Title: Patient Experiences of Therapy for Borderline Personality Disorder: Commonalities and Differences between Dialectical Behaviour Therapy and Mentalization Based Therapy and Relation to Outcomes

Short title: Patient Experiences of Therapy for BPD

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Abstract:

Objectives: Dialectical behaviour therapy (DBT) and mentalization-based therapy (MBT) are widely used evidence-based psychological treatments for borderline personality disorder (BPD). The study aimed to establish evidence on common and unique, and helpful and unhelpful, treatment processes.

Design: Mixed-methods.

Methods: In-depth qualitative interview data on patient experiences during treatment was combined with quantitative outcome measures in 73 patients diagnosed with a personality disorder and receiving DBT or MBT.

Results: Across both DBT and MBT, accounts of learning not to react impulsively, learning to question one's thoughts and assumptions, learning to communicate more effectively, and exposure to painful emotions that may previously have been avoided, were each associated with less baseline-adjusted self-harm at the end of treatment. Difficulties in interacting with other group members were more likely to be described by patients receiving MBT than DBT, whilst difficulties in the therapeutic relationship were equally common. Both of these types of difficult experience were associated with higher baseline-adjusted levels of BPD traits and emotional dysregulation, at the end of the 12-month study period.

Conclusions: The findings identify novel evidence of common therapeutic processes across DBT and MBT, that may help to reduce self-harm. The findings also highlight the potential iatrogenic effect of difficulties in the alliance with therapists or with other group members. This underscores the importance of listening to patients' voices about what they are finding difficult during therapy and working to address these relational challenges, so that the patient is able to progress and make best use of the treatment.

Keywords:

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Personality disorder; deliberate self-harm; psychotherapy

Data availability statement:

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Practitioner Points

- Regardless of whether dialectical behaviour therapy or mentalization based therapy is used, helping service-users to learn not to react impulsively, to question their thoughts and assumptions, and to communicate more effectively, may be beneficial for reducing self-harm.
- Across both types of therapy, exposure to painful emotions is a difficult experience for service-users, but may also be beneficial for reducing self-harm, if carefully managed.
- Whilst, service-users' experiences across both types of therapy have much in common, accounts of mentalization based therapy stand out in more often describing both helpful and unhelpful experiences of interactions with therapy group members
- Service-users across both types of therapy report the benefits of learning intrapersonal mentalization skills, whilst recipients of mentalization based therapy uniquely extend this to learning interpersonal mentalization
- Ruptures in the therapeutic alliance, and distressing interactions with group members, may be iatrognenic and must be carefully managed

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Borderline personality disorder (BPD) is defined by the DSM and ICD diagnostic systems as a severe mental health condition characterised by emotional dysregulation, difficulties in social relationships, self-harm and suicidality (American Psychiatric Association 2013, Oltmans & Widiger 2019). Whilst recognising its contentiousness, the present paper uses the phrase "diagnosed with BPD" to encapsulate the experiences of people who receive this diagnosis in clinical practice.

Dialectical behaviour therapy (DBT) and mentalization-based therapy (MBT) are widely used to help people with this diagnosis and have an emerging evidence base (Dale et al., 2017; Storebø et al. 2020). However, the mechanisms by which they help patients are unclear (Fonagy & Bateman 2006a, Lynch et al. 2006, Taubner &Volkert 2019). Evidence on helpful and unhelpful treatment processes could help optimise treatment approaches and improve patient outcomes.

DBT and MBT are long-term approaches involving 12-18 months of weekly individual and group therapy. DBT arose from cognitive behavioural therapy. It incorporates validation strategies, mindfulness, and a focus on directly improving patients' emotion regulation skills through individual therapy and groups skills training (Linehan, 1993a, 1993b). MBT arose from the psychodynamic tradition. It incorporates an emphasis on fostering mentalization, i.e. the ability to reflect coherently on the mental states of oneself and of other people, through individual therapists, group therapists and other group members encouraging patients to be curious and open-minded about their own and others' thoughts, emotions and intentions (Bateman & Fonagy, 2006).

DBT and MBT may achieve their positive effects via different or via common mechanisms. For instance, the developers of MBT have theorised that other treatment models for BPD,

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including DBT, may encourage mentalization even where this is not explicitly their primary treatment goal (Bateman & Fonagy 2010, Fonagy & Bateman 2006a). Similarly, both DBT and MBT prioritise validation of patients' emotions as a key therapy element (Fonagy et al. 2015, Linehan 1993a). Comparison of patient experiences of beneficial aspects of therapy could yield valuable insights into possible commonalities and differences in treatment. This approach has previously been used by several authors, for example, to understand commonalities and differences in patient experiences of cognitive-behavioural and psychodynamic or metacogntive psychotherapies for depression (Nilsson et al. 2007, McPherson et al. 2020, Straarup & Poulsen 2015). Additionally, quantitization of qualitative data to elucidate the relation between people's experiences and outcomes is an established but under-used methodology (Onwuegbuzie & Combs 2011). Using this process to evaluate the relationship between patient experiences of therapy and improvements in patients' mental health, could elucidate which aspects of treatment are particularly beneficial.

Furthermore, whilst it has been argued that patients diagnosed with personality disorder are particularly at risk of iatrogenic effects from psychotherapy (Fonagy & Bateman 2006b, Mohr 1995), there has been no systematic investigation of what types of experiences during therapy may have negative effects, nor of how negative experiences differ between therapy modalities. Comparison of patient experiences of unhelpful aspects of DBT and MBT could illuminate how negative effects occur, and help to generate ideas on how they can be avoided. Additionally, testing whether patients' negative experiences of therapy are related to poor treatment outcomes could elucidate whether patients' accounts of negative effects relate to quantifiable iatrogenesis in their mental health.

