Tāngata Whaiora / Service User Perspectives on the Effectiveness of a DBT Residential Treatment Programme

A thesis presented in partial fulfilment of the requirements for
the degree of Master of Arts in Psychology at Massey University,
Aotearoa New Zealand.

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2023

Karakia

Manawa mai te mauri nuku

Manawa mai te mauri rangi

Kia mahara ki te whakaaro

Kia mahara ki te aroha

Kia mātau

Kia pakari

Kia aroha tētahi ki tētahi

Hei oranga wairua

Hei oranga hinengaro

Hei oranga tinana

Hei oranga whānau

Kia mauri tū, kia mauri ora

Haumi e, hui e, taiki e

Embrace the life force of the earth. Embrace the life force of the sky. Reflect on the primordial energy of thought. Reflect on the primordial energy of compassion. To grow in knowledge. To build character. To have compassion for one another. For the wellbeing of the spirit, mind, body, and those we hold dearest. For the purpose of good health and wellbeing. Unified, connected, and blessed.

Abstract

The perspectives of tāngata whaiora / service users who have been treated with Dialectical Behaviour Therapy (DBT) in a residential programme in Aotearoa New Zealand were explored to determine which interventions and programme elements were effective and ineffective. People who are typically referred to a DBT residential programme are managing severe and chronic mental distress, use mental health services frequentlywith complex and multiple mental health diagnoses. This was a qualitative study with the aims of giving tāngata whaiora / service users a voice and provide opportunities for clinicians to enhance their service delivery. The foundations of the study were based on community and clinical psychological epistemologies, and predominantly social constructionist theory.

Data was gathered via in-depth interviews with five participants who had been through the programme and analysed using reflexive thematic analysis (TA). Analysis of the data resulted in three main themes and two subthemes that centred around three domains. These domains were related to clinical DBT interventions, environmental and other factors that are not typically assessed when looking at treatment effectiveness, and relationship quality.

The results supported much of the international and local literature that explores service user perspectives. The findings from this study appeared to show that DBT was useful to clients particularly learning and practicing DBT skills. Non-clinical interventions and environmental factors also made a difference, such as time in nature and doing recreational activities as a group. Healthy relationships, including those with peers, support networks, and professionals were vital contributors to any resulting wellbeing, and reciprocity and kindness in professional relating increased trust and aided in turning points. Offsite support to consolidate skill use in the community and establish new identities was valued, and a greater focus on physical health and other non-clinical supports such as secure housing is recommended.

Acknowledgements

Kāhore taku toa i te toa takitahi, he toa takitini.

We cannot succeed without the support of the people around us.

I would like to express deep gratitude to the participants who gave their time, trust, and their precious words for this study. Ngā mihi nui ki a koutou. Thank you for sharing with me, being vulnerable, and for the many insights and laughs along the way. It was, as always, a privilege to work with you.

Thank you also to the board of trustees, management, and staff running the DBT programme that was the site of this research. Thank you for the work you continue to do for some of Aotearoa's most vulnerable people and thank you for the support to me both as a staff member and a researcher. Thank you especially to Dr Shelley Harvill, the clinical manager of the DBT programme, for the flexible work hours, all the discussion about how I could manage the dual roles, and everything in between.

I am also grateful to Associate Professor Julia Ioane, my supervisor at Massey University. Thank you for the support, advice, and encouragement.

Ehara taku toa it te toa takitahi engari he toa takitini. To my ancestors, whānau, and friends that have been patient and supportive, thank you.

Kia tau ngā manaakitanga a te mea ngaro
ki runga ki tēnā, ki tēnā o tātou
Kia mahea te hua mākihikihi
kia toi te kupu, toi te mana, toi te aroha, toi te Reo Māori
kia tūturu, ka whakamaua kia tīna! Tīna!
Hui e, Tāiki e!

Let the strength and life force of our ancestors
Be with each and every one of us
Freeing our path from obstruction
So that our words, spiritual power, love, and language are upheld;
Permanently fixed, established and understood!
Forward together!

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Glossary of Terms

Kupu Māori: Māori Words

Aotearoa: New Zealand

Aroha: Love

Hinengaro: Mind/emotions/psychology

Karakia: Prayer

Kaupapa Māori: Action based on Māori cultural principles and values

Kia tupato: Be cautious

Korero: speak/speech or narrative/discussion

Mana: The inner power of a person

Manaakitanga: Kindness and respect for others

Pepeha: Personal Introduction

Taha: Wall

Tāngata: People

Tāngata whaiora: The people in search of wellbeing. In this thesis it is used to describe Māori service users

Te Tiriti/Te Tiriti o Waitangi: The Treaty of Waitangi

Te Whare Mahana: The warm house. The name of the DBT residential centre where the study on programme effectiveness was based.

Te Whare Tapa Whā: The house with four walls. The name of a holistic health model developed by Dr Mason Durie.

Te Whenua: The land

Tikanga: Appropriate Māori cultural practices

Tinana: physical body

Titiro: Look

Waiata: Song

Wairua: Spirit

Whakapapa: Genealogy

Whakarongo: Listen

Whakataukī: Proverbs

Whānau: Extended family

Wharenui: Meeting house on a marae

Commonly Used Acronyms

ACEs	Adverse childhood events
ASD	Autism spectrum disorder
ADHD	Attention-deficit hyperactivity disorder
DBT	Dialectical Behaviour Therapy
TA	Thematic Analysis
BPD	Borderline Personality Disorder
WHO	World Health Organisation
NSSI	Non-suicidal self-injury
DHB	District Health Board
PTSD	Post-traumatic stress disorder
ED	Eating disorder
SUD	Substance use disorder
NGO	Non-governmental organisation
ACC	Accident Compensation Corporation
EMDR	Eye-movement desensitisation and reprocessing

Chapter 1 Introduction

Pepeha

Ko Aoraki tōku māunga.

Ko Waitaki te awa.

Ko Ngai Tahu tōku iwi.

Ko Ingarangi, ko Kotirana, ko Aerana te whakapaparanga mai hoki.

Ko Otepoti te whenua tupu.

Ko Mohua te kāinga.

Ko Furness tōku whānau

Ko Emma tōku ingoa.

1.1 Locating Myself as a Researcher

There are three main reasons why I have focused my research on hearing the perspectives of tāngata whaiora / service users who have complex needs and presentations.

