THE UNIVERSITY OF HULL

Emotionally Unstable Personality Disorder: Exploring the therapeutic alliance, and engagement in Dialectical Behaviour Therapy

being a Thesis submitted in partial fulfilment of the requirements for the degree of

Doctor of Clinical Psychology

in the University of Hull

by

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BSc (Hons) Psychology

University of York

December 2020

Acknowledgements

Firstly, I'd like to express my gratitude to the eight participants who volunteered their time to share their experiences and insights, especially as they did this at the beginning of a global pandemic.

I would like to thank my research supervisors Jo, Chris, Nathan and Sam for their knowledge, guidance and encouragement throughout the course of this project.

Thank you to my friends who have supported me throughout this journey. A special mention goes to Annabel – you have always stood by me and been an all-around great friend, even though at times it could take seven working days for me to reply to your messages. Thank you to my fellow trainee, Sam – I could not imagine a better or funnier person to have spent the past three years on the course with! Also, thank you to my group of lasses – Anna, Beth and Charlotte, who have also kept me motivated.

Thanks to my mam for all the food, cakes and cups of tea she has made me to keep me fuelled throughout my university years. Thanks to my sister, Sophie, for her help with various aspects of this thesis. Last but by no means least, thank you to Doogie for his much-needed services as an unofficial therapy dog.

Overview

This portfolio thesis consists of three parts: a systematic literature review, an empirical paper and a set of appendices.

Part one of the portfolio is a systematic literature review exploring factors associated with the therapeutic alliance for people with Emotionally Unstable Personality Disorder in psychological therapy. A systematic search of four key databases was performed, which identified 15 papers for review. The findings were summarised and integrated using narrative synthesis. The methodological quality of included studies is also analysed. Implications for future research and clinical practice are highlighted.

Part two of the portfolio is an empirical report of an original piece of research investigating therapists' experiences of engagement with people with a presentation of Emotionally Unstable Personality Disorder in Dialectical Behavioural Therapy. Eight therapists were interviewed, and the data was analysed using Interpretative Phenomenological Analysis. Three superordinate and seven subordinate themes emerged. The implications of the findings for clinical practice in relation to engagement are discussed.

Part three of the portfolio consists of a set of appendices for both the systematic literature review and empirical study. It also includes a reflective statement detailing the researcher's journey throughout the process of completing this thesis, as well as an epistemological statement discussing the philosophical position and underlying assumptions of the work.

Overall word count (excluding tables, references and appendices): 19,027

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Part One: Systematic Literature Review

Factors affecting the therapeutic alliance between people with Emotionally Unstable Personality Disorder and therapists, in psychological therapy: A systematic literature review

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Word Count (excluding references, abstract and tables): 8875

This paper is written in the format ready for submission to the journal *Clinical Psychology Review.* Please see Appendix A for the Guidelines for Authors.

Abstract

Research has demonstrated the robust association between the strength of therapeutic alliance (TA) and positive outcomes in psychological therapy for mental health conditions generally, as well as for those with a diagnosis of Emotionally Unstable Personality Disorder. Less is known about determinants of the TA. Understanding factors associated with TA could help facilitate more favourable therapy outcomes. This systematic literature review aimed to explore factors related to TA in psychological therapy specifically for this group. The findings of 15 studies were summarised and integrated using a narrative synthesis approach, with the methodological quality of studies also appraised using the NICE Quality Appraisal Checklist. Most findings suggest levels of symptomology and functioning are generally not associated with TA. However, a few studies provided contrary evidence, suggesting its potential role cannot be ruled out. Some evidence suggested that attributes that aid in clients' interpersonal communication, such as adaptive social interaction and interpersonal patterns, may be associated with better TA. Additionally, age was associated with better TA across long term periods of therapy. Specific cognitive heuristics and treatment credibility may also play a role. Perhaps the most important finding is that this area of research is underdeveloped, and currently published studies are likely underpowered. Consequently, recommendations have been made for future research.

Key Words Emotionally Unstable Personality Disorder, Borderline Personality Disorder, therapeutic alliance, therapeutic relationship, factors

Highlights

- The evidence base is limited, and methods across studies significantly vary.
- The need for better quality research is indicated, and recommendations are made.
- The relationship between TA & demographics/personality is inconclusive.
- Mental health factors may not be associated with TA, however this is inconclusive.
- Interpersonal style, heuristics and treatment credibility may influence TA.

Introduction

The diagnosis Emotionally Unstable Personality Disorder (EUPD) appears in the tenth revision of the International Statistical Classification of Diseases and Related Health Problems 10 (ICD-10; World Health Organisation (WHO), 1992). The ICD-10 states that key difficulties include impulsivity, emotional instability, disruptions in self-image and interpersonal problems. For ease of reading, the term EUPD will be used throughout; however, the diagnosis is also known as Borderline Personality Disorder within the Diagnostic and Statistical Manual 5 (DSM-5; American Psychiatric Association (APA), 2013). As most of the research involves participants with a diagnosis rather than those with a presentation of EUPD, this paper will refer to this group as people with a “diagnosis of EUPD”.

EUPD as a diagnostic label is often considered to be controversial. Some consider its ‘symptoms’ to be too close to those of a trauma response to hold construct validity (Paris, 2005). Furthermore, as the diagnosis is disproportionately given to women, feminists suggest that such a diagnosis is a way of pathologising women’s emotions (Veysey, 2014). Nevertheless, EUPD appears to be a common diagnosis in mental health settings; it makes up 20% of the mental health inpatient population and 10-30% of the outpatient population (National Institute for Health and Care Excellence; NICE, 2007). Fortunately, people with a diagnosis of EUPD are now more likely to receive psychotherapy, in part due to the emergence of specialist interventions such as Dialectical Behaviour Therapy (DBT; Linehan, 1993) and Mentalisation-Based Treatment (MBT; Bateman & Fonaghy, 2016) as well as policy initiatives such as ‘Personality Disorder: No Longer a Diagnosis of Exclusion’ by the National Institute for Mental Health England (NIMHE; 2003).

However, it is reported that developing a strong therapeutic relationship with people with an EUPD diagnosis is particularly challenging (McMain et al., 2015). This is perhaps unsurprising due to the aforementioned interpersonal difficulties this client group experiences.

The therapeutic alliance (TA) is the quality of the working relationship between therapist and client (Pierò et al., 2013). Focus on this relationship began with Freud (1913) in the psychodynamic approach. However, even today, there is a lack of consensus on the exact definition of the concept of TA, and many consider the term ambiguous (Horvath, 2018). One of the definitions that has the most consensus is Bordin’s (1979) ‘pan-theoretical’ model of the TA, which aimed to operationalise the TA process, and came about through the increasing recognition of common therapeutic processes across different types of therapy. He proposed that it consists of a bond, and agreement on goals and tasks. He asserted that the TA is an essential component of all types of helping relationships. Scales such as the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) have attempted to operationalise the TA based on Bordin’s (1979) model to try and ensure some consistency in definitions in research.

The relationship between TA and therapeutic outcome in mental health interventions has been well-documented in several meta-analyses (Martin et al., 2000, Horvath et al., 2011 & Flückiger et al., 2018). For example, Horvath et al.

(2011) examined the TA-outcome association across a range of studies examining various interventions such as psychotherapies, case management and rehabilitation. All of these meta-analyses have supported the association between TA and favourable outcomes, and that this association is independent of type of intervention or TA measure used. Hence it appears that the TA is a pan-theoretical factor and is therapeutic in and of itself. The TA-outcome link appears to generalise to those diagnosed with EUPD; a review by Barnicot et al. (2012) found that patient-rated TA positively predicted symptom change regardless of the intervention. They concluded that the TA should be made a therapeutic priority by therapists. In light of these findings, it appears that the TA is an important factor to attend to in mental healthcare settings.

Taking the TA-outcome association into consideration, it is important to understand what leads to a strong TA. In terms of general factors, a review by Ackerman and Hilsenroth (2003) found that therapists' flexibility, honesty, respectfulness, trustworthiness, confidence, warmth, showing interest and openness contributed to the formation of a strong TA. Conversely, an earlier review reported factors negatively influencing the TA, namely rigidity, being critical, uncertainty, tenseness, distance and distractibility (Ackerman & Hilsenroth, 2001).

Despite several reviews investigating the promising association between TA and outcome (Martin et al., 2000, Horvath et al., 2011 & Flückiger et al., 2018), as well as some dated reviews of factors relating to TA generally (Ackerman & Hilsenroth, 2013; Ackerman & Hilsenroth, 2001), there is no known review examining the determinants of TA for people diagnosed with EUPD in psychological therapy.

Consequently, it appears timely to investigate this. Such a review could provide insight into how therapists can seek to strengthen and maximise TA with people who have a diagnosis of EUPD in psychological therapy. This is in light of the challenges that therapists reportedly face and could lead to more favourable therapy outcomes.

Review Question

What factors are associated with the TA between therapist and clients with a diagnosis of EUPD in psychological therapy?

Method

Search Strategy

A search was conducted in May 2020 using four electronic databases: PsychInfo, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline and Academic Search Premier. These four databases were used in order to ensure a comprehensive search of the literature. The search was performed on 31st May 2020. No date limiter was used in order to access all available research, therefore incorporating studies from 1979 (inception) to May 2020. A scoping search was conducted prior to this process, to ensure a systematic review on this topic had not been conducted previously and to identify key search terms.

Search Terms

Search terms were based upon those used in similar reviews regarding factors associated with TA (Shattock et al., 2018; da Costa et al. 2020). Some additional terms were added (cluster B, engage*, process*, collab* and interact*) to ensure the detection of relevant papers, following a search with the initial search terms that suggested such additional terms were relevant. The terms were discussed with the review team to ensure they were inclusive yet focused.

The following search terms were used:

(“Emotionally Unstable Personality Disorder”) OR (“Borderline Personality Disorder”) OR (“EUPD”) OR (“BPD”) OR (“cluster B”)

AND

(Therap* OR working OR helping) N2 (relation* OR alliance* OR engage* OR process* OR collab* OR interact*)

AND

(Psychotherapy OR treatment OR intervention OR counselling)

Study selection

Limiters were applied to the search results to eliminate papers that were not in English and had not been peer reviewed. Duplicates were also removed, which left 550 records. These were then screened by title in the first instance. If the title was uninformative, the abstract was read for further information. This process resulted in the exploration of the full text for 58 papers. These studies were then judged against the inclusion and exclusion criteria (Tables 2 and 3), which left 15 papers. The reference lists of included papers were searched, which yielded one additional study. A diagram of the process is presented in Figure 1.

Table 1

Inclusion criteria and rationale

Inclusion Criteria	Rationale
Studies that examined or measures client or therapist factors associated with the TA between patient and therapist in individual psychological therapy.	The review specifically included papers examining factors affecting TA in psychological therapy due to the research regarding the link between TA and favourable outcomes. Psychological therapy was defined as “meeting with a therapist to talk about your feelings and thoughts and how these affect your wellbeing” (National Institute for Health and Care Excellence, 2014). Due to this, Good Psychiatric Management (GPM; Gunderson, 2014), a specialist intervention for EUPD, was included. This is because although it involves case management, the other main component is

	supportive psychotherapy influenced by psychodynamic and cognitive behavioural approaches (Gunderson et al., 2018). Some studies did not aim to investigate factors associated with TA, but if such an association was measured regardless, these papers were included.
Studies investigating factors affecting mean TA scores, and/or factors affecting the magnitude of growth of the TA.	Both factors influencing mean TA scores and the growth of TA were deemed relevant to the review question.
Participants were assessed for a diagnosis of EUPD	Basing inclusion on a recognised diagnosis helped ensure consistency and therefore generalisability.
The study was published in a peer-reviewed journal.	In order to ensure the quality of included studies.

Table 2

Exclusion criteria and rationale

Exclusion Criteria	Rationale
Articles that did not present primary empirical findings (e.g. reviews and discussions).	As the review was concerned with primary empirical findings rather than secondary data or opinions.
Studies published that were not in the	There was no funding available for

English language.	translation of articles.
Studies whereby the data on EUPD was not separated from data on other personality disorders or diagnostic labels.	The review was interested in the EUPD population only.
Studies which investigated TA in group therapy.	The review only included studies investigating TA in the context of individual therapy. This was due to the additional factors and the potential different type of relationship that may be present in group therapy. Therefore, one study (Euler et al., 2018) was excluded.

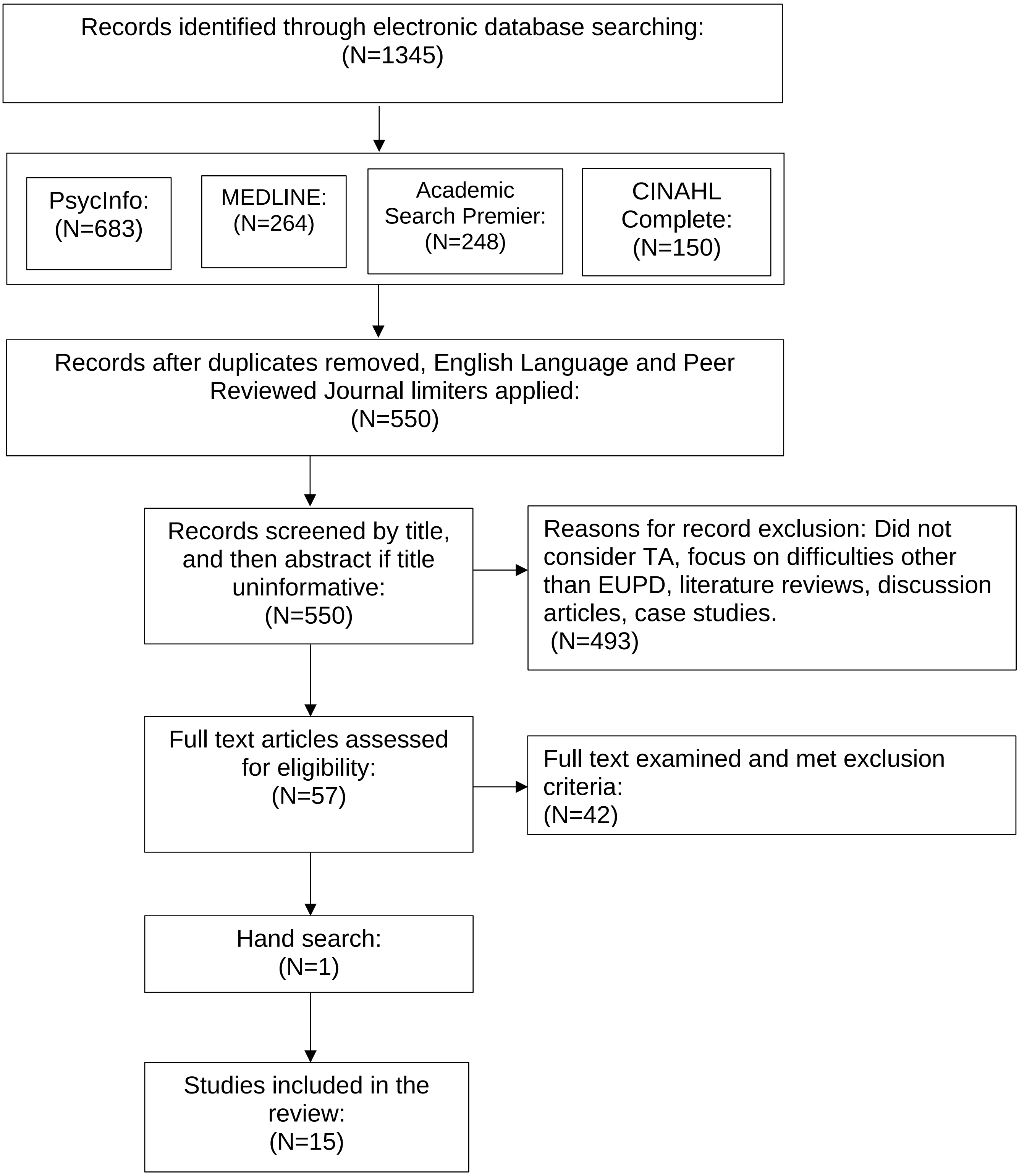

Figure 1. Diagram detailing process of the systematic literature search and selection of articles.

Data extraction

Key information was extracted from each study including: sample, aims, intervention, design, measures and key findings using a data extraction table devised by the researcher (Appendix B).

Quality assessment

The quality of included studies was assessed using the National Institute for Health and Care Excellence (NICE) Quality Appraisal Checklist (Appendix C). This checklist was chosen as it was specifically designed for studies reporting correlations and associations. The checklist allows for the assessment of internal and external validity of a study based on four aspects of a study's design: 1) population, 2) method of selection exposure/comparison group, 3) outcomes and 4) analysis (NICE, 2012). There are five possible scores for each question asked in these four categories, as explained further in Table 4. The external validity total score is derived from summarising the 'population' aspect of the study design. The study's internal validity total score is derived from combining the 'method of selection exposure/comparison group', 'outcomes' and 'analysis' aspects of the study's design.

Table 3

Possible responses to NICE Quality Appraisal Checklist Items

Score	Reason
++	Risk of bias has been minimised
+	All aspects of bias may not have been addressed/answer to checklist question is unclear
-	There are significant sources of bias
Not reported (NR)	Failure to report specific aspect of study design
Not applicable (NA)	Not an applicable question for particular study

Some of the questions were reworded using language relevant to the included studies. It was ensured that the questions were relevant and applicable to the included studies and the aim of the review. For example, item 3.5 was changed from "Was follow-up time meaningful?” to “Were the times at which measures were administered appropriate?”. All eligible studies remained in the review despite the quality score, with this score being used to inform the interpretation of the results. 25% of papers were reviewed for quality by a peer researcher, which yielded an agreement rating of 74.2%. Differing opinions were discussed, leading to an agreement being reached.

Data synthesis

Due to the diversity of variables reported, a meta-analysis was not possible. Thematic synthesis was not considered, as this method is designed mainly for use in analysing qualitative, rather than quantitative findings (Thomas & Harden, 2008). Narrative synthesis encourages the reporting of study characteristics and quality (Lucas et al., 2007), which meant that this method was particularly appropriate for the included studies due to the variation in methods. Consequently, a narrative synthesis approach was undertaken. This approach uses words to ‘tell a story’ of the findings from the included studies (Popay et al., 2006). Guidance from Popay et al. (2006) was used to inform the analysis. In accordance with this method, each paper was read, and relevant data was extracted from each study. Patterns and relationships were searched for across studies, leading to the development of themes. Finally, the robustness of included studies and the review were considered.