This study sought to evaluate these issues in a sample of patients diagnosed with personality disorder who were participating in a multisite non-randomised evaluation of DBT and MBT

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in the United Kingdom (Barnicot & Crawford 2019). The following exploratory questions were addressed.

1) What aspects of therapy do patients experience as helpful, and what aspects do they experience as negatively affecting them?

2) How do patient experiences of positive and negative aspects of therapy differ between DBT and MBT?

3) How do patient experiences of positive and negative aspects of therapy relate to BPD traits, emotional dysregulation and self-harm outcomes at the end of the 12-month study period?

Methods

Design

A mixed-methods evaluation comprising qualitative thematic analysis of patient-reported positive and negative therapy experiences, and quantitative relation of patient experiences to therapy type and treatment outcomes, in patients diagnosed with personality disorder and receiving dialectical behaviour therapy (DBT) or mentalization based therapy (MBT).

Inclusion and Exclusion Criteria

Participants were included if they:

1) Met criteria for any DSM-IV personality disorder

2) Were about to begin either outpatient DBT or MBT.

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The exclusion criteria were intellectual disability or difficulty communicating in English of sufficient severity to prevent completion of study questionnaires, and/or insufficient capacity to provide informed consent for study participation.

Setting

Participants were recruited between March 2014 and September 2016 from six personality disorder services across four NHS Trusts in London in the United Kingdom. Three services provided DBT (12-month course) and three provided MBT (18-month course). All services provided weekly individual and group therapy; the DBT services additionally provided telephone skills coaching.

Ethics approval. The study received ethical approval from the UK NHS Research Ethics Service Committee South East Coast-Surrey (ref.2016/LO/0158).

Study Entry

At the beginning of their treatment, patients were given verbal information about the study by their DBT or MBT clinicians, and asked for verbal consent to be contacted by the research team. A researcher then met with the patient to provide written information about the study and obtain informed consent. Patients were interviewed by the researcher using the Structured Clinical Interview for DSM-IV Axis II, to confirm that they met criteria for borderline personality disorder or another personality disorder (First *et al.* 1997).

Measures

At baseline and at 12 months post-baseline, patients completed self-report quantitative measures of BPD traits (The Borderline Evaluation of Severity over Time (BEST) (Pfohl *et al.* 2009)) and emotional dysregulation (The Difficulties in Emotion Regulation Scale

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(DERS) (Gratz & Roemer, 2004)). Possible BEST scores range from 12 to 72, with higher scores indicating more severe BPD traits. Possible DERS scores range from 36 to 180, with higher scores indicating a greater degree of emotional dysregulation. Both measures demonstrate moderate test-retest reliability, high internal consistency and adequate predictive validity (Gratz & Roemer, 2004, Pfohl *et al.* 2009). The Suicide Attempt Self Injury Interview (SASII) was used to enumerate incidents of self-harm in the 3 months before beginning treatment, and in the final 3 months of the 12-month study period (Linehan et al., 2006). This semi-structured interview demonstrates good inter-rater reliability and adequate concurrent validity (Linehan et al., 2006).

Qualitative Interviews

Patients participated in brief qualitative interviews concerning positive and negative experiences of therapy, at 3, 6, 9 and 12 months after baseline. Two key questions were asked using standardised wording: “Has your therapy been helpful at all over the last 3 months?” and “Has your therapy had a negative effect on you at all over the past 3 months, for example upsetting you or making you feel worse?” Patients replying in the affirmative were asked to provide more details, with the interviewer using open-ended prompt questions such as “Tell me more?”, ”Can you give me an example?”, “How did that make you feel?”, and “How did that affect you?”. Interviews lasted between 10 and 20 minutes and were transcribed verbatim.

If a patient withdrew from treatment, they took part in a qualitative interview about therapy experiences at the next follow-up meeting, but not at further follow-ups.

Reflexivity

Collaborative data interpretation by people with different experiences and perspectives allows a multiplicity of perspectives to influence analysis, yielding insights that are not otherwise

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accessible (Dodgson 2019, Gillard et al. 2012). The analysis team each brought with them varying levels of personal and professional experiences of DBT and MBT. Two analysts have lived experiences of the diagnosis of BPD and receiving DBT; one has personal experiences of providing MBT; one has worked alongside DBT and MBT services for many years as a non-clinical researcher; the remainder have no personal experience of receiving or providing either modality.

Qualitative Analysis

Interview transcripts were analysed using thematic analysis (Braun & Clarke 2006) and employing a critical realist epistemological stance (McEvoy & Richards 2003). A detailed coding framework was derived inductively from the data and codes were then grouped into themes according to their similarity, with the aim of maximising the internal homogeneity and external heterogeneity of the experiences classified under each theme (Braun & Clarke 2006). The coding framework and thematic structure were repeatedly reviewed and refined until all authors agreed internal homogeneity and external heterogeneity had been optimised and that the themes accurately reflected the overall 'narrative' of the data. Initial coding of patients' positive therapy experiences was led by co-authors JH and LC, and initial coding of patients' negative therapy experiences was led by co-author CK, respectively using NVivo and MAXQDA software. A randomly selected 5% of transcripts were then independently re-coded by the opposing coding team. Any discrepancies in coding between the different groups of authors were discussed by the authorship team and agreement was reached on modifications to the coding frameworks. Additionally, first author KB met with each coding team on a weekly basis to review, discuss and refine the coding frameworks, and led on finalising the resultant thematic structures. This team consensus process aimed to enhance the credibility of the thematic structure by taking into account multiple possible interpretations of

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the data and thus avoiding undue influence by any one person's perspective. Following finalisation of the thematic framework, the first author reviewed the detailed coding of experiences under each theme and compared similarities and differences between DBT and MBT patients.