First, I grew up in an unusual setting. My parents ran a homeless shelter in the years directly after deinstitutionalisation in Aotearoa, and I had early insight into the links between poor mental health and poverty and how one can maintain the other. From this perspective it appeared the people that need the most support have the least voice and power to change the support systems they use. It became a personal passion to amplify the voices of and support meaningful change for those that have less power in our wider social settings.

Second are the experiences I have had at my current workplace. I currently work at Te Whare Mahana (TWM), the Dialectical Behavioural Therapy (DBT) residential programme. This is the place I have drawn my participants from. I have worked there for four years and since 2021 I have been the Care Coordinator. As part of my role, I have one-on-one appointments with each resident weekly, and we work on practicing and generalising learned skills in the wider community. I help them take steps towards their Life Worth Living goals [1]and support them with tasks involving outside agencies and their regular trips home. I keep an eye on their trajectory through the programme and work with their primary therapists to assist them with skills plans and any other assigned tasks. I also teach DBT skills classes, including mindfulness, emotion regulation, interpersonal effectiveness and distress tolerance, and coach skills as needed when people are

[1] Life Worth Living goals are a part of DBT and clients define their own goals at the beginning of treatment. They reflect the core values and aspirations that matter to the individual client. They can help with motivation and as a guide for treatment.

distressed. This is meaningful work for me, and I'm very passionate about working with and for this population. Due to my work, I have both an insider and an outsider perspective as a researcher. I am not a service user, but I work in the therapeutic context being asked about. This is a strength for my research, in that I am exposed to both institutional, support worker, and resident patterns of behaviour which an outsider may miss. My work has led me to wanting to explore and expose the perspectives of complex tāngata whaiora / service users whose voices are often missed. It is also a weakness, as my perspective could lead to bias, which requires vigilance, supervision, and reflexivity to monitor. While working with people as a skills coach and a care coordinator, I have seen how hard the residents must work towards their own healing, and how things like secure housing, social support, and adequate resources for medical care, can make all the difference to ensuring that hard work needed during and after treatment is sustainable.

Third, in my studies I have looked at both clinical and community psychology and felt the urge to synthesize the two disciplines. I believe the question of how to treat the individual successfully cannot be asked without a holistic viewpoint. From my perspective, the causes, maintenance, and healing of unwellness happen in the environment, including in the spaces and institutions set up for healing. Measuring the success of interventions designed for increasing wellbeing and lessening suffering must also be holistic and include looking at healing environments as factors that can heal, sustain and/or worsen symptoms. Service user perspectives can offer insights into environmental impacts that are not measured solely by symptom reduction or able to be captured in clinical tests on the effects of a treatment. I believe healing is not just an inside job, where someone with a diagnosis works only on their own reactions, beliefs, thinking patterns, and emotional and relational upskilling. I believe healing happens in context, is transactional, and factors outside of any cognitive or mindfulness-based treatment are necessary ingredients.

Most tāngata whaiora / service users who have complex diagnoses and needs that come to TWM for treatment have experienced deeply traumatic and life changing events. These were experiences that happened in relationship with other people, often in environments with no escape possible. Finding out what worked and did not work for them personally, within a context of healing and in relationship with other people, feels like important work. This will enable people who work in this area to fine tune treatment, and hopefully to support fuller, more holistic healing.

1.2 Introduction to the Research

Life comes with extra challenges for people experiencing severe acute and chronic distress. Ongoing or severe illness and distress can affect learning and employment, which then increases the chance of poverty (Brackertz et al., 2020; Mental Health and Addiction, 2023). Safe and secure housing, access to medical care, adequate food and warmth, and social support are all necessary for wellbeing and can be compromised by severe mental unwellness. (Isogai, 2016; New Zealand Government, 2018; Williams et al., 2017). Severe mental distress and illness come with high personals costs for tāngata whaiora / service users and includes the need to frequently interact with mental health services in different formats, with varying results.

Treatment is often necessary to improve everyday functioning and wellbeing, yet there can be many barriers to suitable treatment (Goodyear-Smith & Ashton, 2019; Every-Palmer et al., 2023; McAllister, 2019). Treatment often needs to include support for physical health, life and relationship skills, vocational support, and psychiatric and psychological interventions, which comes with high costs for the wider community (Office Auditor General, 2017; New Zealand Government, 2018; Meuldijk, 2017). It can also include specialised services, for example support with addiction and or to ensure adequate nutritional uptake. For many, residential treatment is a good option, particularly if suicide risk is high, or ineffective coping behaviours such as substance use, life-threatening disordered eating, or self-harm need to be managed before or during treatment.

There is a great deal of research looking into the effectiveness of a variety of treatments for severe distress presentations (Cusack et al., 2016; Davis & Kurzban, 2012; Meuldijk, 2017). They may test factors such as symptom reduction, hospitalisation rates, or subjective distress. However, if wanting insights into the treatment environment, psycho-social interventions, or other factors that support a person's wellness journey, as well as the clinical interventions, service user perspectives are useful (New Zealand Government, 2018). By consulting tāngata whaiora / service users, researchers and clinicians can understand more about which resources are most helpful and where there are gaps that keep many people in a revolving door situation in our mental health system.

Dialectical behaviour therapy (DBT) is a therapeutic intervention designed for people with suicidal ideation who experience difficulties regulating emotions, and problems in relating with others (Linehan 1993). It is well known for showing efficacy in treating borderline personality disorder (BPD), and increasingly proven effective in a variety of other disorders associated with severe distress (Bankoff et al., 2012; Bohus et al., 2020; Courbasson et al., 2012; Jones et al., 2023; Panos et al., 2014). A DBT residential centre is a place tāngata whaiora / service users live in a supported way, learning DBT skills and undergoing therapy as designed by Marsha Linehan (Linehan, 1993). Additionally, many tāngata whaiora / service users who are typically referred to

and accepted into the DBT residential treatment programme in Aotearoa have experienced sexual assault and/or abuse, and some form of memory reprocessing is necessary to manage post-traumatic stress disorder (PTSD) symptoms (Schnyder et al., 2015; Bohus et al., 2019).