Results

Table 4

Key information and findings of studies under review

Author, (Date) and Country	Sample (no. of participants, mean age, gender)	Aims of Study	Therapy Type and Duration	Study Design	Alliance Perspective, Measure, and When	Key Measures Used and When	Relevant Findings	Quality Score
Barnicot et al. (2016) UK	N=70 32yrs 63F, 7M	To investigate whether skills use affects therapy processes, whether these processes affect self-harm and how these relate to drop-out for people with an EUPD diagnosis.	DBT One year	Longitudinal	Client STAR-P Every two months	GSS (self-efficacy) & TCS (treatment credibility) Every two months	Frequency of DBT skills use (β=.0.12) treatment credibility (β=0.91) and self-efficacy (β=0.17) significantly predicted client-rated TA (all p=<.001) with the therapist.	EV: ++ IV: +

Dimaggio et al. (2019) Switzerland	N=36 NR NR	To investigate the relationships between metacognition, TA and psychological distress in people with an EUPD diagnosis.	GPM GPM-MOTR 10 sessions	Longitudinal, part of RCT	Client and therapist WAI-S After each session	MAS-R (metacognition, rated by observer) At intake session	Regression analysis showed no significant relationship between general metacognition at baseline and both patient and therapist-rated TA mean scores. No effect on TA progression on both client (t(33)=-0,55, p=.59) and therapist (t(33)=0.80, p=.43) measures. However, participants' ability to understand others' minds significantly affected the progression of TA as rated by the therapist (t(33)=1.94, p=.04).	EV: - IV:+

Hirsh et al. (2012) Canada	N=87 31.41yrs 75F, 12M	To investigate whether people with an EUPD diagnosis’ personality traits predict TA development and whether this influences treatment effectiveness.	DBT GPM One year	Longitudinal, part of RCT	Client WAI-S Baseline and every four months.	NEO-PI-R (Big Five personality traits), rated by therapist. Administered at varying times - first month (n=53), first four months (n=11), after first four months (n=21).	Increases in TA over time were significantly larger for more agreeable participants ($\beta=.03$, $p=.01$) but only in DBT ($\beta=.06$, $p<.01$) and not GPM ($\beta=.01$, $p=.62$). Facets of the agreeableness trait (altruism, straightforwardness, trust, compliance, and tender mindedness, but not modesty) demonstrated affected increases in TA at a similar magnitude (all $p=<.05$). Neuroticism, extraversion, openness to experience and conscientiousness did not predict changes in TA over time ($p=>.05$).	EV: + IV: ++

Kivity et al. (2020) Switzerland	N=60 (GPM: N=32, 35.31yrs, 17F, 15M; GPM+MOTR: N=28, 31.43yrs 23F, 5M)	To investigate whether alliance dynamics are affected by tailoring the therapeutic relationship to the individual client with a EUPD diagnosis.	GPM GPM-MOTR 10 sessions	Longitudinal, part of RCT	Client and therapist WAI-S Every session	OQ-45 (symptomatic distress) At pre-, mid- and post-treatment	Session-level symptomatic distress predicted therapist-rated TA at subsequent time points in GPM+MOTR (t_{22}=-2.41, p=.02) but not in GPM. No effect found for client-rated TA (t_{29}=-.16, p=.88).	EV: + IV: ++
Kramer & Golam (2019) Switzerland	N=60 33.17yrs 40F, 20M	To explore how cognitive heuristics in those with an EUPD diagnosis affect TA.	GPM 10 sessions	Longitudinal, part of RCT	Therapist and client WAI-S After every session	CERS (cognitive heuristics) Recordings observed and rated by observers for sessions one, five & nine.	Two cognitive heuristics were found – (TAKE-ALL) and (TRUST-CULPRIT). Linear mixed effects model found significant difference between client-related TA dependent on cognitive heuristic (t(55)=2.30, p=.03), whereby people with the (TRUST-CULPRIT) cognitive heuristic had higher client-rated TA. No difference in changes	EV: + IV: +

							over time in client-rated TA dependent on cognitive heuristic (heuristic x time interaction). No differences for therapist-rated TA in terms of difference between TA dependent on cognitive heuristic, or interaction between cognitive heuristic and time.	
Levy et al. (2010) USA	N=39 NR 39F, 0M	To investigate the relationships between TA, executive attention and mental state vacillations in people with EUPD diagnoses.	TFP DBT SP NR	Longitudinal, part of RCT	Observer WAI Two early therapy sessions	ANT (executive attention; alerting, orienting and conflict), TRS-BPD (mental state vacillations), Rated by observer from one session	Alerting (r=.03) and orienting (r=.03) aspects of executive attention not significantly related to TA. However conflict was significantly moderately correlated to TA on the whole (r=-.34, p=<.05) and to individual aspects of the TA (bond r=-.37	EV: - IV: -

							and goals r=-.33, both p=<.05). Vacillations highly associated with TA (r=-.59, p=<.001). Mediational analysis showed a large effect size between vacillations and TA when controlling for executive attention (R^2=.25, P=<.001). The relationship between executive attention and TA was non-significant when controlling for vacillations (R^2=.02, p=.274). Vacillations as a mediator of relationship between executive attention and TA.	
Marziali et al. (1999) Canada	N=34 NR NR	To examine the relationship between TA and treatment effects for people with	IGP IDP 30 sessions	Longitudinal	Client P-TAS At session	SAS (social adjustment), BDI (depression), SCL-90 (clinical symptoms) & OBI	Early client-rated TA in individual psychotherapy was not associated with pre-treatment measures of	EV: - IV: +

		EUPD diagnoses.			3.	(behavioural dysfunction). Prior to treatment	clinical symptoms, social functioning or behavioural dysfunction.	
Penzenstadler et al. (2018) Switzerland	N=99 32.2yrs 68F, 31M (subsample of 75 used for TA analysis)	To compare the impact of GPM with people diagnosed with EUPD & EUPD+SUD and processes/ outcomes.	GPM 10 sessions	Longitudinal, part of RCT	Client WAI-S After every session	DSM-IV criteria (addiction) At baseline	The positive progression of patient-rated TA over time was significantly more pronounced for those with a diagnosis of EUPD who also had SUD than those without (β=.0.71, p=0.011). Age (β=-.0.02, p=0.871) and gender (β=-1.97, p=0.568) had no effect on TA mean scores.	EV: ++ IV: +
Pierò et al. (2013) Italy	N = 49 36.6yrs 31F, 18M	To explore the effect of personality dimensions in people with a diagnosis of EUPD on TA.	PP 40 sessions	Longitudinal	Client. WAI-S At end of intervention	TCI (temperament and character), SCL-90R (psychopathology), GAF (social and occupational functioning), CGI (symptom	Lower harm avoidance (β=-.54, p=.003), higher psychopathology level (β=.04, p=.022) and age (β=-.26, p=<.001) independently predicted better patient-rated TA. Level of	EV: + IV: ++

						severity). At baseline	novelty-seeking, reward dependence, persistence, self-directedness, co-cooperativeness or self-transcendence had no effect on TA. Symptom severity and social & occupational functioning had no effect. Other demographics (education, gender & duration of contact with mental health services) not associated with TA.	
Richardson-Vejlgaard et al. (2013) USA	N = 35 30.9yrs 31F, 4M	To understand whether participants with a diagnosis of EUPD's levels of depression, anxiety and hopelessness predicted TA.	DBT SP 12 months	Longitudinal, part of RCT	Client and therapist WAI Baseline and two months	BDI (depression), BHI (hopelessness), STAI (anxiety). All at baseline and two months	Hopelessness correlated with client-rated TA at baseline (r=-.40, p=<.05). Depression (r=-.37, p=<.05), anxiety (r=-.48, p=<.01) and hopelessness (r=-.43, p=<.05) at baseline were correlated with	EV: + IV: +

							patient-rated TA at two months. No associations between predictors and therapist-rated TA or between demographics and TA.	
Salzer et al. (2013) Germany	N=228 31.2yrs 211F, 17M	To investigate patterns of self-perceived interpersonal problems in people diagnosed with EUPD, their relationship to symptom distress and whether these interpersonal problems differ in the quality of TA.	IP Varying	Longitudinal	Client and therapist HAQ At six weeks	IIP-C (interpersonal problems) NR	Therapists' ratings of the TA significantly differed depending on the client's interpersonal subtype (F=2.59, p=<0.04). HAQ scores (SD): - Vindictive: 1.06 (0.98) - Moderate Submissive: 1.13 (0.96) - Non-assertive: 1.12 (0.74) - Exploitable: 0.79 (0.821) - Socially avoidant: 0.43	EV: - IV: +

							(1.34) The weakest ratings for the “socially avoidant” subtype. No such effect for client-rated TA (F=1.82, p=0.13).	
Signer et al. (2019) Switzerland	N=50 (GPM: N=23, 18F, 5M, 31.96yrs; GPM+MOTR: N=27, 14F, 13M, 34.7yrs)	To understand the interplay between social interaction patterns and therapist responsiveness with focus on explaining TA and outcome.	GPM GPM+MOTR 10 sessions	Longitudinal, part of RCT	Client and therapist WAI-S After every session	BIPS (social interaction patterns) By observer using recording from one session	In GPM+MOTR, the intensity of social interaction patterns was significantly negatively correlated with therapist-rated TA (r=-.46, p=<.05). Such patterns went on to predict therapist-rated TA (B=-7.92, p=.02). No effect for GPM.	EV: - IV: +
Spinhoven et al. (2007) Netherlands	N=78 (SFP: n=44, 31.7yrs, 40F, 4M; TFP: n=34, 29.4yrs, 32F, 2M)	To investigate the quality and development of TA as a mediator of change in therapies for people with EUPD diagnoses.	SFP TFP 33 months	Longitudinal, part of RCT	Client and therapist WAI At months 3, 15 & 33	BPDSI-IV (severity & frequency of EUPD), IPO (personality organisation), YSQ (schemas) Every three	EUPD symptom severity in the early to mid-stages of therapy was not associated with client-related TA at mid to late stages of therapy (r=-.11, ns.). Scores of EUPD	EV: + IV: ++

						months	symptom severity at mid to late stages of therapy not related to mid to late therapist-rated TA either. Dissimilarity between client and therapists on measures of schemas (r=.26) and personality organisation (r=.30) were both significantly associated with early to mid-treatment changes in client-rated TA (both p=<.05) but not for therapist-rated TA (p=>.1)	
Yeomans et al. (1994) USA	N=20 (from subset of 36) NR 20F, 0M	To understand how treatment contracts, TA, and severity of illness correlate with continuation of treatment for people with EUPD diagnoses.	PP 2 x 45 min sessions/week. NR, but asked participants to stay in study for at least two years.	Longitudinal, data from previously published study	Observer, from recordings CALPAS During contract-setting	CRS (contract setting) Process rated by observer from recordings. During contract setting.	No correlation between ratings on contract setting and TA generally or on specific aspects of each measure (p=>.05).	EV: - IV: -

					sessions			
Zufferey et al. (2019) Switzerland	N=60 (final analysis n=52) (GPM: 29, 31.41yrs, 24F, 5M; GPM+MOTR: 31, 35.23yrs, 16F, 15M)	To test whether agreeableness affects TA and outcome for people with EUPD diagnoses.	GPM GPM+MOTR 10 sessions.	Longitudinal, part of RCT	Patient WAI-S After every session	PA-AS (interactional agreeableness) At intake	Interactional agreeableness did not affect mean TA ratings for either GPM+MOTR (B=5.13, p=.23) or GPM B=-2.19, p=.79). Agreeableness had no effect on TA progression.	EV: + IV: +

Female, F; Male, M; Not reported, NR; HC, Healthy controls; EUPD, Emotionally Unstable Personality Disorder

DBT, Dialectical Behaviour Therapy; SP, Supportive Psychotherapy; PP, Psychodynamic Psychotherapy; TFP, Transference-Focused Psychotherapy; IP, Inpatient Psychotherapy; SFP, Schema-Focused Psychotherapy; IGP, Interpersonal Group Psychotherapy; GPM, Good Psychiatric Management; GPM+MOTR; GPM augmented with Motive-Orientated Therapeutic Relationship Intervention

BDI, Beck Depression Inventory (Beck et al., 1961); BHS, Beck Hopelessness Scale (Beck et al., 1974); STAI, State Trait Anxiety Inventory (Spielberger et al., 1970); WAI, Working Alliance Inventory (Horvath & Greenberg, 1989); Working Alliance Inventory – Short Form; TCI, Temperament and Character Inventory (Cloninger, 1994); SCL-90R, Symptom Checlist-90 Revised (Derogatis, 1994); GAF, Global Assessment Functioning; GSS, Generalised Self-Efficacy Scale (Sherer, 1982), STAR-P, Scale to Assess Therapeutic Relationships in Community Mental Health Care: Patient Version (McGuire-Snieckus et al., 2007); TCS, Treatment Credibility Scale (Borkovec & Nau, 1972); CRS, Contract Rating Scale (Selzer et al., 1989); CALPAS, California Psychotherapy Alliance Scales (External Rater Version) (Marmar & Gaston, 1989); P-TAS, Therapeutic Alliance Scale (Marziali, 1984); CGI, Clinical Global Impression (Guy, 1976); NEO-PI-R, Revised Neo Personality Inventory (Costa & McCrae, 1992b); IIP-C, Inventory of Interpersonal Problems (Horowitz et al., 2000), OQ-45, Outcome Questionnaire – 45.2 (Wells et al., 1996); SAS, Social Adjustment Scale (Weissman & Bothwell, 1976, OBI, Objective Behavioural Index (Marziali et al., 1999); ANT, Attentional Network Task (Fan et al., 2002); CERS, Cognitive Errors Rating System (Drapeau, 2013); MAS-R, Metacognition Assessment Scale – Revised (Carcione et al., 2010); BIPS, Borderline-Interaction-Patterns Scale (Kramer & Sachse, 2016); PA-AS (Zufferey et al., 2019), Plan Analysis-Agreeableness Scale; IPO, Inventory of Personality Organisation (Spinhoven et al., 2007); YSQ, Young Schema Questionnaire (Young, 1994); HAQ, Helping Alliance Questionnaire (Bassler et al., 1995); TRS-BPD, Therapist Rating Scale for BPD (Wasserman et al., 2007).

Study Characteristics

In total, 15 quantitative studies were included in the review. The total number of participants sampled across all studies was 988, comprising 10 unique samples. The most common design was longitudinal (n=15), and many (n=11) were associated with larger randomised controlled trials (RCTs). Specifically, participants were recruited, or their data was used, from larger RCT studies. Six studies (Penzenstadler et al., 2018; Kivity et al., 2020; Kramer & Golam, 2019; Signer et al., 2019; Zufferey et al., 2019; Dimaggio et al., 2019) had samples derived from the same RCT by Kramer et al., (2014). Studies differed in the priority they gave in their aims to study factors associated with TA for people diagnosed with EUPD. Seven studies had this as a primary aim, or included it as one of the primary aims (Barnicot et al, 2016; Dimaggio et al., 2019; Hirsh et al., 2012; Kramer & Goldman, 2019; Levy et al., 2010; Pierò et al., 2013; Richardson-Vejlgaard et al., 2013). It was a secondary aim in three studies (Penzenstadler et al., 2018; Signer et al., 2019; Zufferey et al., 2019), a tertiary aim in one study (Salzer et al., 2013), and a quaternary aim in one study (Spinhoven et al., 2007). Finally, three studies did not aim to investigate the topic of interest, however still reported relevant data (Kivity et al., 2020; Marziali et al., 1999; Yeomans et al., 1994).

The majority of participants (83%) were female, although two studies did not report gender. Ethnicity was only reported in two studies (Barnicot et al., 2016; Richardson-Vejlgaard et al., 2013), who had ethnically diverse samples. Employment rates were reported in seven studies, and ranged from 12-83.9%. All of the countries where research papers originated from were considered ‘Western’, and all had universal healthcare systems, except the USA.

Quality Assessment

All studies described procedures of recruitment and were therefore awarded either a ‘++’ or ‘+’ score for this. Four studies (Dimaggio et al., 2019; Kivity et al., 2020; Salzer et al., 2013; Levy et al., 2010) did not report their inclusion/exclusion criteria. Of those that did, six were given a “++” score, with the remaining five papers gaining a score of ‘+’ due to criteria being generally appropriate but more constrained, without a rationale being provided. Three studies (Dimaggio et al., 2019; Marziali et al., 1999; Salzer et al., 2013) did not report any details regarding the demographics of their samples, with two studies only reporting the gender make up (Levy et al., 2010; Yeomans et al., 1994).

One of the main and most significant weaknesses of the included studies was the lack of inclusion of power analyses. 14 studies did not report that a power analysis had been conducted. One study did (Spinhoven et al., 2007), but did not retain the sufficient participant numbers required. Hence, most studies could potentially be underpowered. Most studies (n=10), where appropriate, adequately identified and adjusted for confounding variables within their design/analysis. Furthermore, most studies (n=14) received a ‘++’ or ‘+’ score for using reliable and valid predictor/outcome measures. All studies employed data analysis methods that were appropriate for the aims of their research and the study design. A more detailed breakdown of scores can be found in Appendix D.

Time

The length of therapy provided and the time at which measures were administered varied across the included studies.

With regards to therapy duration, six studies (Dimmaggio et al., 2019; Kivity et al., 2020; Kramer & Golam, 2019; Penzenstadler et al., 2018; Signer et al., 2019; Zufferey et al. 2019) provided 10 sessions of therapy. Three studies provided one year of therapy (Barnicot et al., 2016; Hirsh et al., 2012; Richardson-Vejlgaard et al. 2013). Two studies (Marziali et al., 1999; Pierò et al., 2013) provided 30 and 40 sessions respectively, while Spinhoven et al. (2007) provided 33 months of therapy. The duration of therapy was not reported or varied across participants in three studies (Yeomans et al., 1994; Levy et al., 2010; Salzer et al., 2013).

Six studies administered measures of the TA at every session (Dimmaggio et al., 2019; Kivity et al., 2020; Kramer & Golam, 2019; Penzenstadler et al., 2018; Signer et al., 2019; Zufferey et al. 2019). Two studies administered TA measures every two months (Barnicot et al., 2016; Richardson-Vejlgaard et al., 2013), with Hirsh et al. (2012) administering them every four months. Three studies administered the measures at early stages; the first session (Yeomans et al., 1994), session three (Marziali et al., 1999) and “two early therapy sessions” (Levy et al., 2010). Finally, one study administered TA measures at the end of the intervention (Pierò et al., 2013), one at six weeks (Salzer et al., 2019) and one at three, five and 33 months (Spinhoven et al., 2019).

Finally, when considering when measures quantifying factors that were then associated with TA, a large proportion of the studies (n=8) only measured these factors at intake (Dimmaggio et al., 2019; Levy et al., 2010; Marziali et al., 1999; Penzenstadler et al., 2018; Pierò et al., 2013; Signer et al., 2019; Yeomans et al., 1994; Zufferey et al., 2019). Five studies administered the measures more regularly; pre-, mid- and post-therapy (Kivity et al., 2020), sessions one, five and nine (Kramer & Golam, 2019), every two months (Barnicot et al. 2016), every three months (Spinhoven et al., 2007) and baseline then every two months (Richardson-Vejlgaard et al., 2013). The administration of the measures was not reported or was variable across participants in two studies (Salzer et al., 2013; Hirsh et al., 2012).

Measures of TA

Working Alliance Inventory (WAI, Horvath & Greenberg, 1989)

Eleven studies used variations of the WAI. This measures TA based on the three components of TA according to Bordin's (1979) pan-theoretical model; the bond, and agreement on goals and tasks. Five studies used the full version of this measure, containing 36 items (client version n=2; therapist version n=2; observer version n=1). 12 studies used the short form version (Tracey & Kokotovic, 1989), comprising of 12 items (WAI-S) (client version n=8; therapist version n=4). The WAI has been validated (Horvath & Greenberg, 1989) and found to be reliable, with good internal consistency, as well as inter-rater reliability for observer measures (Hanson & Curry, 2002).

