of DBT and any changes they experienced.

components of DBT according to Linehan (1993a): skills training, individual sessions, telephone consultation and consultation meetings.

- Studies could include both participants who did and who did not respond to DBT treatment.

Studies were excluded if:

- DBT was delivered to someone other than the individual with a BPD diagnosis, e.g., family members
- Quotations could not be clearly attributed to service users, so could not be separated from views of others, e.g., professionals or family members.

The quality of studies did not inform the selection process as all relevant studies had the potential to contribute to answering the research question. The debate surrounding the use of quality appraisals in the selection of qualitative papers has been articulated elsewhere (Dixon-Woods et al., 2007), with others suggesting quality should not determine inclusion or exclusion (Atkins et al., 2008; Malpass et al., 2009).

Quality was assessed using an adapted version of the Critical Appraisal Skills Programme tool (CASP), a systematic scoring system for the appraisal of qualitative studies (Feder, Hutson, Ramsay, & Taket, 2006). The CASP consisted of nine criteria, which allowed the reviewers to consider key methodological components relevant to qualitative research. The CASP was adapted so that in response to the criteria, studies were scored as follows: zero if not met, one if partially met, and two where definitely met. Each study was assessed by two review authors independently, and disagreements resolved through discussion.

Data abstraction

Following selection and quality appraisal the data were extracted and synthesised using a meta-ethnographic approach as developed by Noblit and Hare (1988) and adapted by Britten et al. (2002) for use in health research. Studies were read and re-read in detail, before the data were extracted, including the findings, direct quotations, discussions and conclusions. Data were then organised into first, second and third order constructs (Malpass et al., 2009). The aim was not to simply build themes from the raw data (first order constructs) but to build on each author's interpretations of the data (second order constructs) to devise third order constructs, which are seen as the overarching interpretations of the synthesists.

Synthesis

The final stage was to synthesise the findings using three forms of synthesis (Noblit & Hare, 1988):

- Reciprocal synthesis: concepts shared across papers are brought together under an existing concept from one of the papers, or under a new concept which accounts for the interpretations of findings across the studies.

- Refutational synthesis: contradictory concepts between papers are brought together in a single concept which allows for the inconsistency.

- Line of argument synthesis: different concepts across papers, whether consistent or conflicting, are brought together to offer new meaning. This

can be seen as the construction of an argument about what a series of papers say, accepting that each paper may well capture a different aspect of a particular phenomenon or experience.

Results

Seven studies were included for review, with a total of 95 participants. Two were theses, and five were articles published in peer-review journals. Table 1 provides an overview of the studies' key characteristics.

Quality appraisal

Debate about the use of quality appraisal in qualitative research surrounds the selection and application of criteria but also whether it should be used at all in the context of meta-ethnography (Mays et al., 2000; Sandelowski & Barroso, 2002). In this review, quality appraisal was utilised to explore the quality of the contributions each paper made to the synthesis and also to inform future research quality.

Table 2 details the CASP scores allocated to each study, which had variable quality. The two theses (4, 5) were awarded a high score on the CASP checklist, but this was due in part to their more generous word count allowing more detailed description, rather than necessarily relative quality. All studies had clear research aims, and appropriately selected a qualitative methodology that addressed their aims. Purposive sampling was used across each of the studies and the process of recruitment was generally adequately described, Page 13 of 44.

though few discussed this in detail. The studies collected their data through interviews, which appeared justified and well described. The findings in all studies were interwoven with direct quotes which appeared relevant and supportive of the authors' discussions.

Four of the seven (1, 2, 3, 6) did not discuss saturation of data, which could impact on the quality of a study and impede content validity (Kerr, Nixon & Wild, 2010). Saturation is defined by Morse (1995) as 'data adequacy', and refers to the point at which no new information is obtained from data collection. Without consideration of saturation, it may be that the studies in question did not capture the breadth of participants' experiences. Two (2, 3) did not adequately discuss potential ethical issues involved in their research. Whilst the assumption was in some cases made in the text that the research had been conducted in line with ethical standards, this was rarely explicit. Surprisingly, only two studies (3, 7) actively included participants who had dropped out of treatment in their sample, with others either excluding them or failing to make explicit this aspect of their inclusion criteria. Despite all studies presenting findings clearly and evidencing these using participant quotes, several failed to draw on existing literature to place their findings into context. Overall, there are clear areas for improvement in quality in future research.