There is a wealth of literature utilising service user perspectives of DBT internationally, and many that assess residential treatments, particularly in the United States (Little et al., 2018; Proctor et al., 2020; Ring & Lawn, 2019; Veysey, 2014). However, there are very few studies conducted in non-Western countries, few that assess success across cultures and none to check if DBT fits culturally in Aotearoa. In the literature that is available, there is no evidence of perspectives from Māori or other ethnic groups, less male representation, and no explicitly rainbow community perspectives.

The purpose of this research is to start to fill this research gap, by asking tāngata whaiora / service users about their experience in a DBT residential programme. The five participants in the study had undergone treatment in a Dialectical Behavioural Therapy (DBT) Residential treatment centre in Aotearoa. Data on their experience in the DBT residential programme was gathered via interviews and analysed through an inductive and qualitative research design utilising reflexive thematic analysis. The main aim of the research was to gain insight into effective aspects of DBT residential treatment from the perspectives of tāngata whaiora / service users at least one year after leaving the residential aspect of the programme. This included understanding how DBT residential treatment works in an Aotearoa. Two other aims were to provide opportunities for clinicians to enhance their delivery of DBT and provide an opportunity to tāngata whaiora / service users to voice their experiences.

The next chapter is a literature review that will attempt to set the scene for the study. This will include an outline of costs to tāngata whaiora / service users and the community, a description of DBT, residential treatment and the treatment centre in this study. Effectiveness of DBT and other relevant interventions will be examined, and the importance of service user perspectives discussed. Useful interventions identified by tāngata whaiora / service users will be reviewed.

Chapter Three will outline the methodology and method. It discusses the theoretical and epistemological underpinnings of the research and outlines the data gathering and analysis used. Participant information, recruitment, and processes for analysing the data are described. Results from the data analysis and the discussion of the results is combined in Chapter Four, titled Analysis. This includes three main themes and two subthemes that are centred around what clinical, non-clinical, and relationship factors that the participants found helpful and unhelpful, and how those factors compare to local and international research. Lastly, there is a conclusion chapter that

includes key findings, practical implications for clinicians, research strengths and weaknesses, and ideas for future research.

Chapter 2 Literature Review

2.1 Introduction to the Literature Review

This literature review attempts to set the scene for exploring the experiences of tāngata whaiora/mental health service users who have been in a Dialectical Behavioural Therapy (DBT) residential programme in Aotearoa. As most tāngata whaiora / service users of residential DBT treatment experience extreme and chronic mental distress, this review will start by outlining the costs of serious mental health issues and barriers to care in Aotearoa. This describes the care that is available and provide rationale for the research.

Following this, the review will describe DBT, residential treatment, and the DBT residential treatment centre in Aotearoa, to showcase the research environment and treatment being assessed. Description may allow readers to better assess whether research results can be transferred to other similar environments and treatments. Literature on the effectiveness of DBT for a variety of diagnoses, both in Aotearoa and internationally, is explored. These descriptions show why DBT is often chosen for clients with multiple and complex diagnoses, and some of the strengths and weaknesses of that treatment for various symptoms of severe distress.

A section on how varying cultural understandings affect treatment outcomes and cultural adaptions for DBT is also provided. As DBT is designed in the United States, it felt important to include research looking at effectiveness in other cultural environments. This includes the Aotearoa environment. People referred to the DBT residential centre frequently arrive with multiple diagnoses and serious distress symptoms, so cultural adaptions for other treatments in Aotearoa that are aimed at complex and severe distress presentations will also be discussed. DBT is commonly known for efficacy in treating borderline personality disorder (BPD), and as this is linked to a history of sexual abuse and chronic invalidation, literature on the connections between the two factors and the potential for misdiagnosis will be examined (Buono et al., 2021; Panos et al., 2014; Perseius et al., 2003). Service user perspectives and their importance, including relevance to DBT, will conclude this review.

2.2 Costs of Serious Mental Health Issues

One tenth of the world's population is estimated to have a diagnosable mental health disorder. The World Health Organisation (WHO) estimates worldwide mental health disorder prevalence at 792 million people, or 10.7% of the population (Dattatni et al., 2021). This review will cover the costs for people experiencing severe psychological distress. In Aotearoa, over the year 2020 to 2021, the prevalence of people experiencing high to very high psychological distress

was 11.2% of the population (Ministry of Health, 2022). Due to the increased visibility of mental illness and distress, many people believe there is an increase in prevalence and severity across the globe (Richter et al., 2019). In line with this belief, requests for access to mental health services in Aotearoa have increased steadily since 2003 and it is estimated that in the last decade 73% more people are accessing services (New Zealand Government, 2018). Between 3-5% of New Zealanders need specialized mental healthcare, such as hospitalisation or prolonged therapy (New Zealand Government, 2018). Suicide attempts were around 20,000 people in 2015 and specific behaviours deemed as serious or severe, such as non-suicidal self-injury (NSSI), are increasing (New Zealand Government, 2018; Office Auditor General, 2017). Whether these high numbers are due to an actual increase in the prevalence of severe mental distress, or an increase in awareness of a variety of diagnoses, help seeking, or population changes, the number of people experiencing serious mental health issues does come with increasing costs (New Zealand Government, 2018; Richter et al., 2019).

Many of those costs are collective, including the financial burden. A large proportion of mental health resources are directed towards specialised care for people experiencing extreme or chronic mental distress (New Zealand Government, 2018). For example, in 2016, approximately 15,000 people in Aotearoa needed hospitalization due to mental distress and the cost of caring for those in hospitals was more than $200 million (Office Auditor General, 2017). Additionally in the same year, 9% of the total health budget, or $1.4 billion was spent on mental health and addiction. From that $1.4 billion, $1.35 billion was allocated to the 3% of people needing specialized services. People in this 3% receiving necessary specialised services have the biggest challenges, and frequently experience chronic and/or acute distress and illness that interferes with function and relationships. They often need medical support, such as hospitalization, alongside psychiatric and psychological interventions, as well as community support from a variety of health and social service professionals (New Zealand Government, 2018; Office Auditor General, 2017). With many resources directed towards this 3%, finding out what interventions are effective, and what are not, is important.