Helping Alliance Questionnaire (HAQ, Bassler et al., 1995*)*

One study (Salzer et al., 2013) used the HAQ German version, which contains 19 questions to assess the helpfulness and supportiveness of the therapist and the ability to work towards common goals. Both the client and therapist versions were used. The HAQ had good internal consistency (Eich et al., 2018), and the German client version has been found to have satisfactory discriminant and convergent validity (Nübling et al., 2017). However, the external validity of the therapist version is questionable (Eich et al., 2018).

California Psychotherapy Alliance Scale (CALPAS,* Marmar & Gaston, 1989*)

One study (Yeomans et al., 1994) used the CALPAS observer version. It measures patient working capacity, patient commitment, working strategy consensus and therapist understanding and involvement. The CALPAS demonstrated construct validity and high internal consistency (Tichenor & Hill, 1989)

Scale to Assess the Therapeutic Relationship – Patient Version (STAR-P,* McGuire-Snieckus et al., 2007*)

One study (Barnicot et al., 2016) used the STAR-P. Although it has good psychometric properties (Snieckus et al., 2007), it measures TA in community psychiatry generally, rather than psychotherapy specifically.

Patient Therapeutic Alliance Scale (P-TAS,* Marziali, 1984*)

One study (Marziali et al., 1999) used the P-TAS, specifically the therapist subscale. Internal reliability, concurrent validity and predictive validity have been found to be good (Marziali, 1984).

Factors affecting TA for people with a diagnosis of EUPD

The included studies examined a range of different factors associated with TA. Factors were grouped into five themes, which were: demographics, mental health, cognitive, personality/interpersonal, and treatment/therapist factors.

Demographic Factors

Three studies included data on the association between demographics and TA, although none explicitly aimed to assess demographics.

Age. Three studies presented findings on the relationship between age and TA.

Pierò et al. (2013) found that higher client age was associated with better ratings of client-rated TA. However, Penzenstadler et al. (2018) found that age was not associated with client-rated TA. Similar findings were found by Richardson-Vejlgaard et al., (2013), whereby age did not correlate to either client or therapist-rated TA. Both Pierò et al. (2013) and Richardson-Vejlgaard et al., (2013) investigated TA in relation to reasonably long interventions, suggesting the low number of sessions in Penzenstadler et al.'s (2018) study likely does not account for these discrepant findings. All used the WAI to measure TA, so cannot account for the inconsistent findings either. However, Pierò et al.'s (2013) sample was slightly older, and they all used different therapies. Perhaps the therapy type, psychodynamic therapy in this case, acts as a confounding variable. All three studies generally had good internal validity, although their controls for confounding variables could have been improved. It is possible that Pierò et al. (2013) had significant findings due to measuring TA after an extended period of therapy. The other two studies had much shorter therapies, which might have meant that the age-TA link may not have had a chance to unfold. Therefore, it is possible age may be an important factor for TA across a longer trajectory.

Other demographic variables. Additionally, Pierò et al. (2013) also included number of schooling years, duration of contact with mental health services and gender into their multiple regression analysis, with non-significant results in terms of predicting TA. Richardson-Vejlgaard et al., (2013) also found that number of children, years of education, gender, employment status, relationship status and ethnicity did not relate to either client or therapist-rated TA. Both used reliable and valid measures of TA and the result appears to be consistent despite the differing times at which TA was measured. It is possible that the lack of significant findings may have been due to insufficient power, due to the lack of power analyses performed and low sample sizes.

Mental Health Factors

Six studies examined the impact of functioning, symptomology and mood on TA.

Functioning. Two studies examined the contribution of social functioning on TA. Pierò et al., (2013) found therapist-rated social and occupational functioning did not predict client-rated TA at 40 weeks. This finding was echoed by Marziali et al. (1999) who found pre-treatment self-reported social functioning was not associated with early client-rated TA. Both studies used measures reported to have good psychometric properties and had comparable overall quality. Furthermore, the result is consistent regardless of whether the rater was the therapist or client, or when TA was measured (after three sessions for Marziali et al. (1999) and 40 sessions in Pierò et al., (2013)).

One study examined behavioural functioning and client-rated TA. Marziali et al. (1999) also measured the impact of behavioural dysfunction, as measured by the Objective Behavioural Index using interviews. Five behaviours are measured: suicide attempts, substance abuse, problems with the law, impulse control and house moves. Like social functioning, behavioural dysfunction and client-rated TA were not significantly related. The OBI relies on participant honesty, leading to potential responder bias which could have affected the result, and TA was only measured after three sessions, so the impact of behavioural functioning on TA across a longer period of time may show a different picture. Additionally, they failed to report the demographics of their sample, so the generalisability of the findings cannot be determined. Finally, statistical power may be an issue in these two studies, as no power analysis was performed and sample size was low.

Symptoms. Six studies examined the impact of psychological symptoms on TA.

Marziali et al. (1999) and Pierò et al. (2013) both used the SCL-90, which measures a broad range of psychological problems and psychopathology via self-reports. Pierò et al. (2013) found higher SCL-90 total score at baseline predicted better client-rated TA at the end of the intervention. However, Marziali et al. (1999) found no such association between this and client-rated TA. Yet only TA measured at session three was recorded by Marziali et al. (1999), whereas Pierò et al.'s (2013) single measurement of TA occurred at the end of 40 sessions. Both studies had good internal validity, so findings suggest that baseline psychopathology affects TA when TA is measured across a longer period of time. It should be noted that they did use different measures of TA, despite both being found to be reliable and valid.

Symptomatic distress was examined by Kivity et al., (2020). They examined the impact of symptomatic distress measured at pre, mid and post-treatment on client and therapist-rated TA. Interestingly, they found higher symptomatic distress predicted lower therapist-rated TA at subsequent time points in a treatment that was augmented to be more individualised to the client. There was no effect for client-rated TA, or for the treatment that was not individualised to the client. Generally, internal validity was considered good, such as the use of reliable measures. However, only a small number of sessions were provided, so the effect of systematic distress over a longer period of unclear. Nevertheless, the generalisability of the sample was very good, so overall the study was of good quality suggesting robust findings.

The impact on TA of specific EUPD symptomology was investigated in two studies. Spinhoven et al. (2007) found no significant association between these variables, for either client or therapist-rated measures. Pierò et al. (2013) also did not find an association. The lack of association was present despite the measure of EUPD severity differing across studies, and measurements of TA being taken at the end of similarly lengthy periods of therapy. Considering these points, the reliability of the above findings are indicated, with validity of both studies also being deemed good.

A single study with high external validity and good internal validity found that the positive progression of client-rated TA was significantly more pronounced for people with EUPD diagnoses who also had a diagnosed co-morbid substance use disorder, as diagnosed using DSM-IV criteria (Penzenstadler et al., 2018).

Two studies examined the impact of mood; Richardson-Vejlgaard's (2013) study had a primary aim to examine this. They measured depression, hopelessness and anxiety, and found that these measures at baseline significantly correlated with client-rated TA at two months. A linear regression analysis revealed a significant relationship between depression, hopelessness, and anxiety at two months and client-rated TA at two months. However, Marziali et al. (1999) did not find a significant association between the BDI and client-rated TA. It should be noted that differing scales for TA were used across both studies, which could have led to differing findings. Additionally, different samples were used across studies - Richardson-Vejlgaard's (2013) study had a sample that was deemed non-representative of the EUPD population, whereas Marziali et al. (1999) did not provide any study demographics. Considering these points, it is difficult to determine the impact of mood on TA from these findings alone.

Cognitive Factors

Three studies examined factors relating to cognition and TA.

Kramer and Golam (2019) investigated the influence of participants' cognitive heuristics, a set of mental operations, on client and therapist-rated TA. They found people with a "TRUST-CULPRIT" heuristic ("a high frequency of overgeneralising and personalising biases which served the individual to present a negative image of oneself, along with mind reading and tunnel vision types of thinking, which serve the individual to maintain a positive image of the self and other", pp. 1325) rated TA higher than those with a "TAKE-ALL" heuristic. 'TAKE-ALL' "represented a cognitive strategy characterised by a high frequency of all-or-nothing thinking, which served the individual to present a positive image of the self", pp. 1325. Although the rationale regarding why these heuristics were investigated was unclear, the measures used were reliable, with measures being administered frequently, adding to internal validity. Overall, the results appear to be reasonably internally and externally valid, however, whether this result would hold up for a longer duration of therapy cannot be determined.

The impact of mental state vacillations and executive control were investigated by Levy et al. (2010). They found that lower executive control (ability to pay attention to certain things whilst ignoring others) was associated with lower observer-rated TA. A mediational analysis revealed that in-session mental state vacillations (indecision) mediated this relationship. Therefore, it is suggested that poor executive attention results in greater vacillations in mental state, leading to lower TA. Although the study only measured observer-rated TA and the tool used to measure vacillations was novel, good inter-rater agreement and internal consistency was high. However, there were some quality issues, such as the sample comprising only of women, minimal measurements being taken, and the psychometric properties of the measure of executive attention not being reported. In summary, the poor ratings of internal and external validity bring the findings into question.

The final cognitive factor investigated was metacognition (Dimaggio et al., 2019). Metacognition generally had no significant relationship with TA, but a specific aspect of metacognition, the ability to understand others' minds, was significantly associated with therapist-rated TA progression. Predictor variables were measured by observers based on transcripts, with a consensus score from two independent raters being derived, aiding internal validity. However, the measure used for metacognition has not had its psychometric properties assessed, so its validity and reliability could not be inferred. Although, inter-rater reliability was excellent. A final point to note is that the generalisability of this finding is questionable, due to the low external validity. This appears more to do with poor reporting, as they did not state their inclusion/exclusion criteria or the demographics of the subsample they used from their larger study.

Treatment/Therapist Factors

Three studies examined factors relating to the treatment or therapists.

Barnicot et al. (2016) found that, in the context of DBT, skills use, treatment credibility and self-efficacy predicted client-rated TA, with the biggest effect size of 0.91 for treatment credibility. A strength of the procedure was that measures were administered frequently, every two months for a year. However, the authors state that measurement of skills use may have been dependent on knowledge of DBT terminology, potentially confounding the results for this factor. Although this is the only study to examine such factors, overall, it had good internal validity, as well as excellent external validity suggesting the findings are generalisable to the population.

A study by Yeomans et al. (1994) found that there was no significant relationship between the ‘completeness’ of the contract setting phase and TA. Both the contract setting phase and TA were measured by observers using the Contract Rating Scale (CRS; Selzer et al., 1989), with the inter-rater reliability for contract setting being high. However, the subjective experiences of therapists and clients are not captured, and the study has questionable internal validity. The study also had low external validity, and therefore is a poor quality study overall.

A final study investigating treatment factors was by Spinhoven et al., (2007). They found that dissimilarity between clients and therapists on measures of schemas and personality organisation, were both significantly related to positive changes in client-rated TA from early-to-mid treatment. Although only a small time frame was assessed, the study had good internal and external validity, suggesting findings are likely generalisable. Despite this, the link between this variable and TA across a longer time period cannot be determined.

Personality/Interpersonal Factors

A total of three studies examined factors related to participants' personalities.

Agreeableness. Two good quality studies examined the relationship between agreeableness and TA. Hirsch et al.'s (2012) study investigated the impact of the 'Big Five' personality traits on client-rated TA. Increases in TA over time were significantly larger for more agreeable participants in DBT, but not in GPM. Zufferey et al. (2019) added support and therefore reliability to Hirsch et al.'s (2012) already good quality findings, as they found levels of agreeableness on the PA-AS had no impact on client-rated TA mean scores or progression in GPM used.

Other Personality Characteristics. Pierò et al. (2013) found that levels of novelty-seeking, reward dependence, persistence, self-directedness, co-cooperativeness or self-transcendence, measured via the TCI, were not associated with client-rated TA. In terms of the other traits that make up the 'Big Five' aside from agreeableness, Hirsh et al. (2012) found no effect of openness, conscientiousness, extraversion and neuroticism on client-rated TA progression over time. However, this may have been due to a lack of statistical power.

Finally, two studies examined the impact of interpersonal factors, specifically interpersonal subtypes and social interaction patterns.

Interpersonal Interaction. Salzer at al. (2013) classified participants with EUPD diagnoses, via the IIP-C, into categories that best described their interpersonal subtypes, derived from self-reports of interpersonal problems. The categories were: ‘vindictive’, ‘moderate submissive’, ‘non-assertive’, ‘exploitable’ and ‘socially avoidant’. They found therapists’, but not clients’, ratings of the TA significantly differed depending on the client’s interpersonal subtype. Specifically, those classed as being ‘socially avoidant’ had the lowest TA. However, they did not report which subtypes significantly differed from others in terms of TA/the impact of total IIP-C score on TA. Despite this, internal validity was good, and significant strengths were noted; it had the largest sample size of all studies sampled, and several confounding variables were controlled for. Overall, the study’s results appear reasonably valid, although their generalisability may be limited due to the overwhelmingly female sample.

A final study by Signer et al. (2019) investigated problematic social interaction patterns, assessed via the observer-rated measure the BIPS, with good inter-rater reliability. This tool measures items such as clients’ assumptions about trust in relationships, beliefs about the meaning and function of relationships and how the client may ‘test’ relationships. It was found that the more intense problematic social interaction patterns were, the lower the therapist, but not patient, rated TA. However, this was only when the therapy was individualised to the participant, suggesting the role of therapy type. The researchers admitted that the number of observations were minimal; however internal and external validity were generally rated good.

Discussion

The current systematic literature review aimed to synthesise the existing research on factors associated with TA between therapist and client in psychological therapies for people with a diagnosis of EUPD. Such a review is useful as there is a well-established link between TA and more favourable therapy outcomes. Therefore, by understanding what influences TA, this could in turn help therapists/services understand how to create better TAs for people with a diagnosis of EUPD. Consequently, this could lead to more favourable therapy outcomes. In total, 16 studies were reviewed, and factors were categorised into five themes using narrative synthesis. Mixed findings regarding factors that affect TA for the people with an EUPD diagnosis emerged. The factors that have been researched are diverse in nature, and were often unique to individual studies, making it challenging to draw broad conclusions regarding which factors may be most pertinent.

It is interesting to note the lack of research regarding factors influencing TA for people with an EUPD diagnosis that are not ‘within’ the client, for example treatment or therapist factors. This could perhaps be due to the belief of mental health staff that people with EUPD diagnoses are more in control of their behaviour than those with other diagnoses (Forsyth, 2007). Several recent reviews have been conducted investigating the determinants of TA with people with psychosis (Shattock et al., 2018; Browne et al., 2019; da Costa et al., 2020). These reviews demonstrate the abundance of research where the investigation of factors affecting TA with people with psychosis has been the primary aim. However, the current review found that for the EUPD population, only half of the papers sampled had a primary aim of investigating factors related to TA. Although important for any mental health difficulty, considering factors influencing TA for people with EUPD diagnoses appears particularly important. This is in light of the fact that staff often perceive this client group to be challenging to work with (Bodner et al., 2015). Therefore, it is surprising that there is relatively little research on the reviewed topic.

Examining the relationship between demographics and TA appeared to be an oversight in the majority of studies, in that although most studies gathered at least some demographic data, the majority did not evaluate its association with TA. Of the three that did, the association between demographics and TA was not a specific aim. Mostly non-significant findings were found for variables such as age, education and gender in the studies that included associations between demographics and TA. However, one study did find that higher age was significantly associated with better client-rated TA (Pierò et al., 2013) across a lengthier period of therapy. This may be the case due to older people having more experience of building personal relationships throughout life, and therefore finding this easier to do this within a therapy context. Additionally, older adults may be more invested in therapy as they may perceive that they have fewer chances to make changes than younger clients. However, the finding did not apply to therapist-rated TA, perhaps due to therapists relating to clients in a similar way, regardless of age. Overall, the quality of studies was good; however the type and more notably the length of therapy was inconsistent across studies. Pierò et al. (2013) used a therapy of a significant duration, whereas the other two studies used fewer sessions, which perhaps allowed for the age-TA association to unfold. Such an idea is supported by previous research, for example, Hersoug et al. (2009), found older age was associated with better TA in long-term psychotherapy in sample of people with a variety of mental health problems. The impact of other demographic variables may have been apparent had more representative samples been used that could be generalised to the EUPD population, and so cannot be ruled out.

The research painted a complicated picture of the association between mental health factors and TA. The main difficulty was the divergence in the length of therapy offered, therefore limiting the points at which TA measures were administered. Social and occupational functioning was found not to be associated with TA across two studies. However, the time at which occupational functioning was measured means that the effect of this variable across a longer period of time cannot be determined. Nevertheless, these non-significant findings appear surprising, considering staff have been found to view people with a diagnosis of EUPD as being more in control of negative behaviours, in this case lack of functioning, than those with other mental health diagnoses, leading to less staff sympathy (Markham & Trowrer, 2010). Therefore, lowered functioning seems likely to decrease TA, as this might be perceived as being controllable.

Considering overall quality and the times at which TA was measured in two studies (Pierò et al., 2013; Marziali et al., 1999), it appears that general psychopathology may be associated with TA further into therapy, as opposed to the start. We might have expected higher general psychopathology to be associated with lower TA when measured across a longer period of time, due to therapeutic burnout commonly emerging for therapists working with this client group (Linehan, 2000), which may be more pronounced for those with higher psychopathology. However, the association between higher psychopathology and better TA over a longer period of time may have been due to clients with higher psychopathology levels having had, or having developed, more motivation to change, leading them to invest more in the TA. In more ecologically valid circumstances, those with higher psychopathology may receive more support from therapists than those with less severe psychological difficulties. The mere exposure effect may occur in such cases, whereby the more exposure a person has to someone or something, the more favourable they view them/it (Zajonc, 1968). However, in both of the aforementioned studies, all clients received the same number of sessions, meaning this explanation is unlikely.

The level of specific EUPD symptoms were seemingly not associated with TA in two studies (Spinhoven et al., 2007; Pierò et al., 2013). The lack of an association between impaired functioning/higher general psychopathology/specific EUPD symptoms and TA may be related to volunteer bias (Martinson et al., 2010), whereby those therapists who volunteered to partake in these studies may have been highly motivated or experienced. This could have then mitigated the effect of mental health factors, and also might explain the lack of an association between functioning and TA. Of course, it is possible that the lack of significant findings may be directly related to lack of statistical power.