Quantitative Analysis

All analyses were conducted using SPSS software v25 (IBM Corp 2017). Qualitative data were converted into quantitative data by creating a variable for each of the 10 qualitative themes and assigning each patient a value of 1 if they had described experiences classified under that theme in at least one 3-monthly interview, and a value of 0 if a patient had not described any experiences classified under that theme. Chi-squared tests were used to test for significant differences in the likelihood of reporting each of the 10 types of therapy experiences (patients receiving DBT vs. those receiving MBT). Generalised linear regression was then used to test the univariate associations between each of the 10 types of therapy experience and BPD traits (BEST total score), emotional dysregulation (DERS total score) and frequency of self-harm at month 12. All models were adjusted for pre-treatment levels of the dependent variable, as failure to adjust for this can introduce confounding (Twisk et al. 2018).

Results

Of the 89 patients in the intention-to-treat sample, 73 took part in at least 1 qualitative interview and were thus eligible for inclusion in this mixed-methods evaluation. Participant flow through the study is summarised in Figure 1. The sociodemographic/clinical characteristics and treatment received by included patients is summarised in Table 1. 97% of

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participants met diagnostic criteria for BPD whilst the remainder met criteria for other types of DSM-IV personality disorder.

Of the 73 interviewed patients, 1 reported solely positive experiences, 14 reported solely negative experiences, and 58 reported both positive and negative experiences of therapy. Positive experiences were classified into 7 themes and negative experiences were classified into 3 themes (summarised in Figure 2). The nature of the experiences described under each theme, and qualitative similarities and differences in the experiences of DBT and MBT patients, are outlined below. Additional supporting quotes are given in Online Supplementary Table 1.

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Figure 1. Participant flow through the study

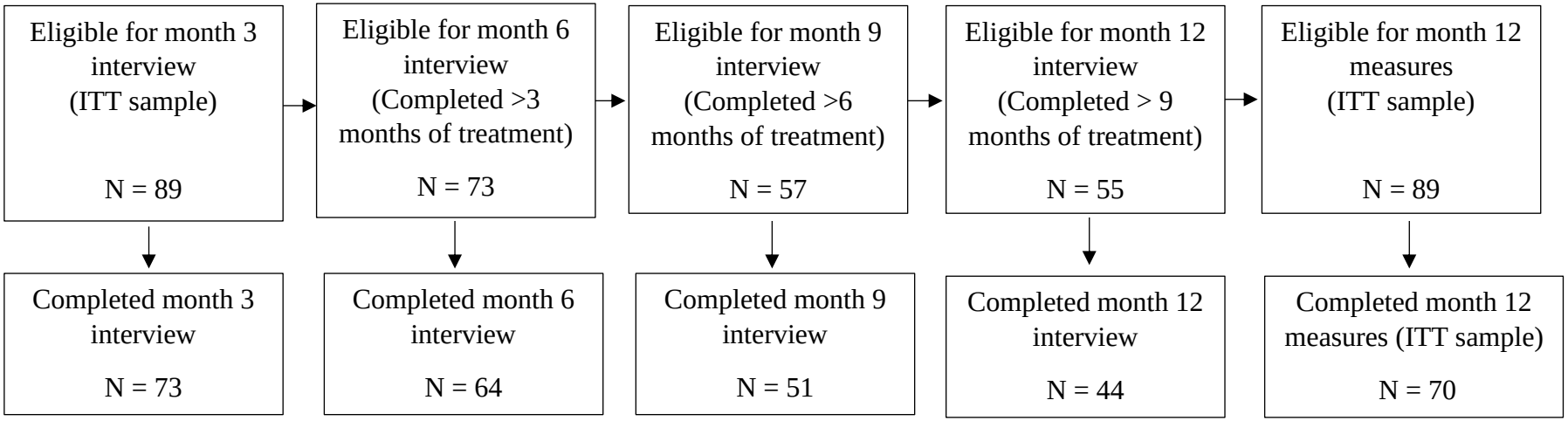

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Table 1. Patient characteristics

		N	%
Sex	Male	17	23.3
	Female	56	76.7
Employment status	Full-time employed	7	9.6
	Part-time employed	11	15.1
	On sick leave	3	4.1
	Not employed	52	71.2
Ethnicity	White British	42	57.5
	White Other	5	6.8
	Black	7	9.6
	South Asian	9	12.4
	Mixed	10	13.7
Diagnosis	Borderline personality disorder	71	97.3
	Other personality disorder	2	2.7
Therapy type	DBT	42	57.5
	MBT	31	42.5
Treatment completion	Completed 12 months	46	63.0
	Dropped out	27	37.0
		Mean	s.d.
Age (years)		30.9	12.6
Baseline BPD severity (BEST)		42.5	9.8
Baseline emotional dysregulation (DERS)		129.5	27.2
Number of self-harm incidents in the 3 months before starting treatment		64.4	80.5