Despite what looks like large amounts of money being directed towards this 3%, there are many places where resources are not adequate, or processes too cumbersome to ensure equitable access or health outcomes (Goodyear-Smith & Ashton, 2019; Kingi et al., 2018). He Ara Oranga, the large survey done in 2018 to assess mental health outcomes in Aotearoa, revealed that Māori, Pacific peoples, people with disabilities, people in the rainbow community, prisoners, migrants, and refugees all had difficulties accessing necessary mental health care and had worse health and wellbeing outcomes than other New Zealanders (New Zealand Government, 2018). One of the

barriers to accessing necessary care is difficulty accessing the mental health system. Since the 1990s and the Mason Inquiry and deinstitutionalisation, most specialised mental health services have been accessed by people living in the community (New Zealand Government, 2018). This means a primary health care agent, such as a medical doctor, is the first port of call for pre-crisis situations. It is not always possible to access a medical doctor when needed and, even when it is, the cost to see a primary practitioner can be a prohibitive factor for people with chronic health issues and low income (Goodyear-Smith & Ashton, 2019; Kingi et al., 2018). A small study done in 2017 showed that 28% of the overall population and 38% of Māori could not access primary health care when it was needed (Goodyear-Smith & Ashton, 2019). As Māori have the highest suicide rate in Aotearoa, this is problematic (New Zealand Government, 2018).

Processes for access to crisis mental health care can also provide a barrier. In a crisis, many people contact emergency services or are taken to a hospital emergency department. Police are often the first responder after a crisis call or when a member of the community contacts about potential threat to self or others (Every-Palmer et al., 2023; McAllister, 2019). Often restraint, force, or detainment is used to contain a person, and this situation can be terrifying and retraumatising for someone already highly distressed (Every-Palmer et al., 2023). For some, reaching out to first responders in a crisis may not feel like an option, especially if the result is restraint, misunderstanding, or even just police presence. If not detained, a person assessed as needing mental health interventions will be taken to an hospital emergency department and experience a potentially lengthy wait to be seen (Every-Palmer et al., 2023).

If referred on to mental health crisis support the next step is an inpatient unit admission. In 2020/21, 17,305 people accessed inpatient care and many inpatient units have been struggling to keep up with the demand (McAllister, 2019; Mental health and addiction, 2023). Once in the unit, although there is a measure of safety offered, studies show there is also a strong possibility of re-traumatisation (Jenkin et al., 2022). In a large qualitative study exploring violence in New Zealand's inpatient units, Jenkin et al. (2022) showed that both staff and patients experienced a significant amount of violence that impacts the therapeutic environment in many complex ways. Lack of adequate staffing and the layout, including lack of space, exits and blind spots, as well as practices such as confinement have been named as also impacting the therapeutic environment (Jenkin et al., 2021; Jenkin et al., 2022; Lewis, 2022; McConnell, 2022; Naish, 2022). Lack of adequate resources for the people with the highest needs can mean less effective treatment, or even the need for additional treatment, which contributes to increased overall cost to everyone involved.

Māori can be especially affected by an inpatient stay. For example, a study done by McLeod et al. in Aotearoa in 2017 showed that Māori in inpatient units are 39% more likely to be placed in

seclusion in comparison to Pākehā. Another researcher, Wharewera-Mika (2012) looked specifically at Māori tāngata whaiora and whānau needs when extreme distress is present, and particularly when using inpatient services. They investigated admission rates, length of stay, and primary diagnoses of Māori who had used mental health inpatient services. They also investigated needs of Māori on admission, which interventions were supportive and which non-supportive, and asked about preferences for alternative care. Discoveries included high rates of admission to inpatient and intensive care services and a greater likelihood of a psychotic disorder diagnosis than Pākehā presenting with similar symptoms.

Once a patient who has experienced severe mental distress is released from an inpatient unit, there is the cost of continued care. In Aotearoa district health board (DHB) settings there are inpatient and outpatient teams that respond to serious mental distress. The outpatient team leads care in the community before and after any inpatient unit admissions, and responsibility for continuity of care is ideally moved back to the outpatient team for care after discharge (McAllister, 2019). However, inadequate resourcing means that this does not always happen, which can lead to adverse consequences for those seeking assistance. For example, Skipworth et al. (2023) analysed the association between discharge from a single acute inpatient unit and referral to prison within a month of discharge, over nine years. They discovered that the risk of imprisonment increases in the month after release from an inpatient unit, especially for Māori or Pacific peoples or those with substance use and psychotic disorders.

Various literature on mental health service effectiveness does show both improved services over time and areas for improvement. For example, Skipworth et al. (2023) described how mental health care in Aotearoa has greatly improved in the last decades as the quality of life that comes with community-based care is often preferred to long-term confinement. There is also a greater and growing awareness of the impacts of compulsory, coercive or restraint-based care, and currently there are plans to build more suitable inpatient spaces (Skipworth et al., 2023). However, when looking carefully at our mental health systems, including the cost and resource availability compared to the need in the community it is clear there are gaps and systemic issues (Lewis, 2022; McConnell, 2022; Naish, 2022). It appears the increasing cost of accessing care puts a great deal of burden on overloaded and understaffed mental health and emergency health teams. With the struggle to ensure access and proper care with less staff, time, and resources than necessary, the pressure to maximise efficiency at the cost of quality care also increases the risk of staff burnout.

The high costs all round mean continuing high health and wellbeing costs for tāngata whaiora / service users. When looking at statistics there is a clear connection between poverty and service use. Approximately 58% of the 190,969 people accessing services in the years from 2020 to

2021 were living in areas with the highest poverty and deprivation, whereas 14% were from the areas with greatest wealth (*Mental health and addiction*, 2023). Any kind of acute or chronic illness affects a person's ability to create or maintain an income, which has knock-on effects for attaining or holding onto healthy housing (Brackertz et al., 2020; Isogai, 2020; New Zealand Government, 2018; Wright & Kloos, 2007). Physical health is shown to be seriously impacted. For example, people diagnosed with one or more mental disorders have a lower life expectancy of 25 years than people who do not (New Zealand Government, 2018). Relationships are also often affected by chronic mental distress, which can lead to less unpaid yet necessary social support (Kyle & Dunn, 2008). Poverty, housing difficulties, low pay, abuse, social isolation, and discrimination are all risk factors for diagnosed disorders and serious mental distress (New Zealand Government, 2018). Much literature shows these factors contribute to initial diagnosis but are also part of what keeps many people in chronic illness and crisis cycles (Baker & Douglas, 1990; Culhane et al., 2002; Kyle & Dunn, 2008; New Zealand Government, 2018; Williams et al., 2017).