A couple of studies found evidence to the contrary regarding the lack of effect of symptomology, however. Richardson-Vejlgaard et al., (2013) found higher levels of depression, anxiety and hopelessness related to lower TA, although the representativeness of the sample is limited. Kivity et al. (2020) found no effect of client distress on TA during the treatment as usual condition, however when treatment was individualised to clients’ specific goals, higher client distress predicted lower therapist-rated TA. This appears a surprising finding, as we might expect a more bespoke therapy, as opposed to one that is less individualised, to be able to better manage symptomatic distress, and therefore have less of an association with TA. It also contrasts with Pierò et al.'s (2013) finding, although the methods of the two studies differed, such as time at which measures were administered. Furthermore, Pierò et al.'s (2013) significant association was in relation to client-rated TA, whereas Kivity et al.'s (2020) significant results concerned therapist-rated TA, suggesting the TA perspective may influence results. Kivity et al.'s (2020) findings also suggest that type of therapy might be a confounding factor when examining the association between variables and TA. Finally, the concepts of psychopathology and symptomatic distress may reflect different constructs, perhaps leading to the discrepant findings. Overall, these findings regarding symptoms are in contrast to other research. For example, da Costa et al.'s (2020) review found that the overwhelming majority of studies investigating the association between symptoms and TA for clients with schizophrenia diagnoses found an association between higher clinical symptoms and lower-rated TA, from both client and therapist perspectives.

Several cognitive factors were found to be associated with stronger TA. Although understanding others' minds predicted TA in Levy et al. (2010), the quality of the research was poor for both internal and external validity, casting doubt on the findings. Several quality issues were also apparent in Dimaggio et al.'s (2019) research, which found an aspect of metacognition, understanding others' minds, and TA were positively related. This finding appears plausible, as according to Bordin's (1979) theory, TA involves joint negotiation and agreement (Hatcher, 2010). Being able to understand others' minds can help the client understand issues from the therapist's point of view, which may aid in the negotiation and agreement process, therefore increasing TA. The importance of the process of negotiation and agreement may also explain why clients classed as 'socially avoidant' and those with more problematic social interaction patterns, also had lower-rated TA (Salzer et al. 2013; Signer et al., 2019). Yet, Dimaggio et al.'s (2019) results may not fully generalise to those with EUPD diagnoses, as demographics were not reported, with similar concerns regarding Salzer et al.'s (2013) research, despite both having good internal validity. Additionally, Signer et al.'s (2019) findings did not generalise to both therapies used in the study, suggesting therapy type may mediate these associations. Evidence was found for specific cognitive heuristics (Kramer & Golam, 2019). However, the process by which the cognitive heuristics were derived was complex, therefore the practicalities of classifying clients in this way would be challenging in clinical practice.

In terms of personality factors, higher levels agreeableness were found to predict higher client-rated TA progression only in DBT, and not GPM. The lack of an association could be due to the intervention used affecting whether agreeableness influences TA progression across time. Hirsh et al. (2012) state that significant findings for DBT may be due to the focus on "intimacy, warmth and genuine engagement" (pp. 624) in this approach, which might be more effective for more agreeable clients. The lack of significant finding for GPM was replicated by Zufferey et al. (2019), suggesting reliability. No other personality factors were found to be associated with TA. This is generally in line with other research, such as Dennhag et al. (2015), who found personality characteristics assessed pre-therapy did not show a relationship to TA. The lack of influence of personality characteristics on TA may also be due to Type II errors caused by the lack of statistical power. Previous research has indicated that it is perhaps the personality of the therapist that influences the TA. For example, Chapman et al. (2009) found higher levels of neuroticism were associated to higher client-reported TA, whereas therapist openness and agreeableness was associated with lower TA.

A few studies focused on the role of therapist or therapy variables. One (Yeomans et al., 1994) focused on the impact of the contract setting phase, but its low quality means that the findings are likely invalid. Notably, however, there was a large effect size for the influence of treatment credibility and higher TA (Barnicot et al., 2016). Treatment credibility encompasses how logical, suitable and efficacious a therapy is perceived to be by clients (Constantino et al., 2019). If clients see their therapy in this light, it may lead them to invest in the TA more, as they will perhaps perceive the relationship as equally beneficial. Interestingly, Spinhoven et al. (2007) found that the more dissimilar therapists and clients were in their personality organisation and schemas, the more the TA grew. Such results suggest that ‘’therapist-client matching’ may not result in better TA. Practically, this means that if a client had impaired personality organisation/schemas, the therapist will be less impaired (dissimilar) and therefore might be able to attend to the TA more. Spinhoven et al.’s (2007) findings appear to align with previous research. For example, though research has not examined personality organisation/schema matching, the impact of gender, income, age and ethnicity/race matching have been found to not significantly contribute to TA (Bhati, 2014; Behn et al., 2018). Ackerman and Hilsenroth (2003) outlined eight therapist attributes, such as flexibility, warmth and trustworthiness, which positively affect TA. Therefore, there still appears to be many therapist variables that would still benefit from being assessed within an EUPD population.

Appraisal of Included Studies

It is important to consider potential limitations of the review. Firstly, the construct of the TA is complex, and there is little consensus within the literature regarding its definition and components, although Bordin's (1979) pan-theoretical model has influenced its definition. Several measures of the TA were used across the sampled studies, meaning that different constructs could have been measured. As TA scales likely measure slightly different things, this may have affected whether a significant relationship could be found between certain factors and the TA. Furthermore, literature examining possible 'proxy measures' of TA (such as empathy) could have been missed.

The studies included in the review different significantly with respect to how many sessions of therapy they provided, as well as when they administered measures. Although every effort has been made, these differences made it challenging to compare the findings. One example is that certain factors may potentially be associated with TA in the longer term, however if only a small number of sessions are provided, the importance of some factors may not come to light. Also, the diversity in how frequently the TA was measured may have meant that studies captured different stages of the TA. Additionally, the therapy types used were wide-ranging. It could be that the type of therapy mediates whether a certain factor influences the TA. However, previous research alludes to the fact that therapy type does not influence the quality of the TA (Hovath et al., 2011).

Many of the studies utilised self-reported predictor and TA measures, with such measures possibly being subject to responder bias (Sharma, 2017). The included participants volunteered and consented to partake in a study. This may introduce bias, as these volunteers may have more insight than those who did not consent to participate which could have confounded the findings.
Social desirability bias may also have been introduced via this process as well.

Most studies had relatively small sample sizes, and it was found that most studies had not conducted power analyses to estimate the number of participants needed to detect any existing effects. This has significant implications for the interpretation of the findings of the included studies, in that there is a high chance of Type II errors. Furthermore, some studies with reasonable sample sizes experienced drop-out which decreased their power. Therefore, it might be reasonable to conclude that some factors that influence TA may not have been detected due to this issue.

Finally, this review focused specifically on people with an EUPD diagnosis. However, this may be problematic because the ICD-10 (WHO, 1992) outline that EUPD has a very diverse set of ‘symptoms’. Consequently, generalising variables associated with the TA in this client group at large is challenging as people with this diagnosis can present in radically different ways and therefore what affects the TA for one person may not be the same for another.

Implications of the Review

This review has attempted to deduce potential factors that may affect TA for people with a diagnosis of EUPD. The factors identified may help inform clinicians on possible avenues to help improve TA. It is then hoped that this in turn might facilitate positive therapy outcomes.

It is challenging to make firm conclusions on which factors may be pertinent, as studies employed such a diverse range of methods and times of measurement, utilised a multitude of different therapies and most likely suffered from low statistical power. Consequently, it appears that more research that specifically focuses on factors that are associated with the quality and growth of TA during therapy are needed in order to better understand how therapists can build positive therapeutic relationships with people who attract a diagnosis of EUPD.

However, from the evidence presented, considered alongside methodological quality, it appears that most of the evidence supports the idea that mental health factors, including functioning and symptoms, may not be associated with TA for people with a diagnosis of EUPD. The main explanations for this appear to be increased client motivation, and potentially highly motivated therapists involved in the studies. However, some evidence did suggest a potential role of symptoms influencing TA, such as higher psychopathology leading to better TA and symptom severity leading to lower TA for a specific type of therapy, despite these associations appearing contradictory to each other. It appears that the type of therapy and time of measurement may be potential confounding variables. As such, the impact of symptoms warrants further investigation. The impact of demographics and personality characteristics were not well supported, but this may have been due to insufficient statistical power, amongst other methodological issues. However, there was some evidence that age may influence TA across a longer period of therapy. Specific cognitive heuristics may impact TA, but the practicality of classifying clients by heuristics is concerning. It appears that attributes that aid in clients' interpersonal communication, such as adaptive social interaction and interpersonal patterns, may lead to better TA. Finally, despite the research tending to focus on client factors, the level of treatment credibility appears to be an important influencer of TA and drives the notion that more therapist/therapy factors should be investigated.

Recommendations

Going forward, particular focus should be paid to therapist factors, as research in this area in relation to EUPD is particularly scarce in the current literature. Researchers may begin by ascertaining whether therapist factors identified by Ackerman & Hilsenroth (2001) are associated with TA for diagnosed with EUPD. Such factors include therapist criticalness, rigidity, uncertainty, distance, distractibility. Furthermore, the role of demographics could be further investigated, due to the evidence of an association being found in other studies on a more general mental health population. Furthermore, the influence of easy to identify variables, such as demographics and symptom levels may benefit from further investigation.

Several recommendations for future research, in relation to methodology, are also indicated:

- Demographic information of participants should be included. Researchers should not omit information regarding the racial or ethnic makeup of their sample. This went unreported in most studies yet may be an important explanatory or confounding factor.

- Power analyses should be conducted in order to increase the likelihood of detecting effects while reducing the potential for Type II errors.

- Studies should aim to gauge TA perspectives from both the therapist and client as these have been shown to often differ. It would be helpful for studies to use the same measure of TA to allow for easier comparability of results. Several valid and reliable measures of TA are available, although much of the previous research uses the WAI. Consequently, future studies may want to use this scale so their findings can be integrated with previous research.

- It would be helpful for a long-term period of therapy to be provided (perhaps 30 sessions), with measures of TA being administered at frequent points throughout in order to capture the trajectory of TA more holistically and across time.

Conclusion

In summary, this review has investigated the research examining factors associated with TA for people with an EUPD diagnosis. Factors found included demographic, mental health, cognitive, personality/interaction and treatment/therapist factors. Symptom levels and functioning do not appear to be associated with TA according to the reviewed research. However, there was some evidence to the contrary, so this factor cannot be ruled out and the findings may be impacted by confounding variables. The evidence also generally shows the lack of impact of demographics, although age be associated with TA across time in longer term therapies. For both symptom levels and demographics, previous research has showed their association to TA, suggesting further research is warranted. However factors relating to interpersonal interaction, cognitive heuristics, and treatment credibility may be associated with TA. Finally, research examining factors associated with TA for people with a diagnosis of EUPD has a lot of scope to be developed as per the recommendations made.

Funding Sources

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

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Part Two: Empirical Paper

Exploring therapists’ experiences of engagement in Dialectical Behaviour Therapy

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Word Count (excluding references, abstract and tables): 10,152

This paper is written in the format ready for submission to the journal *Borderline Personality Disorder and Emotion Dysregulation.* Please see Appendix E for the Guidelines for Authors.

Abstract

Background Emotionally Unstable Personality Disorder (EUPD) is associated with difficulties in treatment engagement across several types of psychotherapy. However, studies show that high completion rates are possible for this client group. Dialectical Behaviour Therapy (DBT) is a specialist therapy for people who present with EUPD and has a focus on client commitment and engagement. The current study aimed to explore therapists' experiences of engagement in DBT with people who have a presentation of EUPD.

Method Eight DBT therapists took part in a semi-structured interview via video and phone calls. The data was analysed using Interpretative Phenomenological Analysis (IPA).

Results Three superordinate themes ('What Engagement Looks Like', 'The Relational Element of Engagement' and Facilitators vs. Barriers') emerged from the data, alongside seven subordinate themes.

Conclusions Active engagement with the programme was perceived by therapists to be important for clients, rather than their mere attendance. Therapists considered client engagement to be an oscillating process. DBT appeared to help contain therapists so that they could effectively address clients' engagement issues, and clients' engagement reinforced the engagement of their therapists. Therapists perceived peer support as helpful for client engagement, and discussed the role of goals and barriers, alluding to the importance of balance.

Key Words engagement, drop-out, dialectical behaviour therapy, emotionally unstable personality disorder, borderline personality disorder, experiences, qualitative

Introduction

The diagnosis Emotionally Unstable Personality Disorder (EUPD) appears in the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems 10 (ICD-10; World Health Organisation (WHO), 1992). The ICD-10 states that key difficulties include impulsivity, emotional instability, disruptions in self-image and interpersonal problems. The National Institute for Health and Care Excellence; NICE, 2007) reported that between 0.7-2% of the general population meet the diagnostic criteria for EUPD. This increases to 20% of psychiatric inpatients and 10-30% of outpatients. It is estimated that approximately 75% of people with this diagnosis are female.

It is acknowledged that the diagnosis of EUPD is controversial, because of its overlap with other mental health conditions due to wide-ranging symptoms, the lack of empirical support for the diagnosis and the stigma associated with it (Lewis & Grenyer, 2009). In the absence of any widely accepted alternatives, this paper will use the term 'EUPD' throughout to refer to this group of people. If a study writes explicitly about people with a diagnosis of EUPD, this will be stated. Otherwise, the term EUPDp will be used, which encompasses people with both a presentation and/or a diagnosis of EUPD.

Existing literature suggests that mental health staff have negative perceptions of clients with an EUPDp. Sansone and Sansone's (2013) review found that clinicians, such as nurses and psychologists, had a range of unfavourable feelings and attitudes. This included anxieties, apathy, frustration, discomfort and feeling challenged, manipulated, and less caring towards these clients. Those with EUPDp were perceived as dangerous and having less coping and social interaction skills. This was associated with clinicians being less helpful and empathetic, angrier, and socially distanced themselves. In comparison to clients with diagnoses of schizophrenia or depression, Markham and Trowrer (2003) found that staff perceived clients with the label of EUPD to be more in control of negative behaviours.

The publication of ‘Personality Disorder: No Longer a Diagnosis of Exclusion’ (National Institute for Mental Health England; NIMHE, 2003), marked a shift from considering personality disorders (PDs) as ‘untreatable’, to a condition that can improve with intervention. One such intervention is Dialectical Behaviour Therapy (DBT), developed by Linehan (1993) specifically to help women with EUPDp who self-harm (Chapman, 2006). Linehan recognised the need for an alternative to Cognitive Behavioural Therapy (CBT). She considered CBT’s main focus on change insufficient and believed that this needed to be balanced with acceptance, which became a central part of DBT (Linehan, 1993). DBT should meet five treatment ‘functions’: enhancing client motivation, teaching skills, generalising skills to the client’s environment, motivating the therapist and improving their skills, and structuring the environment. The five functions are typically met via four treatment ‘modes’: weekly individual psychotherapy, weekly group skills training, telephone coaching as required, and weekly team consultation for therapists (Linehan, 1993). DBT also appreciates difficulties with engagement, and includes a pre-treatment stage to help people prepare for the programme and set goals. A meta-analysis of 16 studies conducted by Kliem et al. (2010) concluded that DBT for diagnosed EUPD was more effective than ‘treatment as usual’. A moderate global effect was found for DBT, as well as a moderate effect specifically for the reduction of suicidal and self-injurious behaviours. It is currently a NICE recommended treatment for women with a diagnosis of EUPD who regularly self-harm (NICE, 2009).

Although psychological intervention for people with EUPDp is now being seen as viable option, this has been associated with problematic completion rates compared to those with other mental health difficulties. A review of 41 studies of psychotherapy non-completion across a range of different therapy types found that the average completion rate for interventions of 12 months or more was 71%, with considerable variability in completion (Barnicot et al., 2011). Additionally, a review conducted in the same year of 25 studies found an overall completion rate of 68% for people with EUPD diagnoses (McMurran et al. 2010). The difficulties with completion for EUPDp appear to be more pronounced than for other psychological difficulties; a meta-analysis of adult psychotherapy by Swift and Greenberg (2012) investigated completion rates across a range of mental health diagnoses such as anxiety, psychosis and eating disorders, incorporating 669 studies. They found that the average completion rate for mental health difficulties generally was over 80%, highlighting the disparate completion rates between those with EUPDp and those without.

Although DBT is a tailored approach for people with EUPDp, with evidence of efficacy for this client group and with specific engagement strategies, engagement may still be an issue. In an outpatient setting, Landes et al. (2016) found a non-completion rate of 51.8% in DBT with a sample of 56 people with an EUPD diagnosis. Zinkler et al. (2007) found a 46% non-completion rate in a sample of 13 participants with EUPD diagnoses. However, a high completion rate can be achieved for this therapy, with some completion rates being higher than what might be expected generally in psychotherapy (Swift & Greenberg, 2012). For example, Perseius et al. (2007) reported a non-completion rate of 11% in a sample of 27 women with an EUPDp, and Kröger et al. (2006) reported that only 12% had dropped out from a sample of 50 participants with EUPD diagnoses in inpatient DBT. This suggests that retention rates in DBT are comparable, and in some cases favourable, to other therapies for EUPDp.

There is currently a lack of understanding as to the causes of such non-completion; research that has investigated this is quantitative in nature. Rüsch et al. (2008) investigated predictors of non-completion for 60 women with EUPD diagnoses who had accessed inpatient DBT. They found that perceived stigma was higher for clients who dropped out. They also found a significant relationship between DBT drop-out and clients' anger/hostility, experiential avoidance and anxiety. Perceived stigma as a predictor of client drop-out suggests that an environment where clients perceive that staff hold negative views about their presentation could contribute to lower levels of engagement within therapy. More recently, the study by Landes et al. (2016) carried out a logistic regression examining predictors of drop-out in clients with EUPDp who accessed DBT. They found that younger age, higher levels of distress at baseline, and a lack of acceptance of emotional responses were significantly associated with drop-out from the DBT programme. Poor therapeutic alliance has also been shown to influence completion rates in DBT in a study by Wnuk et al. (2013), who also found that greater lifetime suicide attempts, anger and higher anxiety/mood disorder comorbidity were associated with non-completion. Conversely, Barnicot et al. (2016) found that neither the therapeutic relationship nor treatment credibility were related to treatment completion. Furthermore, Gaglia et al. (2013) conducted a study aiming to understand the factors involved in non-completion in a DBT programme of 102 people, which had a 58% non-completion rate. They tested several patient-related variables to understand whether they predicted non-completion, such as history of hospitalisation and substance misuse. Interestingly, the only variable that they found related to attrition was care coordination; those with care coordination were more likely to not complete therapy. These results suggest that systemic factors may affect engagement rather than purely client factors.

Research regarding non-completion for EUPDp has focused more on client factors that influence completion or non-completion, as opposed to understanding the process of engagement more generally which could give a broader insight. Qualitative research in this area has the potential to deepen our understanding of this, but there have been just two qualitative studies. The first was conducted by Clarke et al. (2013), who interviewed 23 clinicians from multiple professions in PD forensic services, most of whom worked in inpatient settings. The responses were not recorded, but rather transcripts were formed from rough notes, which could have led to bias in recollection of responses. The results, derived from thematic analysis, indicated that staff perceived that the concept of engagement was about more than simply a matter of attending or dropping out; they appreciated that an active role in the communication between staff and clients was important in their definitions of engagement. Participants discussed client-related factors influencing engagement, such as clients feeling unsafe and therefore being unwilling to tackle difficult emotions, as well as fear of rejection from staff, thus wanting to reject them first. Therapy-related factors included the importance of skilled and effective staff.