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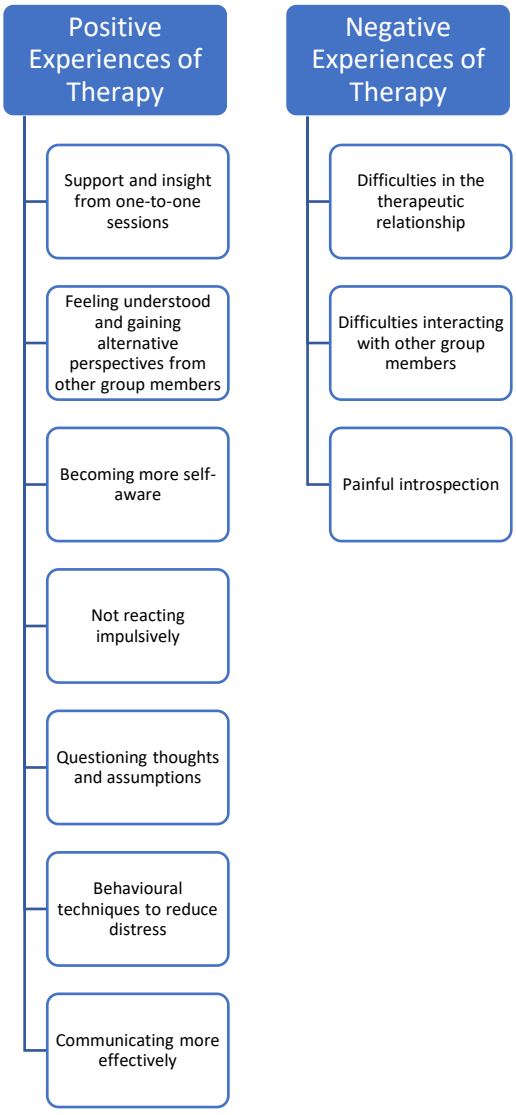
Figure 2. Summary of themes.



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What aspects of therapy were experienced positively?

Theme 1. Support and insight from one-to-one sessions

"My therapist is fantastic because he doesn't sugar-coat anything, he tells me how it is. For example if I say I don't want to come to therapy he helps me understand where that feeling is coming from and to evaluate the impact that not coming would have." (P136, DBT month 6).

38 patients described gaining helpful support and insight from their one-to-one therapist. The types of support and insight described were similar between DBT and MBT patients. Patients described the importance of not feeling judged by their therapist and of being able to trust and open up to them about difficult thoughts and emotions. They valued the belief their therapist had in them and found it helpful when their therapist facilitated insights into their feelings and behaviour — such as identifying typical problematic thinking patterns or the link between their feelings and their behaviour — and suggested techniques for managing them more effectively.

Theme 2. Feeling understood and gaining alternative perspectives from other group members

"When I felt under attack by psychiatrist, social services and by my mum, it's been really helpful to come to the groups and get another perspective on it — it helped me to see maybe they were just being realistic. It's been good to have other people's feedback, even if it's a bit uncomfortable at times" [P207, MBT Month 12].

37 patients described helpful interactions with other patients during the therapy. Both MBT and DBT patients described finding it very helpful to be able to share their experiences and feelings with other patients, especially if others had had similar experiences. This helped

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them to feel understood and to feel less alone. However, the accounts of MBT patients — more so than DBT patients — were also characterised by a sense of learning and changing through interactions with others. For instance, hearing about other people's patterns of thinking and behaviour prompted realisations that they too were engaging in similar dysfunctional patterns and could help them see where they could make changes. When other group members had a different perspective on their situation, this could prompt them to see things differently, whilst witnessing or partaking in conflict between group members helped them gain insight into their own general patterns of relating to others.

Theme 3. Becoming more self-aware

"They get you to pay attention to what feelings you have, getting you to slow down your thoughts and behaviour — if you start to understand where a feeling starts, it's easier to understand it and hence to change it." [P308, MBT month 3]

39 patients described learning to increase awareness of their emotions and thought processes. Across both treatments, patients spoke about learning not to suppress their emotions, and instead to deliberately pay attention to them, acknowledging and accepting them, naming and describing them, and trying to understand what had triggered them and why. Patients also spoke about learning to understand and recognise their automatic thought patterns.

Theme 4. Not reacting impulsively

"Having a pause before I react on something or say something….Not to be afraid to say "Can you give me a minute?" and just compose myself, and stop and think". [P210, MBT month 3].

23 patients described the importance of learning not to react impulsively to situations. Across both DBT and MBT, patients spoke about first becoming aware that they were feeling a

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strong emotion or an urge to react impulsively, and then being able to pause before following through with their urge, and take time to reflect on whether there could be a different way of seeing the situation or a more effective way to react. They said this strategy helped them to reduce interpersonal conflict and communicate more effectively, and helped to prevent impulsive self-damaging behaviour.

Theme 5. Questioning thoughts and assumptions

"If I felt someone was having negative thoughts about me and was judging me, I thought about the facts and challenged my interpretation." [P124, DBT month 6].

34 patients described learning to question and generate alternative perspectives on their automatic thoughts and interpretations. Both DBT and MBT patients spoke about learning not to make assumptions or jump to conclusions about what other people are thinking; however, DBT patients tended to refer to this in both interpersonal and non-interpersonal situations. They also referenced the "checking the facts" skill outlined in the DBT manual, i.e. recognising and challenging judgemental, absolute, and black-and-white patterns of thinking, and considering other possible interpretations and points of view on the prompting situation (Linehan 2015). By contrast, MBT patients tended to emphasise using this skill specifically in interpersonal contexts, by recognising that they cannot know what another person is thinking, and sometimes by actively questioning other people about their thoughts and motivations.

Theme 6. Behavioural techniques for reducing distress

"I haven't self-harmed in 2 months through using self-soothing with lavender, using TIP DBT skills…Putting my face in cold water to bring me back to Wise Mind so that I can think about what skills to use" [P602, DBT month 9].