Through the synthesis process, four main third order constructs were identified, with a number of subthemes (Table 3). There was a clear chronological thread through each of the papers, which reflected in the four constructs.

Synthesis

Life before DBT: a hopeless beginning

All but two studies (6, 7) discussed individuals' reflections on life before DBT, providing a context to the beginning of treatment and a baseline from which to measure progress. Individuals described a lack of hope for the future and a sense of distress and emotional turmoil that they wanted to end (3, 4, 5). For many, hopelessness stemmed from a lack of understanding of themselves, and the sense that there was no alternative: *'I didn't know there was anything to change really, I thought that was my life. That those behaviours I would continue with, I didn't hope for anything different'* (Desperles, 2010, p.101).

Individuals described feeling not understood, unsupported and judged by others due to their diagnosis: *'Yes because they see us as, you know we get told we're attention seekers or we're not feeling what we're feeling'* (Desperles, 2010, p.101).

Hope for change was made scarcer due to the lack of choice of treatments for BPD, with discussion of limited options and ineffectiveness of previous attempts at treatment. DBT was seen by some as the only option, and something decided by professionals rather than by the individual, e.g. *'They thought I would be a good candidate, so I had an interview with them and filled out a form'* (Hodgetts et al., 2007, p.174).

The hopeless beginning was characterised by exhaustion, suffering

and a tendency to cope through the use of self-destructive behaviour (3, 1, 4). For some, a desire for things to be different further provoked suicidal thoughts (4), but for others it turned hopelessness into motivation to change (3).

The relationships that support change

The therapeutic relationship was discussed in every study, as providing the context in which change could occur in response to DBT. Three key subthemes were identified:

Feeling valued, respected and listened to

Five studies discussed the importance of the therapists' attitudes towards clients (1, 2, 3, 4, 5). Above all, it appeared fundamental that individuals did not feel judged but valued and respected. In three studies, individuals spoke about being open and honest with their therapist, and the therapist respecting their views (1, 2, 5). Many participants described the therapeutic relationship as one of equality and companionship, where there is a degree of therapist disclosure helping individuals feel validated and normalised:

'sometimes they put their personal experience in as well which I think is helpful, it stops you feeling quite so much like a schoolchild, makes it more of an interactive experience...' (Barnicot et al., 2015, p.6).

In one study, where there was a perceived imbalance of power in a relationship, therapy was less effective (2).

The importance of therapist knowledge

Individuals in four studies highlighted the importance of the therapists' knowledge in fostering positive therapeutic relationships (2, 5, 6, 7). Each of these discussed the differences between individuals' experiences of mental health professions outside of the DBT programme, and those within it in relation to their understanding of BPD. Specialist knowledge was recognised as of value and this appeared important particularly for supporting the application of skills.

The commonality of experience

Five studies discussed the experience of learning in a group environment as largely positive (1, 2, 3, 4, 7). Being part of a group was seen as a validating and normalising experience, in which individuals met others who shared similar experiences: *'I felt very lonely in my suffering, but in the group I felt, my god, here's a bunch of people that all struggle like I do, just to survive another day'* (Perseuius et al., 2003; p.223). Across studies there was an acknowledgement that learning in a group was at times hard, and despite a general sense that this was manageable there were contrasting individual accounts suggesting that at times therapy in a group setting was too overwhelming.

Developing self-efficacy

Three distinct aspects of individuals' experiences of DBT were identified that seemed to highlight developing self-efficacy as an outcome of the therapeutic process: learning the skills to manage emotions; taking ownership and responsibility; and changes in relationships.