Participants then outlined several techniques to aid treatment engagement including preparatory work, setting boundaries, validation of previous experiences and attending to the therapeutic relationship. A second more recent study by Acford and Davies (2019) examined the ways in which non-PD specialist nursing professionals therapeutically engage with people with a diagnosis of PD in general acute inpatient mental health settings. They conducted focus groups with 19 nursing staff and identified six themes using thematic analysis. The findings identified the importance of the clinician being in the right frame of mind to engage, getting to know the service user, knowing the appropriate time to engage, allowing service user input, creating a unified approach between inpatient staff and community services, and having structured admissions, patient management and discharges. Both studies did not focus specifically on those with EUPDp. As the range of PD diagnostic categories is extensive, presentations can differ significantly depending on cluster and subtype (APA, 2013). Consequently, issues pertaining to engagement may differ markedly across different PD presentations. Hence it is important to investigate engagement specifically for EUPDp. In addition, the aforementioned studies do not examine engagement for specific interventions but rather psychiatric care more generally, thus Acford and Davies (2019) noted the need for future research examining engagement within other settings. In addition, both use thematic analysis, which could limit depth of understanding of the phenomena of engagement.

Rationale of current study

Whilst DBT is shown to be an effective treatment for EUPDp (NICE, 2009), completion rates are varied. Most previous research on non-completion focuses on client factors and adopts a quantitative methodology. Of the two qualitative studies

(Clarke et al., 2013; Acford & Davies, 2019) that exist investigating staff experiences, the EUPDp group has not specifically been examined, but rather personality disorder presentations more generally. In addition, they do not investigate experiences of engagement in relation to a specific and defined intervention.

There is currently no research examining the general concept of engagement in DBT from the perspectives of therapists working within this model, despite this being a key focus of the therapy. Such research can further our understanding regarding what affects engagement, and the process and trajectory of engagement. Understanding the perspectives of those directly involved in DBT could contribute to improved retention rates, as well as improved experience of the process of DBT therapy for clients and therapists, which may yield benefits in relation to therapy outcome. Additionally, evidence suggests working with this client group can evoke difficult emotions; a qualitative investigation can capture emotional responses specifically in relation to therapists' engagement experiences, which could potentially identify staff support needs.

Aim and Questions

Research Aim

To explore therapists' experiences of engagement in DBT with their clients who have an EUPDp.

Research Questions

1. What are therapists' experiences of engagement in DBT with people who have an EUPDp?

2. What do therapists believe influences engagement in DBT for those with an EUPDp?

Method

Design

A qualitative design employing semi-structured interviews was utilised. An interview schedule was used as a guide, which included prompts to invite depth in conversation (see Appendix F for interview schedule). The interview schedule was developed in collaboration between the authors of this study. The questions were discussed in supervision to ensure they were relevant and appropriate for the method selected. Interpretive Phenomenological Analysis (IPA; Smith, 1996) informed the method and analysis.

Participants

To be eligible to take part, participants had to have completed foundation level DBT training (five days of classroom-based training plus six months of clinical work) with experience in working individually with clients who have an EUPDp using DBT (DBT-informed work was excluded). Experiences could be ongoing (currently working with such clients), or historical (up to two years) in an adult setting. This could be inpatient or community and both NHS or private settings. Those who worked in forensic, learning disability and children's services were excluded due the additional variables that may affect engagement in these client groups.

Participants completed a demographic form (Appendix G) which allowed the researcher to collect information on the composition of the sample, which is displayed in Table 1.

Table 1

Participant information gathered from demographics form

Participant	Gender	Service Type	Additional training	Time using DBT (years)	Gaps in using DBT
Audrey	Female	Outpatient DBT	Compliance training	20	No
Rose	Female	Outpatient DBT	DBT intensive training, Advanced Clinical Skills in DBT: Skills for DBT Team Leaders to Promote Adherence, RO-DBT training, Society for DBT (SfDBT) accreditation	10	No
Layla	Female	Outpatient	EMDR,	2	No

		DBT	trauma-focused CBT		
Eileen	Female	Outpatient DBT	DBT intense training, Cognitive Behavioural Therapy, Compassion Focused Therapy	3	No
John	Male	Outpatient DBT	Several DBT "top up days"	6.5	6 months
Kate	Female	Outpatient and inpatient DBT	Intensive training, DBT leader adherence and SfDBT accreditation	8	2 years
Harriet	Female	Outpatient and inpatient DBT	DBT problem solving, DBT PTSD treatment following childhood sexual abuse	6	7 months
Vicky	Female	Outpatient DBT	DBT PE, schema therapy	10	No

Procedure

The University of Hull Faculty of Health and Social Care Research Ethics Committee approved the study (see Appendix H for approval letter).

The study information was advertised in numerous social media websites and an email mailing list to recruit participants via volunteer sampling (see Appendix I for advert). The researcher sent interested people the information sheet (see Appendix J) for further details about the study and provided an opportunity to ask any questions. Demographics and consent forms (Appendix K) were sent to participants and were completed prior to the interview, as interviews took place remotely due to the Covid-19 pandemic. In total, eight participants took part.

Interviews were conducted via video call (N=6) and telephone (N=2). The interviews were recorded and varied in length from 40 to 70 (mean=55) minutes. Participants were given a list of sources of support should this been needed following the interview (Appendix L). With regards to data saturation, the primary researcher discussed the state of the data after each interview with the second and third researchers. It was agreed that after the eighth interview that the data was detailed enough and that no significant new themes were emerging.

The results were analysed using IPA (Smith, 1996). IPA was chosen as it helps to understand the views and experiences of participants, and acknowledges that the understanding of this is inevitably influenced by the assumptions of the researcher. As the researcher had strong views on the topic, the emphasis on being aware of, and managing their assumptions was deemed necessary. Furthermore, IPA incorporates interpretation, which provided a more in-depth analysis of the data. Hence, IPA was chosen over thematic analysis, which focuses more on description rather than interpretation (Braun & Clarke, 2006). Grounded theory (Glaser & Strauss,1967) was also not considered as a potential method because the production of a model or theory was not an aim of the study.

This involved recordings being transcribed by the researcher, followed by the reading and re-reading of transcripts. After this, exploratory notes were made in the margin noting descriptive, conceptual and linguistic points. The notes were summarised into subthemes on the opposite margin. Emerging themes for each transcript were listed and compared between and across transcripts for similarities and differences. These themes were then ordered into the final subordinate and superordinate themes (Smith et al., 2009). Refer to Appendix M for a worked example.

Acknowledging the role of the researcher is important in qualitative research (Berger, 2013). The main researcher had had several experiences where they had witnessed colleagues discussing people with this diagnosis in a negative and at times hopeless way, with this point of view also reflected in the literature that the researcher had read. Consequently, the researcher may have went into the interviews with a pre-determined idea that therapists would discuss their clients with an EUPDp in a negative light. The main researcher had little experience of working within a DBT framework, and so was able to maintain a curious stance on this aspect of the research. A research diary was utilised in order for the principal researcher to reflect on their interpretations and potential biases. To ensure quality, the principal researcher shared transcripts, codes and potential themes with the study’s other researchers who provided recommendations. Following this, some changes to the themes and subthemes were made in order to best reflect the data.

Recordings were deleted following completion of this process. Any identifiable information, such as service names, were omitted to ensure anonymity.

Results

Three superordinate themes and seven subordinate themes emerged from the data as summarised in Table 2.

Table 2

Superordinate and subordinate themes

Superordinate Themes	Subordinate Themes
What Engagement Looks Like	Walking the Walk It's Ups and Downs
The Relational Element of Engagement	Therapists' Relationship to the Model Reciprocal Relationship Between Client and Therapist Emotions are Contagious
Facilitators vs. Barriers	A Life That Facilitates Change Systems

What Engagement Looks Like

This superordinate theme concerns the apparent difference between attendance and active engagement, including which is perhaps seen as more valuable, as well as the trajectory of engagement throughout the course of DBT.

Participants appeared to take a dialectical stance regarding engagement. Dialectics refers to the synthesis of opposites, and in this case relates to the idea that a client can physically attend DBT, but not be engaged actively. There was a sense that change is always happening in relation to engagement, and that the process does not simply end by someone reaching maximum engagement levels.

Walking the Walk

All therapists made a distinction between different types of engagement, and there appeared to be a contrast between physically attending and actively engaging. Participants expressed the importance of clients incorporating DBT into their everyday life, and embodying the model even outside of sessions:

"Erm… well, they turn up and… and… they bring something, that there's some willingness to do the structure of DBT and the content of DBT. So they're willing to do a chain analysis in session, willing to try out" (Kate). Here, Kate suggests that engagement goes beyond presence, and appears attuned to how willing clients are to complete therapy tasks.

"They talk the talk, but don't walk the walk, you know, they turn up and they're in group but they're not really using the skills and, erm, maybe they're saying they are, you know, what they're saying and what they're doing make much different things." (John). Here, John conveys a sense that clients try to make it appear like they are engaging to therapists, even though therapists may perceive that they are not actively engaging.

"I've had, erm, I've had some patients who have, erm, in terms of like their attendance at groups and in individual have had like an excellent like 95% attendance, uhm, 99% attendance, uhm, but have been minimal in terms of actually implementing DBT and actually making changes for themselves." (Eileen)

One therapist passionately described a client who she believed to be an active engager, who had physical attendance difficulties. This suggests that attendance issues do not fully determine someone's ability to engage actively:

"Despite her sometimes kind of patchy attendance, she is using the skills and it feels like she is engaged in the spirit of DBT" (Layla).

Eileen described the process of engaging people actively as getting "*people like hooked in, hooked in to treatment*", suggesting the need for therapists to take a leading role. Further, Kate stated "*I suppose it can feel a little bit like a battle*", highlighting the difficulty of this process. These accounts also highlight the idea that therapists may need to put a lot of energy into engaging clients, perhaps in the face of clients' resistance. This may demonstrate the level of responsibility that therapists feel regarding helping their clients to engage.

The therapists were able to quickly list off many different activities that they would expect to see clients doing if they were engaged. These included completing their diary cards and chain analyses, accessing telephone coaching, and trying new skills, which Audrey described as "*behavioural indices".* Due to this, active engagement is perhaps easier to notice and more ‘quantifiable’ than in other therapies, whereby the markers of engagement may be more intrapsychic, therefore less obvious to an outside observer. Interestingly, Eileen spoke about how some clients had been “*bounced around the system”* and had several previous therapies, which may have had “*more emphasis on… erm, the treatment almost being kept in the room.”*. The importance of socialising clients into the DBT model appears to be important here, and was touched upon by several other therapists too. This is due to the likelihood of clients having had other therapy experiences which may significantly differ to how DBT operates.

Overall, there was a sense that therapists acknowledged how hard it was for clients to engage, and several stated that it is the effort that counts.

It’s Ups and Downs

There seemed to be a consensus amongst therapists that engagement oscillates over time, rather than being a linear process of steadily increasing engagement. They took a dialectical stance on the presence of engagement, in that there was no ‘final destination’ whereby optimal engagement is achieved, but that engagement was an ever-changing process.

“You know, the engagement isn’t a straight, smooth curve, it’s ups and downs and it’s about trying to help people come back.” (John)

“It wouldn’t just be, kind of, linear” (Harriett)

Although the exact nature of the trajectory of engagement varied across accounts of experiences:

For Layla's client, when she was 'signed up' to DBT, the trajectory of engagement got off to a positive start. The exact nature of what it means to be signed up was not elaborated on by Layla. However, being signed up may mean being socialised into the DBT model and ensuring informed consent is obtained, amongst other things. However, the engagement eventually deteriorated: *"It all got messy again that's it so engagement improved initially when she was signed up to actually I think I do wanna give this DBT thing a go and we had a little, a little run of kind of momentum and then it all, which she was about to start group and then it all went yeah, kinda [inaudible].*" (Layla)

The trajectory of engagement for Rose's client appeared to be the opposite to Layla's*: "So there'd be lots of huffing and puffing, and eye rolling and sighing, and I'm not doing this and slamming, you know, her books shut, you know, a lot of ignoring those behaviours. And then in time, when she really was engaged in the process, the behaviours we would see would just be this willingness to… to do really hard stuff... really hard stuff."* (Rose). This account highlights that people may struggle to engage when they commence DBT, but suggests that time can play a big role, with the passing of time potentially offering hope to therapists who see clients initially struggle with engagement.

John discussed how he worked with people who had poor engagement which then increased. Witnessing someone's engagement increase following a period of disengagement appeared to be personally rewarding: *"It's more satisfying when you get somebody who's really disengaged and then you manage to, sort of, rope them in and I think wha- what has happened before is that sometimes it really just, people are not engaged and then they become engaged"* (John)

However, Harriet's account of a participant who engaged well throughout the whole programme suggests that it is possible for a client to fully engage throughout the whole process. The engagement of her client appeared to be active, as she described the client often completed tasks and homework:

"Erm… yeah, so her engagement in the therapy was good, her, erm, in kind thinking about her self-harm, her self-harm fluctuated, but her actual engagement in treatment was positive throughout, erm, she was very, kind of, committed to the therapy" (Harriett). Harriet explained this might have been due to her client's perfectionist tendencies.

For Vicky's client, the decrease in engagement in phone coaching appeared to actually be a positive thing, as it perhaps acted as a marker that the client was experiencing positive psychological change:

"She tapered that off that she didn't need that phone call within a few weeks, you know, she just, she just needed, once she'd, once I'd made the phone call and

she'd heard that she needed to do that, it made her overcome that kinda, that, erm, that avoidance of starting" (Vicky).

Interestingly, when therapists talked about the ever-changing nature of engagement, they appeared to discuss this in a casual manner, suggesting an acceptance of this. Kate vocalised this by stating: "*I don't expect much to begin with*". This apparent acceptance may have come about from therapists' DBT training, or perhaps from the vast experiences of DBT that most therapists reported that they had. It seems reasonable to suggest that therapists' acknowledgement that engagement is ever-changing may be a reinforcer for therapists to engage clients, due to the hope it is always possible to change the trajectory.

The Relational Element of Engagement

Therapists spoke about their experiences in using the DBT model and how it helps to contain them in what can often be challenging work. They highlighted the reciprocal nature of the therapeutic relationship and how this keeps both parties engaged, as well as the positive impact of a group format.

Therapists' Relationship to the Model

The model appeared to provide a sense of security, which Vicky named as *'containment'* to therapists, even though at times it could be difficult to work with. Furthermore, there was little negative talk about DBT, reinforcing the acceptability of the model. For many, it appeared to provide them with a framework and hands-on techniques which they felt able to apply to their work with clients in order to help clients remain engaged. Consequently, they appeared to be able to retain a sense of acceptance of engagement issues:

“I mean, it, it doesn’t necessarily get overwhelming and frightening because you have got the model to fall back on.” (Rose)

“I think it’s kinda containing as well, cos like we’re presenting, we know what we’re doing, you know, there’s a confidence in that of, erm, erm, we’re pretty sure that this is effective, that’s why we do it” (Vicky)

Layla’s sense of acceptance was evident despite an unfavourable outcome for her client. She uses the metaphor of “the ball’s in her court”, with such figures of speech being common in DBT:

“Yeah I think we worked as hard as we possibly could, there’s nothing I would’ve done differently with her. I think it’s kind of, ball’s in her court really, erm, yeah.” (Layla). Here, Layla implies the importance of the client’s personal responsibility regarding her engagement. She suggests that there is a certain distance that the therapist needs to go, but when they have passed this, the client needs to then step up to the game, hence the use of the idiom “ball’s in her court”. There also appears to be a sense of acceptance that there is only so much the therapist can do.

However, the rigid structure may at times be a challenge. For Kate, DBT's rigid structure caused her to sometimes dream about "*a little fantasy I have sometimes around let's just see what happens when we go back to the basics of me just listening, just listening, no pressure to do anything. Just listening, validating, and just being there, being available",* suggesting that although DBT can provide containment, this might get overwhelming at times.

The researcher felt that many of the therapists did not break their DBT 'characters' when being interviewed. It was noted that all therapists were very proficient in using specific DBT terminology and metaphors. This may be indicative of their engagement, immersion and/or belief in DBT, possibly highlighting their belief in the model. Alternatively, it could simply relate to the fact that they were being interviewed about their experiences of DBT and therefore used the relevant language. The importance that the model places on clear communication and limits, appeared to support some therapists in addressing engagement issues head on and feel confident in doing so:

"if somebody isn't engaging as well, I'll have shorter contracts and make it very clear that whilst I want to work with them, I don't just keep working with people that this isn't working for, erm, kind of, yeah, I think the relationship, often, is a big factor in that." (Harriett).

"I do think it is very helpful, it it's very helpful that it's in this model and I think maybe there's some other therapies where you're not that explicit, you're not giving that reflection back of of how you're impacted, erm, and I think it's much better that

you do that very transparently with someone." (Vicky). Here, Vicky appears to highlight the usefulness of explicit communication in the DBT model, referred to as 'radical genuineness'. Additionally, she suggests that other therapy models may benefit from incorporating this approach.

Kate suggested that the therapeutic relationship was a vehicle in allowing her to address problematic engagement in a direct manner: *"DBT, it is, they say it is a real relationship between individuals so I was able to say, you know what, when I've been working really hard week after week to try and get you a life that's worth living"* (Kate).

However, the confidence in addressing issues head-on was not shared by all participants, perhaps due to their clients' engagement being on the boundary between superficial and active. The following examples suggest there might be limits to the confidence some DBT therapists feel to be direct in their communication, and therefore adherence to the model, despite the model being containing overall:

"It was much harder to express the frustration with this other lady because, it was, on the surface, she was doing what you, what I was asking her, or what she needed to do, but the the engagement was sort of superficial with it." (Eileen)

"But often she would kind of come to enough sessions to just stay in so she might come to kind of one and then like miss 3 and then come to 1 so she'd be doing just enough but it wasn't in the spirit of DBT at all anymore at that point so that was really difficult" (Layla)

It may also be due to the complex process of socialising clients to the model: *"It's just hard, it's really hard for people to do DBT, it's a hard therapy and you say this before they sign up, you know I say this is not counselling, this is really hard you know and that's another commitment strategy"* (Kate)

Polarised responses were described regarding clients' reactions to feedback, with some participants' perceiving their clients to struggle to take it onboard. Perhaps it might relate to how socialised someone is into the DBT model, the client's motivation or the therapist's approach:

"Some people accept it, some people errr…… feel….. you know, that they've received it punitively." (Audrey). This may mirror the *"two types of patients in DBT*", which are people who "cling to you" and people who are *"all over the place".*

"Sometimes people kind of say, yeah I know, but it's hard and they take it well, and sometimes people get quite defensive" (John)

Despite the model supporting and containing therapists through the engagement process, they were not immune to negative emotions as a result of disengagement. As therapists appear to have faith and belief in the model and its effectiveness for engagement, these negative emotions when engagement does not go to plan appear unsurprising. These were wide-ranging across participants, and included, sadness, frustration, anger, failure, tiredness:

"Erm, lots of frustration and anger in terms of, erm... erm, emotions" (Eileen)

"I think it's really hard, I think it's attached, there's often a sense of, erm, failure, like I haven't done, erm… yeah failed to keep the person engaged." (Kate)

John had to take a break from DBT, as he felt so burnt-out due to unfavourable engagement. However, he had only recently started working with DBT at that point, which suggests that he may not have been sufficiently socialised, and therefore contained, by the model.