The 3% of the population that experience severe and/or chronic mental illness and crisis cycles, who are the highest users of mental health services, and are most affected by these costs, include the people who are referred to and accepted into the DBT residential programme in Aotearoa (National DBT Service, n.d.). Most people referred to the DBT service are familiar with and have had many experiences in all aspects of the New Zealand mental health system, and a referral to the programme means a participant has navigated many of these access points. With high costs to the collective and to individuals, directing resources to discovering the most effective treatments and processes would be of value to tāngata whaiora / service users and the wider community. One of the aims of this research is to explore the effectiveness of a costly and wraparound residential treatment from service user perspectives. Descriptions of aspects of that care will now be explored.

2.3 Description of Dialectical Behavioural Therapy (DBT)

DBT uses multiple approaches when treating clients. It was originally designed for people who were highly suicidal and is most well known as an effective treatment for borderline personality disorder (BPD) (Linehan, 1993; Panos et al., 2014). DBT has increasingly been used for a variety of other severe distress presentations, including individual or comorbid diagnoses of post-traumatic stress disorder (PTSD), anxiety and mood disorders, eating disorders (ED), and substance use disorders (SUD) (Bankoff et al., 2012; Bohus et al., 2020; Courbasson et al., 2012; Jones et al., 2023). Treatment includes individual therapy, therapist consultation, skills classes in mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness, as well as as-needed skills

coaching (Linehan, 2015). Standard DBT uses a treatment hierarchy, where life threatening behaviours are targeted first, then therapy interfering behaviours, followed by quality-of-life interfering behaviours.

The philosophy of DBT is based on dialectical thinking, and the main treatment dialectic is to accept oneself or one's patient as is, validating emotions and personal experiences, while also pushing and working for change (Linehan, 1993; Linehan, 2015). It is a model that encourages judgement-free thinking from clinicians and clients. Clients take steps with the support of their therapy team towards their own self-designed plan for life and they rate behaviours on their effectiveness in helping them meet their long-term objectives rather than as good or bad. Framing and treating behaviours such as intentional self-harm or substance abuse as effective in the short term but ineffective in the long term can help take judgement out of the picture. Clients track behaviours and spend time working out what motivates both effective and ineffective behaviours. DBT teaches skills to replace short term behaviours, for example using ice water and intense exercise as a replacement for self-harm or for when urges are high as one way to manage extreme emotions in the moment. Behavioural principles are also used, for example modulating warmth so that skilful behaviour is rewarded by high warmth and behaviours that can illicit concern and care from others in the community but are ineffective long term, such as overdosing, are met with less warmth.

DBT is a multi-modal treatment, with a treatment hierarchy, therapy structure, and key strategies for clinicians to employ. The main modes of treatment include talk therapy, skills training, and skills coaching. Clinicians are encouraged to be flexible in their application, authentic in their professional interactions, and have in-the-moment and outside therapy support available for clients so skills can be coached as needed. DBT is used in outpatient and residential settings (Haft et al., 2022; Linehan, 1993). In Aotearoa in 2023 there are five District Health Board (DHB) based outpatient DBT programmes running and one DBT residential service that is a non-government organisation (NGO) (Batchelor, 2005; National DBT Service, n.d.; Segar House, n.d.).

2.4 Description of Residential Treatment

A residential programme is a live-in, wraparound mental health service that offers psychological treatment within a group environment. A residential treatment centre can offer extra levels of safety and intervention for people struggling with suicidal, self-harming, eating disordered (ED), and substance use disordered (SUD) behaviours in open community settings. Most residential services in Aotearoa serve to treat one specific disorder such as ED or SUD, and there are few residential programmes that service complex presentations (*Eating Disorder Services*, n.d.; *Drug*

and alcohol Treatment Centres NZ, 2023). The small number of residential treatments left can act as a 'catch-all' for people whose needs are not being met by specific or outpatient treatments. High costs and multiple interventions and targets mean that it is important, but difficult, to discover what specifically works for people needing such high levels of support.

2.5 Description of Treatment at the DBT Residential Centre

Te Whare Mahana is a non-governmental organisation (NGO) that includes a DBT residential centre as well as a separate community mental health team. It is located in a small rural town in the South Island and at the time of writing, the residential DBT programme is the only one in Aotearoa (National DBT Service, n.d.). People that come to the residential programme are referred from all over Aotearoa and nearly all commit to at least a year in the programme. That means many people coming for treatment give up employment, rented homes, and put in-person social supports on hold in order to commit.

Nearly all clients referred to this residential centre have their treatment funded by Accident Compensation Corporation (ACC) or from what was their local District Health Board (DHB). When referred from ACC, most clients are coming to treat a psychological injury due to a traumatic event and covered under the sensitive claims model (ACC, n.d.). Most clients that come for treatment through ACC have suffered sexual assault and many have experienced childhood sexual abuse. DHB or Te Whatu Ora clients are often referred to the DBT programme to treat BPD because DBT has been shown to be effective to treat chronic and severe distress due to difficulties regulating emotions. TWM advertises it services as currently targeting people who have not had successful treatment in other places:

> Dialectical Behaviour Therapy (DBT) is for people experiencing high levels of distress in their lives and for whom hospital or community treatment has not met their needs. People may have diagnoses of multiple and complex disorders, including borderline personality disorder and post-traumatic stress disorder, and typically have harmful behaviour when trying to cope with intense emotions and disrupted relationships. (*Who is DBT for?* n.d.).

Treatment is 'wraparound'. It could be described as a type of therapeutic community. A weekly programme includes two intensive therapy sessions, four DBT skills classes, short meetings in the morning and evening, scheduled time with skills coaches to practice DBT skills, an appointment with a care coordinator that is part social work, a meeting with the onsite nurse, and several meetings to organise shared living logistics and air/sort grievances that come up in a flatting style community. There is also one day a week scheduled for organised recreation activities.

Mindfulness practice is incorporated into each day, with residents and staff preparing and leading mindfulness activities at the beginning of each meeting. The programme has many targets and interventions and is costly for funders, staff, and residents. Finding out what works for our tāngata whaiora / service users is vital so limited resources can be directed to the most effective places, and the precious time our clients are committing to healing away from loved ones is respected.