Learning the skills to manage emotions

All studies discussed the importance of learning new skills to regulate emotions and tolerate distress. Individuals reported finding the skills helpful in allowing them to cope with situations they would have found overwhelming prior to therapy. Some described the skills teaching as normalising and validating, acknowledging that they came to therapy with skills and were supported to extend and use these (4, 5).

Several studies discussed the process of the skills becoming automatic. Individuals described how through practice and repetition, the skills they learnt gradually became part of their own behavioural repertoire: *'the good thing about DBT is that the skills become ingrained. Over that year, the more you do it the more it becomes part of you, 'til you're doing it without knowing you're doing it'* (Barnicot et al., 2012, p.8). The notion of the skills becoming automatic continued beyond therapy with individuals describing them as *'second nature'* (McSherry et al., 2012, p.544).

The impact of DBT on individuals' ability to manage emotions was discussed in five studies (1, 2, 4, 6, 7). Participants highlighted a shift in their confidence in managing difficult situations and a variety of emotional experiences. Several individuals saw their progress in managing emotions in the reduction in their self-harming behaviour, describing how DBT provided alternative ways to cope. However some individual accounts suggested that there remained situations where utilising the skills felt too difficult due to overwhelming emotions. One participant discussed the concept of not being 'allowed' to self-harm,

yet struggled to use the alternative strategies (2). In two studies (3, 7) individuals described how using the skills became particularly difficult in the closest of relationships.

Four studies included the acknowledgement that the language used in the skills teaching created a barrier to learning the skills (2, 4, 6, 7): *'it sometimes feels like some of the technical words are a bit off-putting. . . possibly making the language more accessible would make it seem less threatening.'* (Barnicot et al., 2015, p.6). The potential for the language to be intimidating and difficult to interpret was evident in many of the accounts: *'like a lot of jargon that's read out to you – does that come with subtitles?'* (McSherry et al., 2012, p.543).

Taking ownership and responsibility

Through reciprocal translation the need to take ownership and responsibility for making changes was identified across five studies (1, 2, 3, 5, 7). Individuals discussed the commitment needed to progress in DBT, and the challenging nature of the treatment. There was a clear notion that change comes from within, and only when an individual takes responsibility for making changes will progress happen: *'it's about me getting off my ass and getting my shit together, not a counsellor doing it for me, and that's why it works.'* (Cunningham et al., 2004, p.251).

The one exception to this was detailed in the only study conducted in an in-patient setting (5). Participant accounts did not conflict with the notion of taking ownership and responsibility, but in the initial stages of DBT, individuals

found safety in passing over responsibility to staff before they gained sufficient confidence to take it back.

Changes in relationships

Refutational synthesis highlighted conflicting experiences of the impact of DBT on participants' relationships. In two studies, changes in relationships were seen as positive, with individuals describing the benefits of improved communication and assertiveness (2, 6). In contrast, participants in one study described how changes in their own communication and assertiveness had a negative impact on their relationships (4). Individuals described how relatives and friends struggled to accept the changes they had made through therapy, and how being more assertive in their communication had the potential to cause conflict: *'well my mum has said oh I don't like this new you, you know what I mean?'* (Tsakapoulou, 2009: p.83).

A shift in perspectives

There was an overwhelming positivity across accounts of the impact of DBT on individuals' perspectives about themselves and the future. Two key sub-themes were constructed:

Insight and acceptance

Insight and acceptance was identified across all but one study (7). Insight related to a greater understanding of the origins of individuals' difficulties, and into the

processes that led to problematic behaviour (2, 4). Individuals reflected on their past selves, acknowledging where and why they had previously had difficulty managing their emotions: *'I have gained a lot of insight. About my own life, about what I have been doing right or wrong, well they say there is no right and wrong just effective and ineffective...'* (Cunningham et al., 2004, p.251).

Discussions surrounding acceptance were in relation to individuals accepting their difficulties, and the view that whilst those difficulties had not been taken away, DBT taught them the means of managing them: *'I've still got paranoia now...that hasn't changed, but I can control it'* (Hodgetts et al., 2007, p.175). One study described a shift in identity of individuals through DBT and a 'decoupling from the diagnosed self' (6). This is best described through the following quote: *'I kind of got more comfortable being me and going yeah, this is me, so what I'm [name], I'm not borderline [name]'* (McSherry et al., 2012, p.544).