Reciprocal Relationship Between Client and Therapist

This subordinate theme incorporates the importance of the relationship between therapist and client, and how the engagement of both can be affected by this relationship. The research questions were initially focused on understanding how therapist experienced client engagement in DBT. However, interestingly, many therapists spoke about their own personal experiences of engagement, and what they believed facilitated this. The fact that the therapists brought this up unprompted highlights the importance of considering both client and therapist engagement, particularly as they seem inter-related. The equal importance of therapist and client engagement was made explicit by Layla:

“I guess when… when I saw the kinda you know the prompt on your question sheet it made me think of engagement from both the therapist and the client, didn’t make me think of one over the other.” (Layla)

The therapeutic relationship appeared to be important for keeping clients engaged and may be central motivator for client engagement in and of itself, as expressed by several therapists:

Audrey thought that the therapeutic relationship may reduce drop-out: *“most people I worked with in DBT make a strong therapeutic alliance relatively... soon and I think that’s because, if they, if they’re less likely to do that, they drop-out”* (Audrey)

Eileen and Harriett hint that this may be due to the reinforcing nature of the therapeutic relationship:

“I think rewards tends to influence engagement. Erm, [inaudible] like, kinda act actual rewards and also, sort of the more interpersonal.” (Eileen). The statement that “actual rewards” are “more interpersonal” suggests that different types of rewards, such as physical gifts, may not motivate clients as much as the relationship.

“The therapeutic relationship and if you’ve got a rapport with somebody erm it’s often quite easy to kind of motivate them along in DBT, particularly using the relationship as a reinforcer” (Harriett)

Validation was also commonly referred to, which the DBT model asserts is essential for change, as summarised by Rose. This highlights the participants' acknowledgement that clients need to know that therapists understand them and the motives for their behaviour:

"You need to validate the place that the client's in, otherwise they're not gonna come along with you"… "if I'm seeing someone who's really distressed and not so engaged, I wanna change that, but unless I validate them first, whatever's valid, then I'm not gonna get that " (Rose).

However, for many therapists, it appeared that clients' apparent motivation to engage and complete the tasks of therapy had a direct effect on their own engagement and appeared to be the main motivator. This suggests that engagement may be a reciprocal process between therapists and clients, highlighting the importance of the therapeutic relationship for both parties. This process appears to reinforce one of the fundamental ideas in DBT, being that the relationship between therapist and client is equal. Consequently, a process such as this may be expected, and is perhaps more specific to DBT than other therapies:

"Well if you're not gonna bother, then I'm not going to bother which is, like, a very horrible thing to say, erm, but that's, that's kind of what happened" (Eileen). Here, there is perhaps a sense of frustration with clients who do not put in effort, which leads Eileen to feel redundant and not put in effort herself.

“Yeah and maybe, erm, more committed, wanting to do more for the person when you see that” (Vicky)

“Erm, for me personally, I find DBT really rewarding, erm, it was extremely rewarding with her, erm... I suppose it kind of works both ways, it’s reinforcing for the therapist as well, so it’s reinforcing for the client, that if you, if you have a bond, if you have a relationship with somebody” (Harriett)

Vicky and Harriett are clear in these extracts that clients serve as a motivator for their own personal engagement.

For Rose, it seemed that clients explicitly and directly made attempts to keep their therapist engaged:

“Most of our clients are quite attachment hungry, so they will quite quickly work out how they reinforce us, and, and, and what, erm, might enhance connection” (Rose). “Attachment hungry” suggests that clients have a strong level of desire to connect with therapists, and likening it to hunger alludes to the idea that such a connection is essential, and that it is something that the client cannot go without.

However, she did describe a client who struggled to engage collaboratively and work on her agreed goals. It appeared that Rose may have begun to disengage from the process of engaging her client due to losing hope:

“There was also in me, this, erm, I don’t know what the emotion would be, excit-, I dunno, but like, erm, this excitement that, yes, she’s not gonna do this in the module, then we can get rid of her, kind of, they were the unhelpful thoughts” (Rose).

Even ‘small wins’ helped to spur John and his team on:

“I think people want to do it because when you get, someone improve, it really is amazing and, you know, even if there’s some, some of my team see it as, even if you work with 10 people and there’s 2 of those who really, really benefit and change their life, it’s worth it.” (John)

Staff consult was mentioned less so in relation to staff engagement, although Audrey stated that it helped her continue with DBT:

“So I got a lot of support from the team just to sort of keep going really”.

The fact that she needed to “keep going” suggests that therapist engagement in DBT can be challenging process.

Emotions are Contagious

This subordinate theme reflects therapists’ perceptions that peer support is an important element of the DBT programme. Several therapists relayed that clients had initial hesitations about engaging in skills group, due to its interpersonal nature.

Audrey used the word ‘terrified’, and Kate used ‘agony’, highlighting the extent of some clients’ apprehensions. This is perhaps due to society’s stereotype that therapy involves two people meeting in a room, leaving clients somewhat unprepared for what to expect. Alternatively, it could reflect interpersonal difficulties which are asserted to affect this client group more than others.

Some concerns were related to clients seeing people in group who they did not want to:

“People do have very realistic concerns that they might bump into people they know you know” (John)

“Given that it’s an inpatient setting, there might be relationship problems and tensions between the patients and they don’t want to be in the group with another person.” (Kate)

“If they have admission... which is the case for about half the patients... they often say to us all, oh, you know… is, uhm, is.. you know, Mary Smith in the group, and... you say... well, not at the moment... but she might be... you know... and, uh, because it’s a.. because it’s a rolling group, obviously, they say oh, I’m not coming if she’s going... you know, that’s quite common” (Audrey)

Although some people may never engage in the group effectively, the group element of DBT can act as a facilitator to engagement for many clients from the perception of therapists, due to the peer support it offers. This appears to be a predictable process, with Audrey stating that this change occurs “*within about three months*”, reinforcing the importance of therapists placing trust in the process:

“Emotions are contagious” “if people are sharing worries or emotions that resonate with you, I think then you can connect with that and it kind of validates you and then you know, you’re able to participate as well.” (Rose)

“I’ve had one girl who was really nervous about coming then it turns out [laughs] [inaudible] someone she knew was in group and that was brilliant for her, for both of them, found that supportive” (John)

Additionally, Layla suggests that clients may be surprised at how beneficial they end up finding working alongside other clients and forming relationships: *“people really do, erm, forge important bonds in group and often come out of it saying you know actually that was that was the most important bit of it for me.”* (Layla)

John’s team appeared to see the value of the group to the extent that they planned to promote it: *“We’ll often invite you know some of the people who’ve been there a bit longer to say something about that they’ve been glad about group for to try and inspire the new starters that actually it’s scary now but it is it’s worthwhile sticking it out.”* (John)

Facilitators vs. Barriers

Therapists expressed the need to balance clients’ motivation with factors that facilitate or deter engagement. The system also plays a role in this process.

A Life That Facilitates Change

When highlighting cases where engagement went well, most therapists discussed the importance of clients having goals to work on which seemingly provided self-motivation. For example, Rose’s client wanted a better life beyond her brother’s drug-taking habit, Kate’s client wanted to get a job, and John’s and Vicky’s clients had children they wanted to be present for. Having such explicit goals appeared be successful in facilitating engagement, as goals were generally not mentioned when therapists discussed cases where engagement did not go well:

> *“In the long term, she wanted to say no, she didn’t want to be fuelling this habit and so they were the sorts of things that she was in time, working on in DBT and to me, that really showed engagement with the programme”* (Rose)

> *“She was a little bit older and had a daughter, so had a motivation to engage”* (John)

Furthermore, Layla talked about a client of hers who had extensive therapy in the past, which seemed to have motivated her to make use of DBT. Participants appeared to suggest that such goals gave clients something to strive for, possibly offering them hope, and therefore aiding their engagement. Vicky in particular appeared to acknowledge the importance of this. She went on to describe a client who appeared to not have a goal or a reason to engage in DBT and tried to turn that around:

"I would have wanted her to get 10 hours of work or study or volunteer, or something before she came into the programme and I normally insist on it, like I'll really, I, I, I make sure that that's gonna happen before I take, otherwise I don't feel the person is committed" (Vicky).

Clients' goals and motivation perhaps need to outweigh individual barriers that they encounter, as therapists discussed the need for clients to be in the right place to engage:

"If they're very motivated on the treatment, then they get through that barrier, but if they're not very motivated, uhm… then they usually drop out." (Audrey)

Kate's client, who did not continue with DBT, struggled with the exposing nature of therapy:

"[She] *just felt therapy so exposing and difficult and challenging. She didn't want to tolerate exposure to difficult emotions.",* with Harriet relaying a similar experience.

Audrey alluded to the fact that some people are just not in a place to even consider one of DBT's main goals – to reduce self-harm. She also spoke about a specific client who was "mistrustful" and "hostile", leading to engagement issues:

“*There are one or two patients who just say... no, I wanna keep self-harming”.*

Several other barriers were identified, which highlight that for some clients, their basic needs are not met. In the following cases, it was access to finances:

“They’ve always got housing crises.. we have.. in any.. any one moment in DBT, we’ve usually got somebody, at least one person who’s street homeless” (Audrey)

“Some of our clients are too poor to even afford the bus to get into the sessions” (John)

For Layla’s client, it was physical health difficulties:

“She had lots of physical pain, lots of chronic pain conditions, medically explained stuff which were then making it very difficult for her to keep coming”, “Erm, money is sometimes a problem, some people struggling financially to kind of get to group” (Layla)

Rose believed that co-morbidities could affect engagement, such as Autism, other personality disorders and substance misuse, seemingly due to not feeling skilled enough:

“I think comorbid diagnoses can get in the, can be, erm, yeah, can get in the way or have a negative effect” (Rose)

These barriers suggest that readiness to engage has both a psychological and practical element to it. When discussing these barriers, there was a sense of understanding and patience from participants, for example: "*I'll will try and be flexible, erm, like practically, as far as I can."* (Audrey), with Rose discussing offering a poor engager a review to help improve engagement. Therapists tended to respond to the barriers proactively, possibly due to feeling empowered by the model, although varying degrees of success were noted. For example, Audrey discussed partnership working with a local charity *"We had a care plan around trying to... improve her attendance by getting her out more"*, although unfortunately, her client *"didn't engage in that either".*

Systems

Therapists appreciated the impact of systems, although systemic factors were varied. It appeared that for Rose's client, family pressure meant that she attended DBT, but perhaps did not want to be there, and therefore did not engage. A similar process occurred for one of Eileen' clients, and she suggested that this was possibly due to DBT being perceived as a "quick fix":

"I'm not even sure if maybe cos they were sent to therapy. I think sometimes people, you know, just come along to therapy because then they can say to their family they're in therapy" (Rose)

“Mum was really keen, and was like, you know, we’re tearing our hair out with her, we don’t know what to do, she’s got to do this, she’s got to do this, and actually, erm.. she didn’t really want to do it at all.” (Eileen)

Much like clients’ individual barriers, Eileen suggests that if systemic pressure matches the client’s goals and motivation, this could be a positive process:

“That’s great when there’s a strong push from outside, and they’re really, erm, motivated to do it, because you have, obviously that support from the wider network, as well as them wanting to do it, so they tend to do really well.” (Eileen)

Further, pressure from within the system could perhaps facilitate engagement once someone drops-out, according to Kate’s experiences, perhaps serving to increase motivation:

“I think often once someone’s dropped out they might realise, ooh.. my… erm… commissioners or home team are not happy about this so I’m probably going to be staying in hospital longer or I might be referred somewhere else that I don’t like or it might be positive” (Kate)

John acknowledged the long NHS waiting times and their impact on engagement. Audrey also touched upon this. Specifically, John discussed how clients complete the commitment phase and then have to wait an extended period of time to commence the subsequent group, which he believed led to drop-out. He highlighted his team’s innovative strategy of ‘splitting’ the commitment phase so clients need not wait as long:

“In terms of split commitments, we’re trying to do, like, three sessions [inaudible] first, and then if they get through that, then, then they start, then they do another 3 sessions before they start the group to try and reduce that drop-out while people are waiting and make sure people are engaged are more likely to be referred” (John)

Here, John seems to acknowledge the need to capitalise on clients’ motivation, which may be higher straight after the commitment phase, rather than after clients have waited an extended period.

Layla acknowledged the practical elements in the system that meant that not as many people could be engaged in DBT:

“*We don’t have enough clinic space, clinic rooms to run that, erm yeah so often it’s kind of really silly logistical stuff that means we can’t really run more. Erm, and engage more people, take people off the waiting list, got quite a long waiting list. So yeah sometimes it’s more systems stuff, kind of group like room availability, clinicians being freed up to run, erm, erm, yeah yeah that is definitely there*.” (Layla)

The practical limitations in relation to phone coaching operation hours were discussed by Audrey, who suggested that people may need it more during the evening:

"But there are real limits for how much they can use it… it, it's the hours they're most likely to want you... uhh, midnight" (Audrey). She discussed how the wider team can support telephone coaching engagement by upskilling crisis teams, although stated that clients' reluctance to use coaching may be the biggest barrier, followed by therapists' reluctance.

Finally, Harriet discussed that wider staff team engagement had been challenging: *"Working within a team where at that point in time, it was very difficult to, kind of, erm, get the staff team on board"*. She spoke about how the team struggled to understand the role of DBT and often would act counter-productive to the model leading to clients not actively engaging. Eileen spoke of a similar process, and suggests that the unique nature of DBT may make wider staff teams wary: "*I think sometimes, we, the DBT therapists, or the DBT team, erm, get viewed as a bit of oh, you know, you're a bit, like, stepping outside of, of the boundaries".* Audrey alluded to the difficulty of wider teams, specifically wards, stating that part of her role as a clinician in client engagement was: *"you know, balancing... uhm, expectations with wards for example".*

Discussion

Overview of Findings

This study aimed to explore therapists' experiences of engagement in DBT therapy with their clients with EUPDp, as well as what they perceived influences this engagement. This study examined therapists' detailed accounts in order provide an in-depth understanding of these research questions. This is the first study to examine the general concept of engagement within DBT from the perspective of therapists. It is hoped that the findings from this study can help to further the understanding of the engagement process in DBT, and how engagement can be improved. Ultimately, this could lead to more favourable therapy outcomes.

Therapists placed emphasis on 'walking the walk', as opposed to merely turning up to therapy without actively engaging in tasks. It is interesting to note that much of the previous research and reviews examining engagement for EUPDp has specifically examined completion rates (McMurran et al. 2010; Swift & Greenberg, 2012). However, it is suggested from the current study's findings that physically attending therapy is only one part of the process of engagement. This may be applicable to all therapies, but might have been particularly noticeable to DBT therapists, due to DBT's focus on dialectics. Specifically, physical attendance but lack of active engagement is possible at the same time. Perhaps it also relates to the fact that indicators of active engagement are behavioural in DBT, such as completing diaries and tasks. Whereas for other therapies, active engagement may be more about intrapsychic processes and changes. Interviewing forensic mental health workers, Clarke et al. (2014) also found a similar contrast between treatment attendance and ‘meaningful involvement’ for people with EUPDp in a forensic setting. They went on to state behavioural indices of active engagement, such as applying skills, however also suggested that clients showing insight and reflection are indicators of their active engagement. These may be useful to help distinguish between different types of engagement in less behavioural therapies. Overall, the need going forward of examining engagement both in terms of completion rates, as well as active engagement, is indicated.

The engagement process was perceived by therapists as an oscillating one, whereby engagement was always being worked on, again in-keeping with the philosophy of DBT. This is in line with research regarding clients’ experiences in DBT by Barnicot et al. (2015), who found that clients also recognised that active engagement required constant commitment and recommitment. The always-changing nature of engagement is perhaps reflective of people with EUPDp often experiencing numerous difficulties, such as impulsiveness (APA, 2013), and being more likely to lead less stable lives (Paris, 2010). These challenges may make it hard for some clients with EUPDp to be consistent in terms of engagement. This may then affect their readiness to change, and therefore engage with the programme. Specifically, they may move between the ‘action’ stage to previous stages of ‘determination’ and ‘contemplation’, as described in the Stages of Change model (Prochaska & DiClemente, 1983).

Working within the DBT model appeared to help to keep therapists feeling contained throughout the ever-changing engagement process, and promoted therapists to accept when things did not go to plan. It provided therapists with tools for engagement at their disposal, such as validation, metaphors, and the promotion of the therapeutic relationship. Use of these tools was evident throughout the interviews, whereby participants adopted a 'DBT character'. The role of the model appeared to function similarly to a 'secure base' within attachment theory (Bowlby, 1958), whereby participants felt able to directly address problematic engagement, seemingly due to feeling backed up by the model. This appears to be a particularly beneficial attribute of DBT for therapists, and may have led to participants' hopeful and positive attitudes towards their clients. Such attitudes contrast with mental health professionals' often negative perceptions of the EUPDp client group (Sansone & Sansone, 2013), perhaps as they do not feel as contained. However, there were some exceptions, particularly when clients' engagement was in between superficial and active.

Therapists' own engagement was perceived to be important by participants. Some therapists discussed how their engagement was affected by how much their client engaged. In such cases, it appears that client engagement reinforces therapist engagement through the process of operant conditioning (Skinner, 1938). This seems to be reflective of the fact that the relationship between therapist and client in DBT is a "real relationship" (Linehan, 1988). Therefore, it is unsurprising that both parties can be influenced by each other across therapy, with a reciprocal relationship in relation to engagement appearing to be the result.

The usefulness of the group format for client engagement was suggested across therapists' experiences, even though clients might be initially hesitant to attend the group programme. Barnicot et al.'s (2015) study found similar results from the perspective of clients, who valued encouragement from more experienced group members to help them to actively use skills. In Tuckman's (1965) model of group formation, it is proposed that a group goes through five stages, which initially begins with formation of the group. Next comes the 'storming' stage; in this case, clients struggling to be in group with certain other people or struggling to open up. From the accounts, it appears that groups are able to reach the fourth stage, 'performing', whereby the group is functional and serves a purpose. In this context, members help others to engage. Overall, it appears that incorporating opportunities for clients with EUPDp to work with others with similar difficulties is helpful for engagement from the perspective of this study's participants, and may be beneficial for other therapy approaches. Perhaps it may provide normalisation for a group that is often stigmatised (Markham & Trowrer, 2003).

There was an appreciation that factors affecting engagement were complex and numerous, which was consistent with Clarke et al.'s (2010) findings. In terms of individual factors, the role of goals and having a reason to change, something that is emphasised in DBT (Linehan, 1993), seemed particularly important for engagement. A recent study found similar results among a group of adolescent DBT clients, whereby participants highlighted the need for self-motivation and having a willingness to change as being essential in DBT (Pardo et al., 2020). This is as opposed to family members wanting their relation to attend the programme, for example. Clients' basic needs were at times not met, such as access to finances and living without extreme pain. Such needs are often considered key for motivation (Maslow, 1943). However, despite these challenging factors, therapists still aimed to engage clients as best they could. Again, this perhaps reflects their feelings of containment from the model. Overall, the importance of facilitators outweighing barriers was evident across participants’ accounts.