2.6 Effectiveness of DBT

There is a great deal of literature outlining the efficacy of DBT (Ali et al., 2021; Batchelor, 2005; D'Anci et al., 2019; Kothgassner et al., 2021; Panos et al., 2014; Robins & Chapman, 2004; Tsirides et al., 2021). As the clients targeted in this study are frequently being treated for suicidal and parasuicidal behaviours, as well as diagnosed disorders including borderline personality disorder (BPD), post-traumatic stress disorder (PTSD), eating disorder (ED), substance use disorder (SUD), and a variety of neurodivergent presentations, the literature on the efficacy of DBT for these diagnoses will be explored.

DBT is a treatment that has shown to effectively treat diagnosed BPD (Panos et al., 2014; Tsirides et al., 2021). BPD is defined in the *Diagnostic and statistical manual of mental disorders* (5th ed.) as including patterns of relationship, identity, and emotional instability alongside impulsivity. Symptoms can be fear of abandonment, identity disturbance, suicidal and/or self-harming behaviours, high reactivity, chronic emptiness, paranoia and severe dissociation (American Psychiatric Association, 2013). BPD is commonly understood to be difficult and costly to treat (Proctor et al., 2020). Many DBT treatment spaces have been set up to treat BPD, including the symptoms of high emotional dysregulation, chronic and acute suicidality, and non-suicidal self-injury (NSSI).

Aside from BPD, DBT has shown effectiveness with other presentations. Multiple randomised and controlled clinical trials have shown that DBT lessens frequency and severity of suicidal and self-harming behaviours and results have shown a lowering in hospitalisation rates and increase in both social and global adjustment for those treated (Ali et al., 2021; Batchelor, 2005; Brassington & Krawitz, 2006; D'Anci et al., 2019; Kothgassner et al., 2021; Robins & Chapman, 2004). In the 30 years since DBT became widely known, the treatment has also been shown to effectively treat people who struggle with SUD, PTSD, and ED (Bankoff et al., 2012; Batchelor, 2005; Bohus et al., 2020; Brassington & Krawitz, 2006; Courbasson et al., 2012; Haft et al., 2022; Jones et al., 2023). Treatment has shown to be effective with adolescents, elderly, and people in the justice system, as well as with people with several mental illness diagnoses and those regarded as hard to treat (Batchelor, 2005; Kothgassner et al., 2021).

Severe eating disorders are also hard to treat, particularly when comorbid with other diagnoses, and people referred to the DBT residential treatment centre in Aotearoa often have some form of eating disorder (Federici et al., 2012). Federici et al. discuss the effectiveness of DBT for eating disorders, and theorise that skills acquisition helps when disordered eating is a coping mechanism for distress and lack of control, but also that DBT likely helps because eating disorder treatments do not typically directly target suicidality, self-harm, or trauma associated symptoms. However, non-specialised outpatient DBT is not designed to monitor prescriptive food planning or the physical health monitoring that are necessary when ED behaviours become life threatening. Targeting just one set of diagnosis-related symptoms without the other can leave people with multiple diagnoses, including ED, short of important care. For severe or life-threatening ED, ED-specific inpatient or residential treatment is often required and when there is a complex diagnostic picture, multiple interventions are necessary. Some of these will be looked at in detail below.

DBT has shown to be effective for PTSD, particularly when adapted to include trauma memory reprocessing alongside or after skills acquisition (Bohus et al., 2020; Harned et al., 2021; Oppenauer et al., 2023; Snoek et al., 2020). Studies have shown that adding prolonged exposure (PE), or eye-movement desensitisation and reprocessing (EMDR) for traumatic memories to DBT increases positive results for clients with complex PTSD and BPD both in controlled trial and outpatient clinical settings (Harned et al., 2021; Snoek et al., 2021). A newer version, DBT-PTSD, that includes DBT skills training, exposure practices, and some parts of compassion-focus therapy (CFT) and acceptance and commitment therapy (ACT), has also shown efficacy in laboratory and clinical settings for adults with trauma from childhood abuse (Bohus et al., 2020; Oppenauer et al., 2023).

When it comes to substance use disorders the group skills training part of DBT has been used as a standalone treatment. One study that looked at the links between alcohol addiction, avoidance, and emotion regulation skills concluded that DBT skills training can improve addictive behaviours in a study with a sample of 186 people (Cavicchioli et al., 2020). Warner and Murphy (2022) completed a systematic review of the literature to test the theory that just the skills training element of DBT would be helpful for people with substance use disorders. They also concluded that skills training alone did reduce substance use and helped with emotion regulation overall, but also that larger and more rigorous trials were necessary to confirm this.

There is very little research on whether DBT as a whole treatment is effective for a single diagnosis of substance use disorder. Most research on DBT effectiveness is about comorbid BPD and substance use, however that is also described as ‘scant’ (Kienast et al., 2014). Comorbidity is common, with 78% of people diagnosed with BPD also having substance use issues, but research

on the combination is less common as participants with active addictions are frequently excluded from clinical trials (Buono et al., 2021). However, the studies that do exist show promise. For example, adapted DBT has been shown to lessen anxiety and depression for those diagnosed with BPD and SUD, reduce substance use, and improve overall functioning (Buono et al., 2021; Kienast et al., 2014).

Adults presenting with neurodiversity are also treated in the DBT residential setting. This could include autism spectrum disorder (ASD) and attention-deficit hyperactivity disorder (ADHD). There is currently very little research on the effectiveness of DBT for either diagnosis, but Sakdalan and Maxwell (2023) have investigated the overlap between BPD and ASD and proposed that DBT may help adults with ASD. This overlap between the diagnoses includes the impact of invalidating environments, sensory issues, black and white thinking, social skill issues, anxiety, potentially offending behaviours, and emotional dysregulation. Pilot studies show that adapted DBT can be effective for people diagnosed with ASD and stand-alone skills training was found to be helpful according to service users (Sakdalan & Maxwell, 2023; Ritschel et al., 2021) However, service users have also described DBT terminology and learning material formatting as difficult to comprehend (Chenoweth, 2014). Adapting materials and classroom techniques for individuals with neurodiverse needs is recommended, with some new and specialised written supports emerging (Irvine, 2019; Moyer, 2023; Wise, 2022).