Hope for the future

Across six studies individuals' accounts of the impact of DBT were united around a theme of hope. In two of the studies themes of the therapy as 'life-changing' and 'life-saving' were identified (2, 5). Across the various accounts there was a sense of a shift from a hopeless beginning to hope for the future, a desire to go on living and feelings of empowerment. Some individuals spoke of the more visible markers of change: *'I have a lot more hope. Before I got into DBT it just seemed like the only solution to my problem was hospitalisation...since DBT I haven't been hospitalised at all.'* (Cunningham et al., 2004, p.255). Others spoke about shift in outlook, to one that focused on a future: *'before DBT there was no future and now there is'* (Hodgetts et al., 2007).

In some accounts there remained a sense of fear and uncertainty about the future (1, 4). Fear was discussed in relation to a fear of returning to their previous selves: *'I'm scared of things going back to how they were before'* (Desperles, 2010, p.118) whereas uncertainty related more to the process of recovery and the confusion over the meaning and nature of recovery in BPD: *'I'd like to know whether you can recover fully or whether you do just manage; I've never had an answer to that...'* (Tsakapoulou, 2009, p.94).

Discussion

In this review we aimed to critically appraise and synthesise findings from qualitative studies to gain further understanding of individuals' perceptions of the process and impact of DBT. The included studies were of different methodological quality, but each offered first hand data and insightful second order constructs which when synthesised offered new meaning and clarity. For the most part, the aims of the studies were broad and aimed to capture the experiences of DBT. The synthesis highlighted clear homogeneity in the data across the studies with participants reporting similar experiences. Whilst there remains the possibility that further research with similar objectives and methodologies will produce novel findings, future studies may benefit more from a narrower focus, perhaps considering a single process or outcome such as self-efficacy over the course of therapy.

In addition, further research would benefit from improved methodological rigour, and particular attention to quality measures if using qualitative methods such as the saturation of data and the importance of relating findings to the

wider theoretical context. Studies would also benefit from detailing further the steps taken to consider and address ethical issues, particularly in light of the reliance of qualitative research on the researcher-participant interaction (Sanjari, Bahramnezhad, Fomani, Shoghi, & Cheraghi, 2014). Finally, research would benefit from gathering data from a wider sample, inclusive of those individuals who drop out of a DBT programme.

A process of change was identified from life before DBT through to the impact of the therapy on individuals' lives. Several important aspects of the therapeutic content and environment were considered, and allow the generation of some hypotheses regarding the psychological processes underlying change in DBT.

Process of DBT

The synthesis highlighted several key aspects of DBT that participants felt influenced the outcomes of therapy. Although individual experiences do not directly indicate the process of change as such, they highlight important aspects of the therapy that they felt were relevant to the outcomes later experienced. Increased hope, as an example, could be both an unintended outcome but also a yet-unexplored process in relation to intended outcomes of DBT, although this would warrant further development of its potential connection to the theoretical underpinnings of DBT, and then empirical investigation. Participants discussed the importance of learning and using new skills, taking responsibility for change and the therapeutic relationship in effecting change.

A deficit in emotional regulation is fundamental to a diagnosis of BPD and findings highlighted the importance of learning and using skills taught during DBT to cope with distress. In addition, findings support the suggestion made by several researchers of the use of new behavioural skills as a possible cause of change (Neacsiu, Rizvi, & Linehan, 2010). However the synthesis also highlighted the potential for the language used in the skills teaching to act as a barrier to learning and developing skills, including jargon and language viewed as intimidating. This is something practitioners should consider to increase engagement with DBT.

The importance of taking ownership for change during therapy is congruent with theories of responsibility for change in therapy, which suggest that progress is impacted upon by the attribution of improvement (Arnkoff, Glass & Shapiro, 2002; Lambert & Ogles, 2004). If individuals believe that success in therapy is not primarily dependent on the therapist, this improves their engagement in therapy and subsequently result in more favourable outcomes (Delsignore, Carraro, Mathier, Rg Znoj, & Schnyder, 2008).