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22 patients spoke about learning and using helpful behavioural techniques for reducing the intensity of their emotional distress. This sub-theme was dominated by quotes from 19 DBT patients. Using DBT terminology, DBT patients spoke about using "the skills" and in particular "mindfulness" and "distress tolerance" in order to help manage and reduce the intensity of emotional distress. The specific techniques most commonly referenced were: focussing on breathing to prevent impulsive reactions and enable a more considered response to difficult situations, using ice to dampen emotional distress, and using self-soothing. Only 3 MBT patients mentioned using techniques that fell under this category, which were the use of breathing exercises to cope with anxiety, and the use of distraction to take themselves out of negative emotions.

Theme 7. Communicating more effectively

"It's helping me with my daughter. I shout less, I ask about her feelings more — I think more clearly about it before I talk to her". [P203, MBT month 12]

27 patients discussed learning techniques to communicate more effectively with other people. Both DBT and MBT patients spoke about the value of learning to be more open with others about their own thoughts, feelings and motives. They described learning to communicate in ways that were constructive and did not damage relationships, such as staying calm and thinking carefully about what to say. Other helpful techniques mentioned included reducing avoidance of social interactions, being more aware of others' feelings, asking for support from others and being more assertive.

What aspects of therapy were experienced as having a negative effect?

Theme 8. Difficulties in the therapeutic relationship

"It feels like I'm being told all the time that because I have this condition, my interpretations

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are always wrong. I feel so restricted.… it made the self-harm worse. I feel like maybe my therapist doesn't get it. I want DBT to work for me — maybe you're going by the textbook, but maybe not all of it relates to me." [P124, DBT month 9].

55 patients described experiencing negative feelings about their therapists. Thematic analysis found both similarities and differences in experiences across the two modalities. At times, both DBT and MBT patients reported feeling that their therapists were misattuned to them and did not understand their experiences; for example, by underestimating the severity and not understanding the context of their distress, by forming interpretations of their behaviour that they did not agree with, or by not understanding their difficulties with attending sessions. Similarly, patients commonly reported feeling that their therapist had not stood up for them during conflict in group situations, or had not managed the groups well to prevent others dominating or being aggressive. A number across both therapy modalities felt anxious and angry in response to high expectations and strict rules, such as expectations regarding understanding new ideas during the skills teaching groups or completing homework, or the rules on the consequences of missing sessions or of self-harming. Patients in both modalities at times felt their therapists were incompetent and did not know how to help them. This led to patients feeling hopeless and feeling that coming to sessions was a waste of time. Some DBT patients reported behaviour from their therapist that was perceived as actively hostile, including being very critical, shouting at them, and making belittling comments or suggestions, whereas very few MBT patients reported these experiences of active hostility. Patients explained that these difficulties with their therapists caused emotional distress, and in some cases had a negative impact on their mental health.

Theme 9. Difficulties interacting with other group members

"I felt overwhelmed with hearing other people's situations. I feel as though my situation is not as bad as I think it is, or certain situations they are going through that I wouldn't be able

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to handle — it makes me think that my situation is not that serious. It can make me feel worse as I feel that I'm not strong enough….I tend to shut down and end up not saying anything at all." [P201, MBT month 6].

46 patients described experiencing difficulties in interactions with other group members. Thematic analysis identified both similarities and differences in experiences across modalities. Both DBT and MBT patients said that at times it was hard to share their experiences and emotions with other group members. They felt embarrassed and under pressure to speak, and worried about the other group members judging or misunderstanding them. They emphasised that it took time to build enough trust to feel comfortable talking to other group members, and that changes in group membership exacerbated this challenge. MBT patients more commonly said that they also found it hard to listen to other group members talk about their own experiences. Sometimes this made them feel sad, or reminded them of their own difficulties. At other times patients compared themselves to others in the group and felt they could not identify, that they were therefore somehow alien and different, and that they were out of place within the therapy group and less deserving of help than others. Feeling upset by group members' behaviour was also more common among MBT patients. Some found others in the group very vocal and dominant, which made it harder to find an opening to speak about themselves. Some found it upsetting and frightening to witness conflict between other group members, or felt frightened and angry when others in the group appeared aggressive or critical.

Theme 10. Painful Introspection

"Talking about things in my 1 to 1 sessions brings up bad memories. This can lead to extreme dissociation where I end up walking for miles not knowing where I am….Talking about the bad memories makes me cry, which makes me feel ashamed, which makes me want

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to hurt myself more." [P111 DBT Month 3].

47 patients described a painful process of thinking and talking about difficult personal experiences, thoughts, emotions and behaviours. Across both modalities, patients reported experiencing high levels of distress when they talked to their therapists or other group members about difficult past or current experiences, such as traumatic memories or difficulties in family relationships. Some found aspects of therapy — such as being asked to engage in imagery exercises, or witnessing conflict between group members — could trigger upsetting memories. Additionally, patients found that having to admit to and talk about their own thoughts, emotions and behaviours in therapy could be upsetting, triggering feelings of shame and anxiety. Relatedly, some patients felt that therapy necessitated a confusing and exhausting process of self-analysis; of constantly questioning the reasons behind their thoughts and feelings and the appropriateness of their behaviour.