Overall, the literature shows that DBT is effective as a treatment for a variety of diagnoses. However, effectiveness in many of these studies often means a reduction in hospitalisation, substance use, or clinically diagnosed symptoms, rather than full remission of symptoms. Very few listed in the above section measured wellbeing or included service user perspectives. One aim of this research is to investigate service user perspectives and amplify their voice, and another is to offer their insights on what was and was not effective, and what did and did not enhance wellbeing to clinicians to potentially improve services. Literature on the importance of service user perspectives will be discussed in a later section.

2.7 Effectiveness of DBT with Cultural Adaptions

As a therapy that is structured, yet flexible, with multiple interventions included, DBT has shown to be successful for many complex presentations. However, the treatment was designed and developed in the United States and, most research looking at treatment effectiveness was done in Western contexts (Haft et al., 2010). Additionally, most participants in studies that show treatment efficacy have been from the ethnic majority in their country (Haft et al., 2010). There is no literature showing that DBT is clearly effective for all ethnic or cultural groups, and no studies from Aotearoa

that show efficacy of DBT for Māori, Pacific Peoples, and other ethnic and cultural groups. In Aotearoa, Māori are 1.5 times more likely to be diagnosed with a mental illness and twice as likely to complete suicide, and approximately one fifth of people diagnosed with BPD are Māori (Bourke, 2022). Because there are big disparities in health outcomes for different ethnic groups, the consensus is it is important to ensure treatment, and adapted treatment, is effective across cultures (Haft et al., 2022).

A review of the literature, including a systematic review, showed that there was not enough specific research or evidence to support the theory that culturally adapted DBT was more effective than non-adapted DBT (Haft et al., 2022; Madden et al., 2021). However, there was a large range of results in the research, with some studies that showed adapted therapy to be nearly five times more likely to be effective than no therapy, and some that showed client deterioration from adapted therapy (Beckstead et al., 2015; Haft et al, 2022; Madden et al., 2021; Wright et al., 2011). The words 'cultural adaptions' in the studies looked at included a variety of modifications, which could also account for the variety in effectiveness in each study. Overall, clients appeared more likely to accept therapy and stick with it when it included cultural adaptions, which could account for a higher chance of success. Higher retention rates were associated with better therapeutic outcomes and there was evidence that residential treatment, including therapeutic communities, can help people with conditions related to trauma, those experiencing homelessness and Australian indigenous peoples (Madden et al., 2021).

As cultural adaptions were so varied, some of the more common ones will be discussed. There were variations in how the therapist worked, in content, and some differences were in the organisation structure (Haft et al., 2022). Language changes ranged from full translations to swapping out words or concepts that did not fit in the cultural context. Metaphors and stories used to teach were changed to include local stories, sayings, or aspects of the natural world and self-disclosure was measured in cultural terms. People with cultural knowledge were either trained to deliver the treatment or offer advice and some treatment centres added programme elements, such as a sweat lodge. One change included critical race theory into the biosocial model and named systemic racism as a risk factor. Some aspects of skills training, like self-respect, that had cultural assumptions embedded in them were adapted or omitted. Life goals included social or group goals, and not just individual ones. With such a wide variety of adaptions, it could be difficult to pinpoint what adaptions were effective without service user accounts.

Haft et al. (2022) identified the elements that appeared to contribute to greater success. Using staff that were already integrated into the cultural community, and including cultural experts in all aspects of designing and implementing interventions were flagged as very important by

tāngata whaiora / service users. Therapist self-disclosure was also seen as important, and specific DBT factors, such as diary cards and behavioural chain analysis, were viewed as flexible tools that could be tailored to suit clients. Culturally relevant behavioural reinforcements were recommended, and directly addressing any potential stigma clients may feel for doing treatment was a vital factor in some cultural settings. Open discussions of the impacts of generational trauma, racism, and discrimination were also recommended for marginalized cultural groups. Validation of emotional reactions to discrimination was seen as important and skill classes teaching social skills may need adapted, as it was identified some of the skills trainings have cultural assumptions embedded in them. Therapeutic communities, or residential settings where community living is part of the treatment, were found to be more effective for indigenous people with co-morbid mental illness diagnoses (Madden et al., 2021).

The DBT residential in the current study is situated in Aotearoa, and participants are from diverse cultural backgrounds. There are some cultural adaptions to DBT in the programme, which are mostly used with a therapist when individualising treatment. For example, a client who wishes can frame their treatment targets and life goals through the Te Whare Tapa Whā framework (Durie, 1985), which is described in the next section. Aside from use of karakia and waiata (prayer and song) as part of the daily routine, cultural adaptions depend on both the client's desire and the individual cultural knowledge and understanding of staff members.

2.8 Effectiveness of Cultural Adaptions for Other Types of Treatment in Aotearoa

Although there has not been a lot of research on the effectiveness of cultural adaptions to DBT in Aotearoa, there have been studies looking at cultural adaptions of other psychological treatments and critical literature that supports use of more holistic and culturally adapted mental health models (Kingi et al., 2018; Rossouw, 2008; Tudor & Rodgers, 2021). Rossouw (2008) employed a hermeneutic phenomenological approach to look critically at psychological practices that favour a biomedical and positivist worldview, including empirical testing for effectiveness of treatments. They suggest that these practices do not make cultural sense for everyone in Aotearoa, and that using treatment manuals in mechanical ways removed from context, culture, and spiritual factors means missing vital information. They theorise that a biomedical framing can lead to unreasonable expectations that if specific actions are taken a cure will follow. Tudor and Rodgers (2021) also critically examined the formation of psychology epistemologies and how they inform practices in Aotearoa. They looked specifically at the history of the development of the person-centred approach, how it is connected to colonization, and how it impacts Māori. Both studies concluded