Individuals also attributed progress in DBT to important relationships within therapy. Whilst the therapeutic relationship as a vehicle for change in therapy is not unique to DBT (Lambert & Barley, 2001), there were several factors considered to be important by participants that distinguish the relationships in DBT from others.

DBT therapists are encouraged to engage as 'real people' in a collaborative

relationship with the client. This includes a degree of self-disclosure not typical of other therapies (Swales, 2009). The findings of the synthesis are consistent with those of a recent review of common factors in treatments for BPD. Alongside DBT, other treatments such as mentalisation based therapy also assign an 'active role' to the therapist (Weinberg, Ronningstam, Goldblatt, Schechter & Maltzberger, 2011). Perhaps for this particular client group, specific factors within the therapeutic relationship are key in facilitating change. Further investigation into the key aspects of the therapeutic relationship in DBT is warranted, to explore effective components of relationships within this particular therapy.

Impact of DBT

Quantitative research into the outcomes of DBT has primarily focused on self-harm and suicidality as key measures for its effectiveness (see Panos, Jackson, Hasan & Panos, 2013 for a review), alongside other outcomes such as frequency of service use. These outcomes are in line with the aims of DBT, in which problematic behaviours such as self-harm are considered the focus of treatment. These outcomes were acknowledged in participants' accounts across the studies reviewed, but were apparently given less attention by individuals undertaking therapy than researchers considering its efficacy. The synthesis highlighted improvements in self-efficacy as a key outcome of DBT, and whilst this may in part impact on the frequency of self-harm, that measure alone, nor any others used in existing studies of effectiveness, would capture this outcome as described by participants across the studies reviewed.

Furthermore, individuals perceived DBT as life changing with the progression from a hopeless beginning to hope for the future. This apparent change in hopelessness adds an interesting finding in light of the quantitative outcome literature. Studies have demonstrated varying results in relation to changes in self-reported hopelessness, with some finding no significant change (Linehan et al., 1991), and some identifying a significant reduction in following DBT (Koons et al., 2001). This raises questions surrounding how hopelessness is measured within DBT trials, and whether the life changing progression described by individuals in qualitative research is translated through quantitative outcome measures. The field may benefit from further exploration of the construction of 'hope' by individuals with BPD in the context of DBT.

Through the process of therapy participants gained insight into their own behaviour and embraced acceptance of their difficulties. Clients' perceptions of the impact of DBT fit within the key dialectic of acceptance and change, as they report both positive changes, whilst acknowledging a degree of acceptance of their difficulties. Acceptance is fostered in DBT both through the dialectical stance of the therapists, and through the practice of mindfulness techniques. Research suggests that sustained attempts to control thoughts and emotions through inhibition, suppression or avoidance are associated with BPD-related features (Bijttebier & Vertommen, 1999; Cheavens et al., 2005; Kruegelbach, McCormick, Schulz & Grueneich, 1993; Lynch, Robins, Morse & Krause, 2001), suggesting a link between acceptance and the reduction in symptoms associated with BPD which is supported by the findings of the synthesis.

The findings suggest that current outcome measures do not necessarily capture the changes experienced by individuals undertaking DBT. However, the changes highlighted across the studies are somewhat at odds with the aims of DBT. The focus of the treatment largely relates to behaviour change, as opposed to intrapsychic changes akin with other treatment modalities. Indeed it has been said that “patients in DBT acted better...but their life were still miserable” (Linehan, Tutek, Heard & Armstrong, 1994). The suggestion that outcomes extend beyond changes in behaviour and interpersonal functioning warrant further more detailed exploration.