Patient Experiences in DBT versus MBT and Association with Treatment Outcomes

The results of quantitative comparison between DBT and MBT patients of the likelihood of reporting each type of experience, and the associations between reporting each experience and baseline-adjusted outcomes at the end of the 12-month study period, are summarised in Table 2. DBT patients were significantly more likely than MBT patients to report learning helpful behavioural techniques for reducing distress (Theme 6), whilst MBT patients were significantly more likely than DBT patients to report both helpful and difficult interactions with other group members (Themes 2 and 9). Across modalities, patients who described learning not to react impulsively (Theme 4), to question their thoughts and assumptions (Theme 5) and to communicate more effectively (Theme 7) each reported less baseline-adjusted self-harm at the end of the 12-month study period. Despite experiences of painful introspection being classified by patients as a negative aspect of their therapy experience

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(Theme 10), patients who described this also reported less baseline-adjusted self-harm at the end of the 12-month study period. Conversely, patients who described difficulties in their relationship with their therapists (Theme 8), and those who described difficulties in their relationships with other group members (Theme 9), reported higher levels of baseline-adjusted BPD traits and emotional dysregulation at 12 months.

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Table 2. Patient experiences in MBT versus DBT and cross-modality association with outcomes at month 12 *

Patient-reported experience	DBT (N = 42)		MBT (N = 31)				BPD traits at month 12**			Emotional dysregulation at month 12**			Number of self-harm incidents month 11 to 12**		
	n	%	n	%	X^{2*}	p	B	95% CI	p	B	95% CI	p	IRR	95% CI	p
One-to-one sessions	18	42.9	20	64.5	3.35	0.07	0.65	-4.68 to 5.98	0.81	2.97	-13.93 to 19.87	0.73	1.43	0.86 to 2.35	0.17
Other group members	13	31.0	24	77.4	15.4	<0.01	1.91	-3.47 to 7.29	0.49	9.60	-8.08 to 27.29	0.29	0.67	0.40 to 1.10	0.11
Becoming more self-aware	20	48.8	19	61.3	1.11	0.29	-1.93	-7.24 to 3.38	0.48	-6.31	-23.36 to 10.75	0.47	0.66	0.40 to 1.08	0.09
Not reacting impulsively	11	47.8	12	52.2	1.15	0.28	-4.90	-10.52 to 0.72	0.09	-14.06	-31.47 to 3.35	0.11	0.43	0.23 to 0.77	<0.01
Questioning thoughts and assumptions	16	47.1	18	58.1	2.57	0.11	-1.05	- 6.31 to 4.22	0.70	-8.80	-25.33 to 7.73	0.30	0.54	0.33 to 0.90	0.02
Behavioural techniques for reducing distress	19	46.3	3	9.7	11.2	0.01	3.13	-2.71 to 8.98	0.29	-1.57	-19.88 to 16.74	0.87	0.65	0.38 to 1.11	0.12
Communicating more effectively	12	29.3	15	48.4	2.75	0.10	-4.79	-10.09 to 0.52	0.08	-10.81	-27.41 to 5.80	0.20	0.31	0.18 to 0.54	<0.01
Difficulties in the therapeutic relationship	31	75.6	24	77.4	0.03	0.86	8.99	3.24 to 14.73	<0.01	39.76	20.22 to 59.30	<0.01	0.84	0.47 to 1.51	0.57
Difficulties with other group members	19	46.3	27	87.1	12.71	<0.01	8.84	3.80 to 13.87	<0.01	26.55	9.65 to 43.44	<0.01	0.83	0.50 to 1.37	0.46
Painful introspection	28	68.3	19	61.3	0.38	0.54	-0.19	-5.86 to 5.49	0.95	-10.64	-28.18 to 6.89	0.23	0.53	0.30 to 0.91	0.02

df = 1; ** Adjusted for pre-treatment value of the dependent variable. Experience-outcome associations are cross-modality.

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Discussion

Summary of Findings

The main findings of our mixed-methods analysis of positive and negative experiences of therapy are summarised in Table 3.

Table 3. Summary of findings on therapy experiences

Theme	Association with quantitative outcome data	Differences between DBT and MBT
POSITIVE		
Support and insight from one-to-one sessions	None identified	None identified
Feeling understood and gaining alternative perspectives from other group members	None identified	Statistically more common amongst MBT patients. [b] MBT > emphasis on learning & changing through interactions with others [c]
Becoming more self-aware	None identified	None identified
Questioning thoughts and assumptions	Associated with less baseline-adjusted self-harm at month 12[a]	MBT > emphasis on interpersonal contexts [c]
Not reacting impulsively	Associated with less baseline-adjusted self-harm at month 12[a]	None identified
Behavioural techniques for reducing the intensity of distress	None identified	Statistically more common amongst DBT patients [b]
Communicating more effectively	Associated with less baseline-adjusted self-harm at month 12[a]	None identified
NEGATIVE		
Difficulties in the therapeutic relationship	Associated with more baseline-adjusted BPD traits and emotional dysregulation at month 12 [a]	DBT > reports of active hostility from therapist[c]
Difficulties interacting with other group members	Associated with more baseline-adjusted BPD traits and emotional dysregulation at month 12 [a]	Statistically more common amongst MBT patients.[b]

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		MBT > reports of difficulties hearing others' experiences & being upset by behaviour of group members[c]
Painful introspection	Associated with less baseline adjusted self-harm at month 12 [a]	None identified

[a] Statistically significant association with quantitative measures at month 12 (baseline-adjusted); [b] Statistically significant difference; [c] Observed difference during thematic analysis.