Implications for Clinical Practice and Future Research

The findings suggest the importance of DBT therapists paying attention not only to physical attendance, but also to active engagement within sessions, to potentially achieve better outcomes. Active engagement may be easier to monitor within DBT due to the many behavioural tasks involved. However, it is still possible in less behavioural therapies, perhaps through monitoring reflection and insight. Most previous research on engagement focuses entirely on completion rates. Therefore, future research could seek to understand engagement more holistically and consider active engagement going forward. The results also suggest the importance of therapists ‘trusting the process’ regarding clients’ engagement trajectory, as this appears to oscillate throughout the programme.

The DBT model appeared largely effective in containing therapists, allowing them to address engagement issues with their clients, suggesting that similar structures may be beneficial for other therapies. When clients were engaged, this appeared to act as a powerful reinforcer to keep therapists engaged in the process also. The present study suggests the importance of considering therapist engagement alongside client engagement, as they appear to be intertwined. Therefore, the monitoring of therapist wellbeing and engagement could perhaps facilitate therapist and client engagement.

Although group support may be initially unwanted by clients, therapists perceived it as valuable in keeping clients engaged. Services offering therapies to people with EUPDp who struggle to keep clients engaged may benefit from offering group sessions alongside individual support, or another form of peer support. A more detailed examination of the formation of groups in DBT, and their influence on engagement at different stages of the programme would be a useful future piece of research.

Finally, therapists acknowledged the many factors that may influence client engagement, with the importance of goals particularly standing out. However, these goals appeared to have to outweigh other stressors, such as the impact of personal difficulties, and systemic influences. Therefore, it seems important to ensure that therapists continue to collaborate with clients to ensure achievable and realistic goals, and proactively work towards reducing barriers both individual and those within the system.

Critique

A small homogenous sample of participants were interviewed, in accordance with IPA (Smith et al., 2009). However, due to the qualitative methodology used, the findings may not be generalisable and reflect the views of DBT therapists more broadly. However, this is generally not an aim of qualitative research (Kitto et al., 2008). Participants were recruited via volunteer sampling, which could have introduced self-selection bias into the study (Sharma, 2017). Specifically, the participants who volunteered may have been particularly passionate about DBT and favoured the model, which may have been why DBT was considered in a mostly positive light in relation to engagement.

Participants’ accounts were subject to interpretation by the researcher, meaning that the researcher’s assumptions, beliefs and meanings influenced the analysis of the data. Consequently, there may be multiple and differing possible interpretations of the data that have not been provided in the current study. However, the data and themes were discussed in supervision, aiding reliability. Furthermore, the ‘DBT character’ adopted by participants may have constrained the interviews, as this may have meant that participants could have been less forthcoming in talking about less positive aspects of the programme. Consequently, those less socialised into the model may have significantly different experiences and views which could not be captured.

The use of video/phone calls may have been meant that participants spoke less openly, due to these methods potentially restricting the development of rapport between interviewer and interviewee. Despite this, video interviews have been found to still be effective means of collecting data, with participants often describing the experience as highly satisfactory (Archibald et al., 2019).

Conclusions

This study highlights therapists' experiences of engagement within DBT, both their clients', and their own. The DBT model appears to help contain therapists during the oscillating process of engagement, and there appeared to be a reciprocal process of engagement between therapists and their clients. The importance of tending to active engagement is suggested, with the role of peer support from the group component also being perceived by therapists as being helpful for clients, despite initial unfavourable reactions. Finally, the balance between goals and barriers was noted to be important by therapists in relation to client engagement.

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Part Three: Appendices

Appendix A: Guidelines for Authors – Clinical Psychology Review

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

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- All tables (including titles, description, footnotes)
- Ensure all figure and table citations in the text match the files provided
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Graphical Abstracts / Highlights files (where applicable)
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Appendix B: Data Extraction Form

Author and Date	
Title	
Country	
Aims	
Sample (N, mean age and gender)	N = ……….., mean age……….., F……., M…….
Intervention	
Design	
How EUPD assessed	
Methodology	
Variables measured (Predictors and TA outcome)	
Relevant Findings	

Appendix C: National Institute for Health and Care Excellence (NICE) Quality Appraisal Checklist

Study identification: Include full citation details		
Study design: • Refer to the glossary of study designs (appendix D) and the algorithm for classifying experimental and observational study designs (appendix E) to best describe the paper's underpinning study design		
Section 1: Population		
1.1 Is the population from which the sample has been drawn well described? • Inpatient or outpatient? • Where study took place – country/city etc.	++ + - NR NA	Comments:
1.2 Is the eligible population or area representative of the source population or area? • Were the inclusion/exclusion criteria representative of the EUPD population?	++ + - NR NA	Comments:
1.3 Does the sample included in the study represent the EUPD population? • Were demographics (age, gender, education etc.) representative? • If participants came from RCT, (I.e. paper was a secondary analysis), does it state how they were chosen? Or from the eligible population? • Was EUPD assessed appropriately?	++ + - NR NA	Comments:
Section 2: Method of selection of exposure (or comparison) group		
2.1 Selection of exposure (and comparison) group. How was selection bias minimised? • How was selection bias minimised	++ + - NR NA	Comments:
2.2 Was the selection of explanatory variables based on a sound theoretical basis?	++ +	Comments:

• How sound was the theoretical basis for selecting the explanatory variables?	- NR NA	
2.3 Was the contamination acceptably low? • Did any in the comparison group receive the exposure? • If so, was it sufficient to cause important bias?	++ + - NR NA	Comments:
2.4 How well were likely confounding factors identified and controlled? • Were there likely to be other confounding factors not considered or appropriately adjusted for? • Was this sufficient to cause important bias?	++ + - NR NA	Comments:
2.5 Is the setting applicable to the UK? • Did the setting differ significantly from the UK?	++ + - NR NA	Comments:
Section 3: Measures and Outcomes		
3.1 Were the measures and procedures reliable? • Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels ++ vs self-reported smoking −)? • How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)? • Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?	++ + - NR NA	Comments:
3.2 Were the outcome measurements complete? • Were all or most of the study participants who met the defined study outcome definitions likely to have been identified?	++ + - NR NA	Comments:
3.3 Were all the important outcomes assessed? • Were all the important benefits and harms assessed? • Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?	++ + - NR NA	Comments:
3.4 Was there a similar follow-up time in exposure and comparison groups? • If groups are followed for different lengths of time, then more events are likely to occur in the group	++ + - NR	Comments:

followed-up for longer distorting the comparison. • Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).	NA	
3.5 Were the times at which measures were administered appropriate?	++ + - NR NA	Comments:
Section 4: Analyses		
4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)? Or has the author acknowledged potential issues may have been caused due to lack of power? • A power of 0.8 (i.e. it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard. Is a power calculation presented? • If not, what is the expected effect size? Is the sample size adequate?	++ + - NR NA	Comments:
4.2 Were multiple explanatory variables considered in the analyses? • Were there sufficient explanatory variables considered in the analysis?	++ + - NR NA	Comments:
4.3 Were the analytical methods appropriate? • Were important differences in follow-up time and likely confounders adjusted for?	++ + - NR NA	Comments:
4.4 Was the precision of association given or calculable? Is association meaningful? • Were confidence intervals or p values for effect estimates given or possible to calculate? • Were CIs wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?	++ + - NR NA	Comments:
Section 5: Summary		
5.1 Are the study results internally valid (i.e. unbiased)? • How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? • Were there significant flaws in the study design?	++ + - NR NA	Comments:
5.2 Are the findings generalisable to the source population (i.e. externally valid)?	++ + -	Comments:

- Are there sufficient details given about the study to determine if the findings are generalisable to the source population? - Consider: participants, interventions and comparisons, outcomes, resource and policy implications.	NR NA	

Overall strengths of study

Overall weaknesses of study

Appendix D: National Institute for Health and Care Excellence (NICE) Quality Appraisal Checklist

	NICE Quality Checklist Item																		
Study	1.1	1.2	1.3	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	3.5	4.1	4.2	4.3	4.4	5.1	5.2
Barnicot et al. (2016)	++	++	++	NA	+	NA	+	++	+	-	+	NA	++	NR	++	++	++	+	++
Dimaggo et al. (2019)	+	NR	-	NA	++	NA	-	++	+	++	++	NA	+	NR	-	+	++	+	-
Hirsh et al. (2012)	++	+	+	++	+	NR	++	++	++	NR	+	NA	++	NR	++	++	++	++	+
Kivity et al. (2020)	+	NR	++	++	++	++	-	++	++	NR	++	NA	+	-	++	+	++	++	+
Kramer & Golam (2019)	+	++	+	NA	-	NA	+	++	++	NA	++	NA	+	-	+	+	+	+	+
Levy et al. (2010)	+	NR	-	NA	++	NA	-	+	-	NR	-	NA	-	NR	+	+	++	-	-
Marziali et al. (1999)	++	++	-	++	+	++	-	++	++	NR	++	NA	-	-	++	+	-	+	-
Penzenstadler et al. (2018)	++	++	++	NA	++	NA	+	++	++	+	+	NA	+	-	+	++	++	+	++
Pierò et al. (2013)	++	+	+	NA	++	NA	+	++	++	NR	+	NA	+	-	++	++	+	++	+
Richardson-Vejlgaard et al. (2013)	++	+	-	NA	-	NR	+	+	++	NR	++	NA	+	-	+	++	++	+	+
Salzer et al. (2013)	++	NR	-	NA	+	NA	++	++	++	NR	++	NA	-	NR	++	-	-	+	-
Signer et al. (2019)	+	++	+	++	-	++	+	++	+	NR	++	NA	+	-	+	++	++	+	+
Spinhoven et al. (2007)	+	+	+	++	++	++	++	++	++	-	++	NA	+	-	++	+	+	++	+
Yeomans et al. (1994)	++	+	-	NA	-	NA	-	+	-	-	++	NA	-	-	++	++	+	-	-
Zuffrey et al. (2019)	+	++	+	++	++	++	+	++	+	+	+	NA	+	NR	+	++	++	+	+

Appendix E: Guidelines for Authors – Borderline Personality Disorder and Emotion Dysregulation

Aims and scope

Borderline Personality Disorder and Emotion Dysregulation provides a platform for researchers and clinicians interested in borderline personality disorder (BPD) as a currently highly challenging psychiatric disorder. Emotion dysregulation is at the core of BPD but also stands on its own as a major pathological component of the underlying neurobiology of various other psychiatric disorders. The journal focuses on the psychological, social and neurobiological aspects of emotion dysregulation as well as epidemiology, phenomenology, pathophysiology, treatment, neurobiology, genetics, and animal models of BPD. Contributions investigating the broad field of emotion regulation and dysregulation as well as related pathological mechanisms such as dysfunctional self-concepts and dysfunctional social interaction are welcomed, as are studies of novel treatments for BPD. In addition, the journal considers research into the frequent, co-occurring psychiatric disorders like Post-traumatic Stress Disorder, ADHD, depression, eating disorders, conduct disorders, drug abuse, and social phobia.

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Smith JJ. The world of science. Am J Sci. 1999;36:234-5.

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Article within a journal by DOI

Slifka MK, Whitton JL. Clinical implications of dysregulated cytokine production. Dig J Mol Med. 2000; doi:10.1007/s801090000086.

Article within a journal supplement

Frumin AM, Nussbaum J, Esposito M. Functional asplenia: demonstration of splenic activity by bone marrow scan. Blood 1979;59 Suppl 1:26-32.

Book chapter, or an article within a book

Wyllie AH, Kerr JFR, Currie AR. Cell death: the significance of apoptosis. In: Bourne GH, Danielli JF, Jeon KW, editors. International review of cytology. London: Academic; 1980. p. 251-306.

OnlineFirst chapter in a series (without a volume designation but with a DOI)

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Complete book, authored

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Online document

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Online database

Healthwise Knowledgebase. US Pharmacopeia, Rockville. 1998. http://www.healthwise.org. Accessed 21 Sept 1998.

Supplementary material/private homepage

Doe J. Title of supplementary material. 2000. http://www.privatehomepage.com. Accessed 22 Feb 2000.

University site

Doe, J: Title of preprint. http://www.uni-heidelberg.de/mydata.html (1999). Accessed 25 Dec 1999.

FTP site

Doe, J: Trivial HTTP, RFC2169. ftp://ftp.isi.edu/in-notes/rfc2169.txt (1999). Accessed 12 Nov 1999.

Organization site

ISSN International Centre: The ISSN register. http://www.issn.org (2006). Accessed 20 Feb 2007.

Dataset with persistent identifier

Zheng L-Y, Guo X-S, He B, Sun L-J, Peng Y, Dong S-S, et al. Genome data from sweet and grain sorghum (Sorghum bicolor). GigaScience Database. 2011. http://dx.doi.org/10.5524/100012.

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Borderline Personality Disorder and Emotion Dysregulation

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Footnotes to the text are numbered consecutively; those to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data). Footnotes to the title or the authors of the article are not given reference symbols.

Always use footnotes instead of endnotes.

References

Examples of the Vancouver reference style are shown below.

See our editorial policies for author guidance on good citation practice

Web links and URLs: All web links and URLs, including links to the authors' own websites, should be given a reference number and included in the reference list rather than within the text of the manuscript. They should be provided in full, including both the title of the site and the URL, as well as the date the site was accessed, in the following format: The Mouse Tumor Biology Database. http://tumor.informatics.jax.org/mtbwi/index.do. Accessed 20 May 2013. If an author or group of authors can clearly be associated with a web link, such as for weblogs, then they should be included in the reference.

Example reference style:

Article within a journal

Smith JJ. The world of science. Am J Sci. 1999;36:234-5.

Article within a journal (no page numbers)

Rohrmann S, Overvad K, Bueno-de-Mesquita HB, Jakobsen MU, Egeberg R, Tjønneland A, et al. Meat consumption and mortality - results from the European Prospective Investigation into Cancer and Nutrition. BMC Medicine. 2013;11:63.

Article within a journal by DOI

Slifka MK, Whitton JL. Clinical implications of dysregulated cytokine production. Dig J Mol Med. 2000; doi:10.1007/s801090000086.

Article within a journal supplement

Frumin AM, Nussbaum J, Esposito M. Functional asplenia: demonstration of splenic activity by bone marrow scan. Blood 1979;59 Suppl 1:26-32.

Book chapter, or an article within a book

Wyllie AH, Kerr JFR, Currie AR. Cell death: the significance of apoptosis. In: Bourne GH, Danielli JF, Jeon KW, editors. International review of cytology. London: Academic; 1980. p. 251-306.

OnlineFirst chapter in a series (without a volume designation but with a DOI)

Saito Y, Hyuga H. Rate equation approaches to amplification of enantiomeric excess and chiral symmetry breaking. Top Curr Chem. 2007. doi:10.1007/128_2006_108.

Complete book, authored

Blenkinsopp A, Paxton P. Symptoms in the pharmacy: a guide to the management of common illness. 3rd ed. Oxford: Blackwell Science; 1998.

Online document

Doe J. Title of subordinate document. In: The dictionary of substances and their effects. Royal Society of Chemistry. 1999. http://www.rsc.org/dose/title of subordinate document. Accessed 15 Jan 1999.

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Doe J. Title of supplementary material. 2000. http://www.privatehomepage.com. Accessed 22 Feb 2000.

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Organization site

ISSN International Centre: The ISSN register. http://www.issn.org (2006). Accessed 20 Feb 2007.

Dataset with persistent identifier

Zheng L-Y, Guo X-S, He B, Sun L-J, Peng Y, Dong S-S, et al. Genome data from sweet and grain sorghum (Sorghum bicolor). GigaScience Database. 2011. http://dx.doi.org/10.5524/100012.

Prepare supporting information

Please make sure you have the following information available before you submit your manuscript:

Author information

Full names and email addresses of all co-authors on your manuscript.

Cover letter

A cover letter that includes the following information, as well as any additional information requested in the instructions for your specific article type (see main manuscript section above):

- An explanation of why your manuscript should be published in *Borderline Personality Disorder and Emotion Dysregulation*
- An explanation of any issues relating to journal policies
- A declaration of any potential competing interests
- Confirmation that all authors have approved the manuscript for submission
- Confirmation that the content of the manuscript has not been published, or submitted for publication elsewhere (see our Duplicate publication policy)
- If you are submitting a manuscript to a particular special issue, please refer to its specific name in your covering letter

Peer reviewers

You may suggest potential peer reviewers for your manuscript. If you wish to do so, please provide institutional email addresses where possible, or information which will help the Editor to verify the identity of the reviewer (for example an ORCID or Scopus ID). Intentionally falsifying information, for example, suggesting reviewers with a false name or email address, will result in rejection of your manuscript and may lead to further investigation in line with our misconduct policy.

Excluding peer reviewers

During submission you may enter details of anyone who you would prefer not to review your manuscript.

Appendix F: Interview Schedule

Version 1

Date: 17.04.19

Interview Schedule

Title: *Exploring therapists' experiences of engagement in DBT*

1. **What does engagement in DBT therapy mean to you?**

Prompt:

- What is your definition of therapy engagement?

-How would you know that someone was engaging in therapy?

> What would they be saying?

> What would they be doing?

2. **Can you talk about times when therapeutic engagement with a client who had a presentation consistent with a diagnosis of BPD/EUPD went well in DBT. What were these situations like?**

Prompts:

- How did this make you feel?
- What did you do?
- How did you make sense of this?

3. **Can you talk about times when therapeutic engagement with a client who had a presentation consistent with a diagnosis of BPD/EUPD did not go well in DBT. What were these situations like?**

Prompts:

- How did this make you feel?

- What did you do?
- How did you make sense of this?

4. **What is your role in engagement with clients with presentation consistent with a diagnosis of BPD/EUPD in DBT?**

<u>Prompts:</u>

- Do you make any adjustments?
- Do you pay particular attention to anything?

5. **What is the role of the client with a presentation consistent with a diagnosis of BPD/EUPD in engagement in DBT?**

6. **Are there any other factors in DBT that you think aid or limit engagement?**

<u>Prompt:</u>

- What is expected of the client?

7. **Is there anything else you would like to add? Is there anything I haven't asked you which I perhaps should have?**

Appendix G: Demographic Form

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Title: *Exploring Therapists' Experiences of Engagement in DBT*
Researcher: *Emmah Jassim, Doctorate in Clinical Psychology, University of Hull*

Demographic Form

1. What is your gender?

……………………………………………………………………….

2. How long has it been since you completed DBT foundation training?

………………………………………………………………………………

………………………………………………………………………………

3. Do you have any additional training?

………………………………………………………………………………

………………………………………………………………………………

4. How long have you worked using DBT?

………………………………………………………………………………

………………………………………………………………………………

5. Have there been any gaps in this work?

………………………………………………………………………………

………………………………………………………………………………

6. What service is/was this in? (i.e. client group, inpatient/outpatient)

………………………………………………………………………………

………………………………………………………………………………

Appendix H: Ethical Approval Letter

[REMOVED]

Appendix I: Study Advertisement Image

Do you deliver DBT with people who have a presentation consistent with BPD/EUPD?

I would like to invite you to participate in my research study which aims to better understand therapists' experiences of engagement in DBT with people who have a presentation consistent with BPD/EUPD.

If you are interested, please contact me for some additional information.