Limitations

There are limitations to this review. In synthesising any qualitative studies there will often be challenges when distinguishing between first and second order constructs. The first order constructs have already been selected by the authors and could be said to not represent the totality of an individual’s experiences (Atkins et al., 2008). In addition, a number of the studies lacked adequate description of the methodological process and ethical considerations, meaning the context of the participants’ views was limited. The inconsistencies between studies in whether they included participants who had dropped out of treatment presents a further limitation. Arguably, the accounts of those who do not complete the treatment could offer valuable insight into the barriers to treatment, as well as providing a fairer representation of the experiences of individuals who experience the programme. Despite this, the variety in aims and locations of the studies included allowed for the synthesis of data from different

time points in therapy, identifying a coherent journey through the DBT process.

Conclusion

This review highlights the perceived positive impact that DBT can have for individuals diagnosed with BPD, beyond changes in problematic behaviour specifically targeted by the treatment. Impact is widespread and current outcome measures used in clinical practice and trials may not capture the complexities and magnitude of change following treatment. Furthermore the review offers unique insight into the process of DBT through the eyes of the individuals undertaking the therapy. The review reiterates the importance of listening to clients' views of therapy, in offering more detailed and nuanced accounts of the aspects of therapy perceived to be beneficial.

Recommendations for clinicians:

The synthesis highlighted the positive impact of DBT for some individuals, and barriers to accessing the therapy and using the techniques. Careful consideration should be given to the language used by clinicians when delivering the therapy, as this has the potential to alienate individuals and hinder the use of skills and techniques. Conflicting accounts within the synthesis suggested that changes brought about through DBT improve individuals' interpersonal effectiveness, however this can then bring about both beneficial and detrimental changes within their closest relationships. Where possible, support or education for those supporting the individual outside of therapy may ensure these changes do not impact negatively on individuals' progress.

Recommendations for researchers:

Qualitative research in the field of DBT remains limited, and existing work largely consists of studies with a broad focus, aimed at capturing the experiences of individual participating in DBT. Future work would benefit from a narrower focus, perhaps further investigating the factors impacting the process and outcome of the therapy detailed in this review. Future qualitative work would benefit from greater methodological rigour and more detailed consideration of ethical issues. It would be of benefit to give more consideration to the experiences of those who drop out of treatment in future studies. In assessing the effectiveness of DBT in future trials, consideration should be given to process and outcome measures that best capture change for individuals in light of the above findings.