Relation of Findings to Previous Literature on Treatment Mechanisms

Our novel cross-modality analysis of positive experiences of therapy highlights both common and unique therapeutic processes within DBT and MBT. Theme 1 (Support and insight from one-to-one sessions) and Theme 2 (Feeling understood and gaining alternative perspectives from other group members) map onto two non-specific therapeutic processes identified as important across the psychotherapy literature: the therapeutic alliance (Wampold 2001) and group cohesiveness (Yalom 1995). The alliance is outlined as a key therapeutic ingredient by both the DBT and MBT treatment manuals (Linehan 1993a, Bateman & Fonagy 2006) and has been identified as a consistent predictor of positive therapy outcomes amongst people diagnosed with BPD and more widely (Barnicot et al. 2012, Wampold 2001). Group cohesiveness — a sense of belonging and identification with other group members — has been named as the bedrock of group therapy and an essential precursor of positive therapeutic outcomes (Hornsey et al. 2007, Yalom 1995). Previous qualitative interviews with DBT and MBT patients have also highlighted the value of feeling connected to other group members and developing trusting therapeutic relationships (Little et al. 2018, Morken et al. 2019, Ó Lonargáin et al. 2017). Theme 3 (Becoming more self-aware) maps both onto DBT's aim to promote mindfulness of current thoughts and emotions (Linehan 1993a), and MBT's aim to promote mentalization via increased awareness of one's own mental states (Bateman & Fonagy 2006). Similarly, Theme 4 (Not reacting impulsively) maps onto the "riding the

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wave" and "STOP" skills taught in DBT, which promote remaining aware of one's emotions without acting on them (Linehan 2015), and onto MBT's conceptualisation of mentalizing as providing a buffer or "pause button" between feeling and action (Allen 2001, Bateman & Fonagy 2016). These cross-modality experiences of gaining self-awareness of mental states, and pausing to reflect before acting, provide novel empirical evidence to support the theory that common therapeutic processes — whether we call them mindfulness or mentalizing — operate across successful therapies for patients diagnosed with BPD (Bateman & Fonagy 2010, Fonagy & Bateman 2006a). Learning not to react impulsively (Theme 4), learning to question one's thoughts and assumptions (Theme 5) and learning to communicate with others more effectively (Theme 7) were each associated with a lower rate of baseline-adjusted self-harm at the end of the 12-month study period, suggesting these could be important cross-modality treatment mechanisms.

Analysis also revealed experiences that were unique to each modality. The accounts of MBT patients were more characterised by experiences related to learning to mentalize in interpersonal contexts: helpful interactions with group therapy members were more frequently described and were linked to gaining insight on their own mental processes and behaviour (Theme 2). Accounts of learning to question their thoughts and assumptions (Theme 5) were placed in interpersonal contexts and embodied a "not-knowing" stance about other people's thought and emotions, whereas amongst DBT patients, these accounts were placed in both interpersonal and non-interpersonal contexts and referenced DBT skills terminology such as "checking the facts". Furthermore, the accounts of DBT patients were uniquely characterised by learning distress tolerance and emotion regulation skills: they more frequently described learning and using helpful behavioural techniques for reducing the intensity of their emotional distress (Theme 6). These differences provide novel empirical

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evidence to support the theory that learning to mentalize in interpersonal contexts may be much more characteristic of the therapeutic process of MBT than DBT, whereas learning to mentalize in intrapersonal contexts may be common across modalities (Goodman 2013). Conversely, evidence suggests skills acquisition is a key specific treatment mechanism in DBT (Barnicot et al. 2017, Neacsiu et al. 2010).

Implications for Clinical Practice and Further Research

Two of the identified types of negative therapy experiences — alliance ruptures (Theme 8) and difficult interactions with other group members (Theme 9) — increased the likelihood of ongoing high levels of BPD traits and emotional dysregulation at the end of the 12-month study period. Alliance difficulties and difficult interpersonal interactions are well-documented in this patient group (Fonagy & Allison 2014, Gersh et al. 2017, Lorenzini & Fonagy 2013, McMain et al. 2015, Muran et al. 2009). However, this is the first time to our knowledge that patients' own qualitative accounts of their experiences have been linked to poor treatment outcomes. Better addressing these difficulties may help to improve patient outcomes and prevent iatrogenesis. Our findings highlight that from the patient's perspective, there are a number of therapist behaviours that contribute to alliance difficulties, including inadequate validation of the patient's perspective, and behaviour that is experienced as critical and hostile. Patients diagnosed with BPD can often evoke strong emotions in therapists and counter-transference feelings are an acknowledged difficulty (Kernberg et al. 2008, Fonagy et al. 2015). The DBT model in particular acknowledges the "therapy-interfering" effect of such negative therapist feelings and behaviours, and stresses the need for therapists to take responsibility (Linehan 1993a). In our sample, some DBT patients reported behaviour from their therapist that was experienced as actively hostile, critical or belittling. Some of the reports in our data could be interpreted as misapplication of the

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"irreverent communication" DBT technique, whereby therapists attempt to shift patients' thinking by reframing situations in an unorthodox matter, employing a deadpan or highly intense style, plunging into sensitive areas, or engaging in direct confrontation of clients' behaviour (Linehan 1993a). Our findings reinforce the DBT manual's suggestion that such interventions must be employed very carefully and sensitively (Linehan 1993a). Our findings further emphasise the importance of identifying and working to repair ruptures in the therapeutic relationship. Successful rupture repair is associated with better therapy outcomes in this patient group (Boritz et al. 2018, Gersh et al. 2017, Muran et al. 2009). Both the DBT and MBT models agree that rupture repair must be approached carefully, focussing first on decreasing patients' level of emotional arousal, through empathic validation of their thoughts and feelings and acknowledgement of the therapist's role in triggering emotional distress (Bateman et al. 2014, Fonagy et al. 2015, McMain et al. 2015).