Email: e.jassim@2017.hull.ac.uk (Researcher: Emmah Jassim, Doctorate in Clinical Psychology, University of Hull)

Or you can direct message me on social media.

Participation would involve a one hour interview in person, or via telephone/Skype.

Appendix J: Information Sheet

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Participant Information Sheet

You are being invited to take part in a research study which aims to explore DBT therapists' experiences of therapeutic engagement with their clients who have a presentation consistent with a diagnosis of Borderline Personality Disorder/ Emotionally Unstable Personality Disorder (BPD/EUPD).

Research suggests that people who have received such a diagnosis may be more likely to drop out of therapy. There has been some quantitative research which has been carried out which investigates the predictors for drop-out in therapy for this particular client group, which largely focuses on client factors.

DBT therapists' experiences of engagement with this client group has not been investigated. Furthermore, much previous research focuses on drop-out as opposed to investigating engagement at different stages of therapy more generally.

This study is interested in DBT therapists' experience of engagement with these particular clients, given the specific focus on engagement and commitment in DBT. The study is also interested in what therapists believe helps and hinders engagement. The study is equally interested in experiences of engagement in therapy that has not gone well as when it has gone well.

Who will conduct the research?

Emmah Jassim – Doctorate in Clinical Psychology student at the University of Hull is the principal investigator. Two qualified clinical psychologists from the University of Hull, and two qualified clinical psychologists from Humber Teaching NHS Foundation Trust are also part of the research team.

Title of the Research:

"Exploring therapists' experiences of engagement in DBT".

What is the aim of the research?

The research aims to:

- To explore therapist experiences of engagement in DBT with their clients who have a presentation consistent with a diagnosis of EUPD.

Why have I been invited?

Because you are a clinician who uses DBT and works with or has worked with people who have a presentation consistent with a diagnosis of EUPD.

To be eligible to take part in the study, you will also have completed DBT foundation level training or equivalent (five days of training plus six months clinical work in DBT) with experience of working with people who have primary presentation consistent with a diagnosis of EUPD. Your experiences can be ongoing (i.e. you are still working in this area) or in the past (up to two years ago). This criteria has been set so that participants have had a sufficient amount of experience to discuss in the interview. A further criteria is that your experience is not within a learning disability, CAMHS or forensic setting as engagement may differ in these settings.

What would I be asked to do if I took part?

Attend a semi-structured interview lasting up to one hour at a convenient location. Alternatively, interviews can be conducted using online communication services such as Skype, and additionally by telephone. If these methods are used, the researcher will take steps to ensure confidentiality by using a private room. If Skype is used, the interview will not be recorded through Skype itself, and this function will be turned off. You would be asked questions about your experiences of therapeutic engagement with clients who have a presentation consistent with a BPD/EUPD diagnosis. This interview will be recorded onto an encrypted NHS laptop.

What are the risks of taking part?

The topic may be considered sensitive by some participants and talking about your experiences may cause some upset. If this happens, the researcher will provide suggestions of what you could do to access further support should you require it.

What are the benefits of taking part?

There are no direct benefits to participating in this study. However, your participation will contribute to furthering knowledge regarding therapy engagement with people with this client group. This may lead to a better understanding of this client group and suggest ways to improve engagement.

Will I be paid for participating in the research?

There is no payment for participating in the research.

What will happen to the collected data?

The data will be transcribed and analysed using Interpretive Phenomenological Analysis (IPA) with themes being extracted from this data. This will then be written up as my doctoral thesis. This will be published on the University of Hull's online research repository Hydra (hydra.hull.ac.uk). The research may also be published in academic journals or be presented at academic conferences.

Data Handling and Confidentiality

Your data will be processed in accordance with the General Data Protection Regulation (GDPR) (2018).

Each participant will be assigned a pseudonym or code which will be used on their transcripts. A list of participant names with their pseudonym/codes and real name will be kept in a lockable cabinet at the University of Hull. This is so a transcript can be identified should there be a request to remove a participant's data. Anonymised transcripts may be accessed by any member of the research team.

When writing up the results into the final thesis, there will be no identifiable information attached to any data - if using a direct quote, a pseudonym or code will be used. If the quote contains any other identifiable information, such as places/other people's names, these will also be anonymised.

After the completion of the research, your personal and demographic data and audio recording of the interview will be destroyed. However, anonymised interview transcripts will be stored in an online University of Hull repository for a period of ten years. However, upon conclusion of this study, if you would like to receive a summary of the results, your contact details will be kept to send this, and subsequently destroyed.

The only time that information cannot be kept confidential is if you disclose something that suggests that you or someone else is at risk of serious harm. Where there are concerns about clinical practice, the principle investigator will discuss this confidentially with the research supervisors. If this happens during the interview the researcher will need
to contact appropriate authorities to ensure that you and other people are safe. It is unlikely that this will happen and the researcher will discuss this with you unless urgent action is required.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Information Compliance Manager Mr Luke Thompson [l.thompson3@hull.ac.uk]. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What happens if I do not want to take part or change my mind and want to withdraw my data?

Having read this information, you are free to not proceed to being interviewed. If you choose to proceed with the interview, you can stop the interview at any time by informing the interviewer.

You have a right to withdraw your data from the research after it has been collected up to two weeks (14 days) after the date of your interview, after which point the data will be committed to the final report. No reason needs to be given in any case of withdrawal.

Who should I contact about the study?

If you have any questions or require more information about this study, please contact me using the following contact details:

Emmah Jassim
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
E-mail: e.jassim@2017.hull.ac.uk

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the research supervisor's details below for further advice and information:

Dr Chris Clarke
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX

Tel: + 44 1482 464106
E-mail: c.clarke@hull.ac.uk

Dr Jo Beckett
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
E-mail: jo.beckett@hull.ac.uk

Appendix K: Consent Form

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Version number and date: 11.10.19 version 1

CONSENT FORM

Title of study: *Exploring therapists' experiences of engagement in DBT*

Name of Researcher: Emmah Jassim, Doctorate in Clinical Psychology, University of Hull

Please
initial box

1. I confirm that I have read the information sheet dated 17.04.19 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw without giving any reason, without my legal rights being affected. I understand that I am able to withdraw my data up to two weeks (14 days) after the date of my interview, after which point the data will be committed to the report and cannot be withdrawn. ☐

☐

3. I understand that the research interview will be audio recorded and that my anonymised verbatim quotes may be used in research reports and conference presentations.

4. I give permission for the collection and use of my data to answer the research question in this study. ☐

5. I would like to receive a summary of the study's results (your contact details will be kept for the purpose of sending these, and then subsequently destroyed). ☐

☐

6.I agree to take part in the above study.

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix L: Sources of Support Sheet

Sources of Support

If you are struggling at the moment, and need some additional support, the following are some options that you could consider:

- There is a DBT special interest group run by the BABCP which you might find helpful to join. Their website is: www.babcp.com.
- If you are struggling at work, it may be helpful in the first instance to speak to your ***Line Manager or Supervisor*** to see if they can offer you further support, adjustments or advice.
- If you are having difficulties at your place of work or with your job, and believe that you may benefit from reasonable adjustments, consider making an appointment with your employer's ***Occupational Health*** department.
- If you are concerned about an incident involving yourself or others at your place of work, and feel unable to speak up about this to your Line Manager or Supervisor, you should consider using the ***whistleblowing*** policy at your place of work. If you work within an NHS setting, you may find it helpful to discuss your concerns with your ***Freedom To Speak Up Guardian***.
- An additional source of support is to seek advice from your ***professional governing body***. The key bodies are listed below:
    - Royal College of Nursing (for Registered Nurses): @: https://www.rcn.org.uk
    - Health & Care Professions Council (HCPC) (for Practitioner Psychologists, Occupational Therapists and Social Workers): @: https://www.hcpc-uk.org

- If you believe that you need further support external to work, or have additional difficulties not directly related to work, you might find it helpful to visit your ***General Practitioner (GP)***. They may be able to refer you to a relevant service that best suits your needs.

If you need immediate support and you feel like you or others are at immediate risk, you can attend your **local A&E department**.

Appendix M: Worked example of IPA analysis

Emergent Themes	Transcript	Exploratory Notes
Trajectory of engagement Therapist engagement Supported by the model?	V: *"Erm, I think, erm…. I'm just trying to think about what she was like in group, and how [inaudible] experienced her… erm, she was very respectful, erm, er, she, er, there was a couple of times, you know, there was, I remember, she had a real problem of getting up out of bed in the mornings and getting to do things starting the day and then once that happened, she'd just be the whole day in the bed, or on the sofa and she would be proactive in trying to come up with plans, so, if I hadn't thought of an idea, she might suggest one, erm, and, erm, and I, I remember I was using phone calls outside of my work week at the weekends and if I, if I just phoned her and said, listen, get up and make the breakfast, do the dishes and wash the floor, if you just, that was enough to get her to do it and she tapered that off that she didn't need that phone call within a few weeks, you know, she just, she just needed, once she'd, once I'd made the phone call and she'd heard that she needed to do that, it made her overcome that kinda, that, erm, that avoidance of starting and so, and then once she did that, she'd be off and would have the rest of her day, and, erm, erm, and I think, erm, she was very honest person, erm, so, like, she looked for helped but she did-, you know, she looked for help and you'd give it to her, but then, if she could activate it herself, as soon as*	Initially needed more support/to engage more at the beginning, but then was able to taper this off – less engagement a good thing here? Sense of going the extra mile (weekends) – due to liking client as she was 'respectful'? Language suggests the importance

Walking the walk, taking responsibility Importance of goals	*she could activate it herself, she would, and then I think she was just a very honest person as well. I don't know how I know that but, erm, she was just very straight about what her difficulties were, erm, erm, she wasn't, she was ashamed, but she wasn't trying to hide them, erm, and I think she was particularly easy to work with because she was so motivated by her children and her kids were in CAMHS services and d-, and in fact it's her, the, her partner was more of an impact, negative impact on her kids than her, she was actually the one holding it all together, erm, and she probably knew more about her children from her experiences than the CAMHS services, but she'd be very, you know, she's be very tolerant of their input, but she was better knowledgeable with her kids than most professionals, I thought. Erm, so I suppose seeing her work so hard to manage both her adult children and her young children and be a good mother with them was, erm, yeah, so she was super motivated by those things."*	of being firm and direct, almost like speaking to a child? Directness emphasised in model. Not just talking the talk – was able to actively engage herself – 'activate' Suggests the importance of personal responsibility. There needs to be a point to engaging – such a lot at stake possibly outweighed any barriers.

Appendix N: Epistemological Statement

It is recognised that the experiences and assumptions of the researcher can affect the way in which they approach research, such as how they perceive and seek to obtain knowledge, and the research methods they chose to utilise to seek this. Therefore, this statement will discuss the researcher's epistemological and ontological positions, in order to bring to light the assumptions that underpin the project. Ontology refers to the true nature of what exists and is real in the world, whereas epistemology is concerned with how knowledge is obtained (Klakegg & Pasian, 2016).

A positivist stance carries the assumption that there is a 'true reality' that can be observed (Ryan, 2006). However, given that the diagnostic criteria for EUPD is so wide-ranging (American Psychiatric Association; APA, 2013), and the likely variability across DBT services, it is probable that DBT therapists have unique experiences of engagement. Furthermore, although working under the same structured model, therapists may also differ in their values and beliefs, leading to variation in their perceptions of similar experiences. Before the commencement of the research planning, the researcher experienced first-hand the differing values and beliefs held by therapists working with clients presenting with EUPD their first clinical placement, which provided further motivation to understand therapists' subjective accounts. Given the researcher's ontological position, seeking quantifiable and generalizable data did not appear appropriate for the aims and questions of this research project.

Furthermore, detailed accounts of engagement were lacking in the existing literature base, which could give further insight into the process of engagement.

Therefore, a constructivist epistemological position was adopted, which suggests there is no objective truth, but rather engagement with the world shapes truth and meaning.

This epistemological position influenced the methodology that a researcher chose. For this project, a qualitative approach was perceived to align with this. Specifically Interpretive Phenomenological Analysis (IPA; Smith, 1996). IPA helps to understand the views and experiences of participants, and acknowledges that the understanding of this is inevitably influenced by the assumptions of the researcher, resulting in a ‘double hermeneutic’. As the researcher had strong views on the topic, the emphasis on being aware and managing their assumptions was particularly important. Ultimately, this was why IPA was chosen over Thematic Analysis, which focuses more on description rather than interpretation (Braun & Clarke, 2006).

References

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5®)*. American Psychiatric Pub.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Klakegg, O. J., & Pasian, B. (2016). Ontology and epistemology. *Designs, Methods and Practices for Research of Project Management,* 87-96.

Ryan, A. B. (2006). Post-positivist approaches to research. *Researching and Writing your Thesis: a Guide for Postgraduate Students*, 12-26.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, *11*(2), 261-271.

Appendix O: Reflective Statement

It is really difficult to know where to start with the reflective statement, as it has been such a long journey and I have experienced so many different emotions through the process. When I was despairing over my thesis, I found it comforting reading previous trainees' reflective statements. Reading about their ups and downs made me feel a sense of solidarity, and it inspired me to make my own reflective statement a transparent reflection of my own experience.

I remember attending the research fair in year four and feeling a bit underwhelmed at the projects on offer. Nothing really grabbed my attention, partially because I didn't really know what I was interested in. I knew that the thesis spanned the entire three years of the doctorate, and so I wanted to do something that I found interesting and engaging. Consequently, I started to think about my own research topic.

During my first clinical placement at an adult community mental health team, one of the most common things that I overheard staff talk about was their difficulties with engagement with people who presented with EUPD. I noticed that these staff members often used quite strong language when talking about these clients, and it sat really uncomfortably with me. I have been interested in the 'free will vs. determinism' debate within psychology since I first heard about it during my A Levels. From then on, I began reading more into it and how it relates to political systems such as neoliberalism and capitalism. I then started to wonder whether engagement is truly about simply 'deciding' and taking 'personal responsibility' to attend and engage in therapy i.e. exercising one's free will, or whether it is more nuanced than some of the staff's perceptions that I'd heard.

The research proposal process helped me to develop the scope of my research further. At this point, I did feel a bit behind others, who I perceived as being further along the process than me. However, having a couple more years to get the work done meant that overall I didn't feel particularly anxious. However, the downside of this, I admit, was that I procrastinated a bit because it seemed like there was no urgency in getting things done quite yet. I think I also felt like I didn't know where to start, because it was such a big piece of work. Ultimately, this process has taught me the value of "chipping away" at things so that I don't become overwhelmed later on.

My research question took several turns, but I eventually settled on investigating staff experiences of engagement with the EUPDp group. However, the anxiety of embarking on a research project that I had conceived of myself was something that made me feel a lot of apprehension. I think there were multiple reasons for this: 1) my previous academic experiences - I was used to writing essays and reports on pre-defined topics and so wasn't used to thinking of my own ideas; 2) I felt my knowledge on conceptual issues regarding personality disorders and engagement was lacking and 3) my research supervisor at the time was experienced in qualitative research methods but not issues pertaining to my research question. During my fifth year, my current research supervisor was leaving for a new job, and there was a gap of a few months before I was given my new and current university supervisors. I fell a bit off track at this point, and it felt like the project fell by the wayside. if I had this time again, I would perhaps been more proactive in getting my project moving forwards.

I was then told who my new university supervisors were. It was at this point that it was suggested that I would benefit from a field supervisor. Two local clinicians agreed to field supervise my project, and their knowledge on DBT helped clarify the specifics of the project. It was at this point it was discussed that the experiences of clinicians may vary significantly depending on the therapy that they offered, which may limit the depth of information gathered. We thought about focusing on a specific type of therapy, and agreed that a focus on DBT had a sound rationale. The focus on DBT challenged me, as I had little knowledge or experience on it and I had to read around the topic a lot.

Now it was time to apply for ethical approval. I submitted my ethical approval application and then had to re-submit after making changes several times. Although it was somewhat frustrating to have to keep completing amendments, I was appreciative of the comments I received and think that it helped me think through certain aspects of the project in more depth.

And then it was approved and I was onto recruitment! I had heard that recruitment is often one of the most difficult parts of conducting a research project. My experience so far had been really difficult, so suffice to say, I was dreading it!! In particular, most of my anxiety was due to the fact that I was relying on only a few sources of recruitment, which in the initial stages was a special interest email list and social media. I knew that there were plenty of DBT therapists working within the NHS; however I could not recruit them directly without additional approval. Fortunately though, to my surprise, recruitment went completely smoothly. I distinctly remember sitting in the library waiting for my MOT to be done and posting the ad onto a Facebook group. Within minutes, I had several expressions of interest, and it felt like a weight had been lifted!! As I was not expecting such interest, I think this taught me to not catastrophise so much, and the importance of trusting the process.

Interviewing participants was one of the more enjoyable parts of the research process. Initially I lost sight of the fact that IPA is a methodology, and not just a way to analyse data. As a result of this, some of my questioning in my initial interviews was a bit constrained. I reflected on this, and tried to ensure that my ‘prompting’ questions remained as open as possible in subsequent interviews.

I found myself asking my supervisors and peers for reassurance a lot of the time; I had never felt so anxious about a piece of academic work. The fact that I was so anxious and constantly needed reassurance regarding my thesis work really annoyed me, and I felt like a bit of a pest!! I remember reflecting back to when I was a third year undergraduate, and had handed my final year project in weeks before the deadline. I soon reasoned that this comparison wasn’t helpful… and that the current situation was significantly more challenging due to a) it being a doctoral project, b) it was the middle of a global pandemic. I remember hearing another trainee saying about how her thought process was a mess, because the world was a mess, which I very much related to.

I had collected my empirical data, and now it was time to start on my SLR. I admit that I was so pre-occupied with my empirical project that my SLR went neglected for longer period of time than I would have liked. Finding a topic for my SLR was difficult. I spent a lot of time on EBSCO and the process at times felt endless. The problem was either the question I had searched for had already been done, or there was not enough literature to do the question. This process was particularly aggravating for me and I felt like I was never going to finalise a question. However, once I had all of my papers, things started falling into place and I felt motivated to get going with it. The process of narrative analysis was interesting, as I had never done it before, and its structured approach appealed to me. Making conclusions from the studies was quite challenging, due to the difference in methods across the papers. Overall, I felt that one of the most helpful findings was that further research should be undertaken in the area. Conducting a SLR has ultimately allowed me to appreciate the fact that a single piece of research should not necessarily be taken at face value, and has reminded me to compare and contrast research. However, I felt that I could pick out several flaws in each piece of research, and it led me to think: ‘Is any piece of research truly valid?’

The final task was to analyse the transcripts for my empirical project. I had a lot of anticipatory anxiety ahead of doing this, due to having had little experience of qualitative data analysis. However, when I started to code the transcripts and develop themes, things seemed to fall into place. I particularly enjoyed the interpretation aspect of the analysis, and going beyond simply what someone had said.

Despite the difficulties I have encountered, I have learnt a great deal from the process of completing this thesis. It has reminded me of the value of critiquing my own and others’ research. I have had the opportunity to learn new methods of data analysis, which I think will stand me in good stead for undertaking research as qualified Clinical Psychologist if needed. I think one of the most important take home messages for me, is to not doubt myself and my ideas as much as I normally do.