Figures and Tables

Figure 1: PRISMA statement

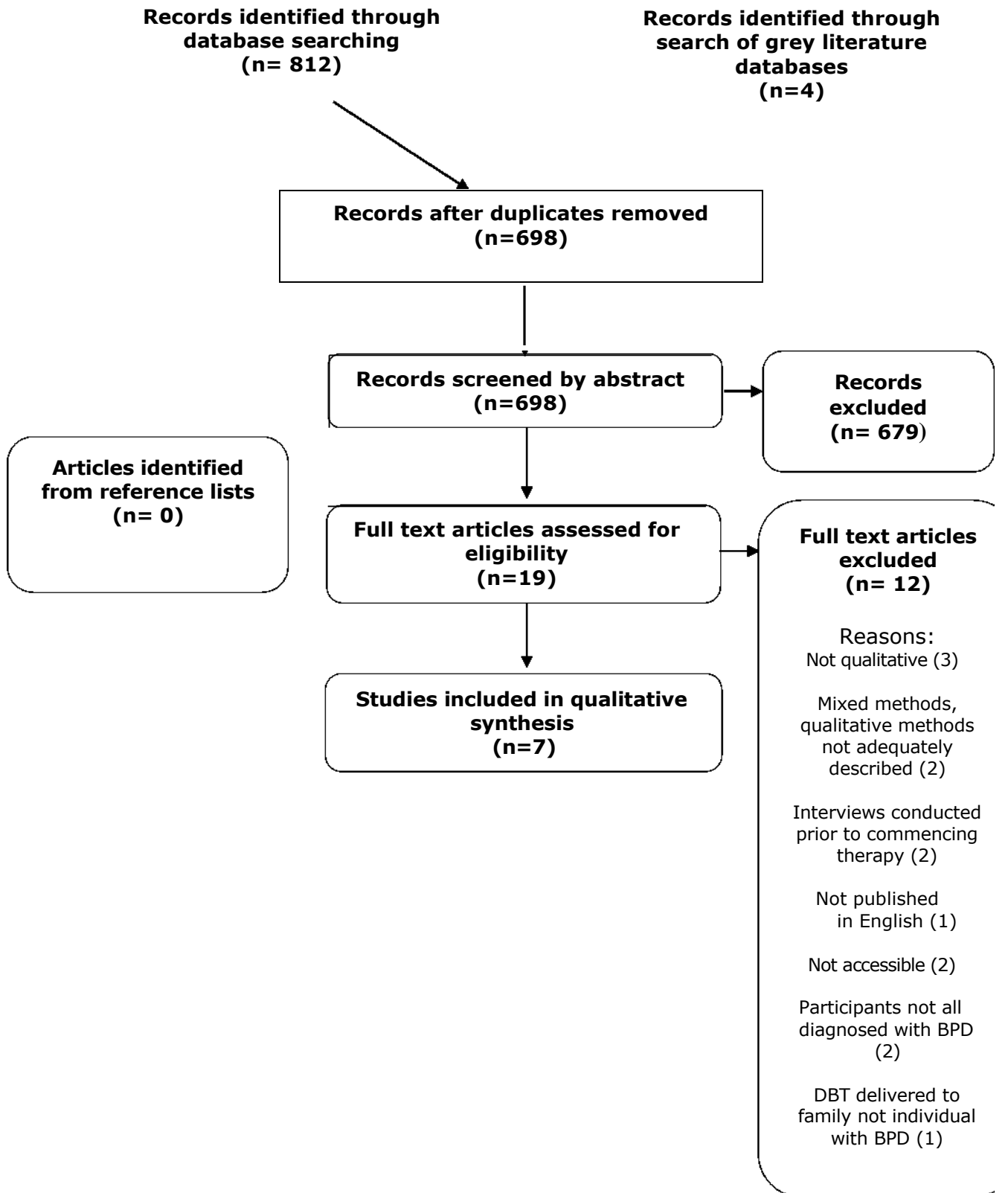


Table 1: Study characteristics

No.	Source paper	Setting	Sample size	Sample characteristics (age, gender, ethnicity)	Method of data collection	Methods of data analysis	Aim(s)	Conclusion(s)
1	Perseuius, Ojenhagen, Ekdahl, Asberg & Samulsson (2003)	Community Team, Sweden	10	Gender: 4 F – 10, M– 0 Ages: 22-49 Ethnicity: NR	SSI	CA	Describe patients' and therapists' perception of receiving and giving DBT treatment.	DBT radically changed the lives of the patients Effective components of DBT according to the patients and therapists: understanding, respect and confirmation, cognitive and behavioural skills. Effectiveness of DBT is contrasted by patients' negative experiences from previous psychiatric care
2	Cunningham Wolbert & Lillie (2004)	Assertive community treatment team, USA	14	Gender: F– 14, M – 0 Ages: 23-61 Ethnicity: NR	SSI	TA	Understand from the perspective of the client what is effective about DBT and why.	All interviewed believed DBT had a positive impact on their lives. They reported behaviour changes leading to more manageable and liveable lives.
3	Hodgetts, Wright & Gough (2007)	Community DBT service, UK	5	Gender: F – 3, M – 2 Ages: 24-48 Ethnicity: White British	SSI	IPA	Explore clients' experiences of DBT and the impact this treatment has on their lives	Chronological process highlighted with three stages: Joining, experiencing and evaluating a DBT programme.
4	Tsakapoulou (2009)	Community team UK	9	Gender: F – 9, M – 0 Age range: 20-51 Ethnicity: 7 White British; 1	SSI	IPA	What does recovery mean to people diagnosed with BPD? Do people at the advanced stages of DBT consider	Participants experienced changes on personal and interpersonal levels such as gaining insight, learning skills, overcoming

4 F= female, M= male, NR= not reported, SSI= semistructured interview, CA= content analysis, TA= thematic analysis, IPA = Interpretative analysis.