Our findings also highlight that patients' distress in response to difficult interactions with group members must be carefully managed to avoid iatrogenic effects. A systematic review of qualitative interviews with DBT patients highlighted that the group element of therapy is often experienced as overwhelming (Little et al. 2018). Similarly, patients in Ó Lonargáin and colleagues' (2017) qualitative interview study described the MBT group as an unpredictable and challenging place where they felt unsafe, with difficulties particularly stemming from feeling criticised by other group members, and other group members dominating so that they felt unable to speak. Such experiences could heighten patients' epistemic hypervigilance when interacting with other group members, preventing them from being able to learn new ways of understanding themselves and others (Fonagy & Allison 2014). Our finding that distressing group interactions were more common in MBT than DBT is arguably to be expected. The psychodynamic grounding and aims of group therapy within

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MBT — where group members talk about their difficulties in-depth, discuss their feelings about others in the group, and actively challenge each others' thinking — inherently renders interpersonal distress and conflict more likely than in DBT, where the emphasis is on psychoeducational skills training in a group context. Our earlier published findings on this sample showed that MBT patients experienced a less rapid reduction in emotional dysregulation and self-harm than DBT patients (Barnicot & Crawford 2019). Potentially the difficulties in group interactions experienced by MBT patients could be one of the factors contributing to this, given our findings on the link between this experience and emotional dysregulation. Conversely, accounts of helpful interactions with other group members were also more common amongst MBT than DBT patients, highlighting the power of such intense interactions to both hurt and heal.

Our findings on the theme of painful introspection (Theme 10) relate to the idea that therapy involves exposure to previously avoided painful emotions and that in some cases, this can make patients feel more distressed. Such exposure-related increases in distress have previously been shown to be transient and followed by alleviation of distress and improved mental health in the long-term (Foa et al. 2002, Tarrier et al. 1999). In line with this, patients describing painful introspection in our sample also reported lower baseline-adjusted self-harm at the end of the 12-month study period — suggesting such experiences did not impede progress in therapy and may even have been helpful overall. However, caution is advisable as the commonly stated maxim that patients must feel worse before they feel better has previously been used to justify implementation of therapies that are in fact harmful (Lilienfeld & Lynn 2003). The role of the therapist is important here as intense emotional experiencing has cathartic effects only when patients are able to process their emotional experiences and make sense of them, in the context of an emotionally validating and

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supportive therapeutic alliance (Bohart 1980, Whelton 2004). Other aspects of this theme link to the idea that for some patients the cognitive scrutiny involved in therapy can fuel increased anxiety (Berk & Parker 2009).

The findings underscore the importance of actively listening to patients' voices about what they are finding difficult during therapy, and working to address these relational challenges so that they are able to progress and make best use of the treatment. Further research should focus on examining how each of these identified difficulties can be addressed. It could be useful to investigate whether actively monitoring the alliance with the therapist and with other group members during treatment, perhaps using weekly or monthly patient-rated alliance measures, could help therapists detect difficulties in these areas earlier and prioritise resolving them. Additionally, our data suggested that some patients' difficulties during group sessions related to feeling attacked and invalidated by other group members. Future research could investigate whether training group members to use emotional validation strategies with each other could help patients feel more understood, in turn decreasing epistemic hypervigilance and opening them up to learn new ways of mentalizing about themselves and others (Fonagy & Allison 2014). Finally, we hope that our analysis has shown the novel insights that can be generated by comparing patient experiences across different therapy modals and relating these to outcome; future research could employ such a design in relation to other therapeutic modalities to better understand their relative strengths and challenges, and to better understand how patient experiences drive good and poor clinical outcomes.

Strengths and Limitations

This is to our knowledge the only study triangulating positive and negative experiences of therapy amongst patients experiencing two different evidence-based interventions for BPD —

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DBT and MBT — and relating patient experiences to quantitative data on treatment outcomes. This was a large study conducted in real-world services across multiple treatment centres — increasing the ecological validity and generalisability of the findings. The leading role in data analysis played by individuals with lived experiences of receiving psychological treatments for BPD may have yielded new insights that would not otherwise have been accessible (Gillard et al. 2012). However, whilst the interviews were conducted by a researcher who acted independently of the participating treatment services, some participants may have nonetheless perceived her as affiliated with the staff and in a position of power, and may therefore have felt reluctant to disclose negative experiences of treatment (Corless, Buckley, & Mee, 2016). Additionally, whilst 82% of the intention-to-treat sample were interviewed at least once, we were not able to interview the entire sample and we do not know whether there may have been important differences in the experiences of non-interviewed patients.

Conclusions

This study has generated novel findings based on patient accounts of common therapeutic processes within DBT and MBT: the therapeutic alliance, group cohesiveness, and common processes relating to mindfulness and intrapersonal mentalizing. Further, novel evidence on four cross-modality processes that may help to reduce self-harm was identified: learning not to react impulsively, learning to question one's thoughts and assumptions, learning to communicate more effectively, and exposure to painful emotions that may previously have been avoided. There were also processes unique to each modality: mentalization in interpersonal contexts was characteristic of MBT whilst learning distress tolerance and emotion regulation skills was characteristic of DBT. Patient accounts of difficulties in the alliance with therapists or with other group members were linked to poorer treatment

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outcomes, suggesting that these factors could contribute to iatrogenesis if poorly managed. This underscores the importance of actively listening to patients' voices about what they are finding difficult during therapy and working to address these relational challenges, so that the patient is able to progress and make the best use of the treatment. Further research could investigate whether increased monitoring of alliance difficulties, and use of emotional validation techniques, can help to prevent and repair alliance ruptures and improve outcomes.

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