				White Irish; 1 Black British			<p>themselves to be in recovery?</p> <p>What are the specific elements of therapeutic treatment that facilitate or hinder recovery from BPD?</p>	<p>interpersonal challenges and moving on. They weren't always able to define their experiences as recovery, in part due to the BPD diagnosis.</p> <p>Importance of hope and the therapeutic relationship with this client group.</p>
5	Desperles (2010)	Inpatient DBT service, UK	9	Gender: NR Ages: 26-37 Ethnicity: White British	SSI	IPA	<p>Examine clients' experiences of DBT in an inpatient setting in order to assess if inpatient experiences of DBT raise similar themes to those of outpatients.</p> <p>Examine the impact of the inpatient system on clients' experiences of DBT, and to explore the obstacles and benefits of completing DBT in such a structured environment.</p>	<p>Inpatient DBT appeared as acceptable to participants as community DBT</p> <p>A number of themes following a patients' journey through DBT were discussed</p> <p>Promoters and obstacles were discussed.</p>
6	McSherry, O'Connor, Hevey & Gibbons (2012)	Community mental health team, UK	8	Gender: F- 6 M - 2 Ages: 32-55 Ethnicity not reported	SSI and focus group	TA	<p>Examine service users' perspective on the effectiveness of an adapted DBT programme and its impact on their daily lives.</p>	<p>Two key themes were identified: evaluation of therapy and treatment impact</p> <p>Therapy specific factors and personal challenges were features of the therapeutic process. Treatment impact was related to a renewed sense of identity and changes in daily life</p>

7	Barnicot, Couldry, Sandhu & Priebe (2015)	Community DBT service, UK	40	Gender F – 34 M – 6 Mean age – 33 Ethnicity: 22 white, 18 black or other ethnic minority	SSI	TA	<p>What factors do clients experience as barriers to DBT skills training?</p> <p>How do clients experience overcoming barriers to skills training?</p> <p>How do experiences of barriers to skills training, and overcoming such barriers, differ between treatment completers and drop-outs?</p>	<p>Key barriers to the progression in DBT included the language used during the teaching of the skills and overwhelming emotions both within and outside of the sessions.</p> <p>Ways of overcoming these barriers included sustaining their commitment and practicing of the skills; personalising them and using them until they become automatic. The importance of relationships with other group members; therapists and family were also seen as beneficial.</p>
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Table 2: CASP quality criteria scores

Quality criteria	Study number						
	1	2	3	4	5	6	7
<i>A clear statement of aims</i>	2	2	2	2	2	2	2
<i>Qualitative methodology appropriate</i>	2	2	2	2	2	2	2
<i>Research design appropriate to meet aims</i>	2	2	2	2	2	2	2
<i>Recruitment strategy appropriate to meet aims</i>	1	1	2	1	1	1	2
<i>Data collected in a way that addressed the research issue</i>	2	2	1	2	2	2	2
<i>Relationship between researcher and participants adequately considered</i>	2	0	1	2	2	0	2
<i>Ethical issues taken into consideration</i>	2	0	1	2	2	2	1
<i>Data analysis sufficiently rigorous</i>	1	2	2	2	2	1	2
<i>Clear statement of findings</i>	2	2	2	2	2	1	2
TOTAL	17	14	15	18	18	14	17

Table 3: Third order constructs and subthemes

Part of the process	Third order constructs and sub-themes	Study number						
		1	2	3	4	5	6	7
Process of DBT	Life before DBT							
	A hopeless beginning	*	*	*	*	*		
	The relationships that support change							
	Feeling valued, respected and listened to	*	*	*	*	*		
	The importance of therapist knowledge		*			*	*	*
	The commonality of experience	*	*	*	*			*
	Developing self-efficacy							
	Learning the skills to manage emotions	*	*	*	*	*	*	*
	Taking ownership and responsibility	*	*	*		*		
	Changes in relationships		*		*		*	
Impact of DBT	A shift in perspectives							
	Insight and acceptance	*	*	*	*	*	*	
	Hope for the future	*	*		*	*		*

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