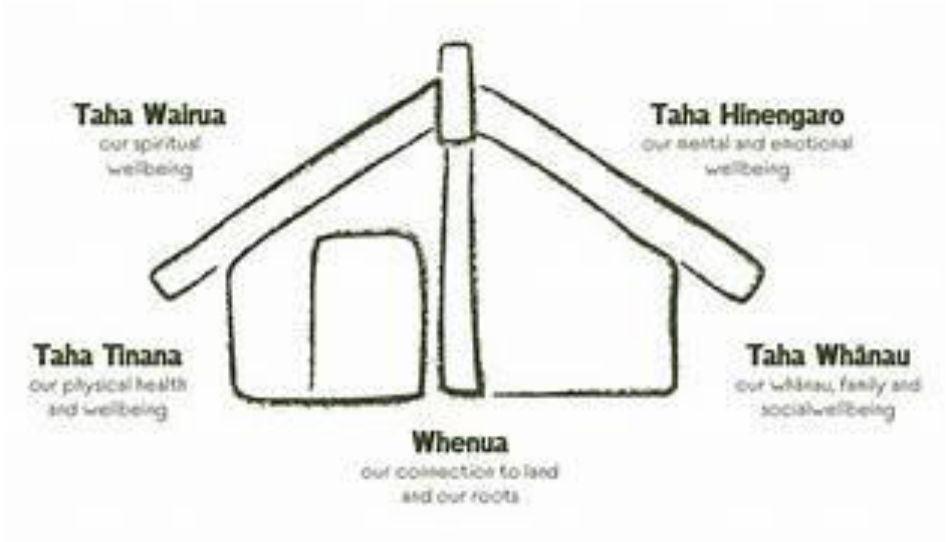
that a flexible and culturally responsive approach is necessary, especially when working with Māori.

Most culturally adapted psychological interventions in Aotearoa have been utilised within the New Zealand Department of Corrections, to be responsive to the large percentage of the prison population that is Māori (Kingi et al., 2018). For example, assessment of adapted cognitive behavioural therapy (CBT) incorporating Māori concepts and practices has resulted in lowered reoffending rates and improvements in depression symptoms (Kingi et al., 2018). While there is little literature assessing the effectiveness on cultural adaptions of western therapies for Māori with severe or complex distress, there is a growing amount of literature on ways to utilise the most well-known Māori health models to good effect. For example, Bennet advocates for culturally appropriate therapist self-disclosure to build and enhance the therapeutic relationship, a factor echoed in the international cultural studies above (Kingi et al., 2018; Haft et al., 2022). Appropriate self-disclosure can also improve the therapeutic alliance, which is heavily supported through research as a necessary ingredient for successful therapy (Baier et al., 2020). Understanding the values of the person in front of you, including the place of their family, whānau and social support system is another factor commonly seen as effective (Kingi et al., 2018).

Various Māori health models have been tested and are utilised in mental health practices in Aotearoa (Kingi et al., 2018; Kiyimba &Anderson, 2022). The most widely known and used is Durie's model, Te Whare Tapa Whā (Durie, 1985). Te Whare Tapa Whā is a holistic health model that uses a metaphor of a wharenui, or meeting house on a marae (see Figure 1). Each of the four walls and the foundation are necessary for health and wellbeing. The foundation is te whenua, representing the importance of connection to the living land, to our place of belonging, and to the ancestors. The four walls, or taha, include wairua (spirituality/the spiritual realm), hinengaro (mind/emotions/psychology), whānau (family, extended family, social support), and tinana (physicality). Each aspect is considered during case formulation and treatment planning.

Figure 1

Te Whare Tapa Whā



Note. From *How Te Whare Tapa Whā Supports Wellbeing.* Takai, n.d. (https://www.takai.nz/findresources/articles/how-te-whare-tapa-wha-supports-wellbeing/). Used with permission.

Kiyimba and Anderson (2022) used a critical lens to examine how Te Whare Tapa Whā fits into treatment for people who have experienced trauma. The authors discussed how most trauma research has been done in countries with lower populations and higher incomes, which has resulted in less understanding about differing cultural concepts of trauma and how to manage it well. The authors theorise that trauma is predominantly constructed by academics and practitioners as an experience that happens to, and needs solved by, an individual. The theorised results are that collectivist perspectives are marginalised and environmental factors such as dislocation, poverty, and inequality are minimised. Kiyimba and Anderson proposed that spirituality, one of the four pillars of Te Whare Tapa Whā, is the heart of Māori collective wellbeing and emphasised the importance of support for holistic interventions with spirituality prioritised. In their book about Māori mental health, Bennet also discussed the need to incorporate spirituality into therapy, at the very least by understanding the possibility of varying explanations for phenomena that would be classed as pathological by Western psychiatry (Kingi et al., 2018). The importance of spirituality to healing, and how it is understood in varying contexts, is also echoed in international research that focuses on service user perspectives (Lietz et al., 2014; May et al., 2014; Pond et al., 2023).

Overall, there is very little literature assessing the effectiveness of culturally adapted practices in Aotearoa, and what is available tends to advocate for and outline processes for use of more holistic and culturally sensitive health models (Kingi et al., 2018; Kiyimba &Anderson, 2022;

Mathieson et al., 2022). Service user perspectives are one possible avenue for assessment of whether these practices are meeting client needs.

2.9 The Importance of Service User Perspectives

When assessing progress in wellbeing, service user perspectives have been increasingly utilised to investigate improvements in quality of life and other factors (Ali et al., 2021). In Aotearoa, service user perspectives have been used to assess and improve suicide prevention and other mental health strategies (Ministry of Health, 2019; New Zealand Government, 2018). One rationale for the need for research to include service user perspectives in assessment of services is that it prevents an etic or 'top down' service, where the experts are on the outside assessing what is natural and normal, and from there what needs healing (Kingi et al., 2018; Morgan et al., 2011). Psychiatric assessment history that includes experts pathologising varying behaviours in ways that are now viewed as harmful include the more well-known examples of diagnosing and pathologising various sexualities, which led to forced treatments (Spandler & Carr, 2022). An example closer to home is the diagnosis and treatment of schizophrenia of many Māori who were hearing voices, which can be a revered phenomenon within Māori culture (Kingi et al., 2018). It is generally accepted now that it is important to hear from those with less power, especially when others have power to assess, detain, and treat them. Gathering service user perspectives becomes ethically imperative, to better understand the grey areas between what can be defined as mental illness and what is culturally accepted as normative responses to environmental stimuli.

There can be other consequences when service user perspectives are not utilised. Jones and Brown (2013) looked critically at the consequences of omitting service user perspectives when assessing treatment outcomes for those with long term illness. They theorised that one consequence of solely using the biomedical model to assess and treat chronic mental distress or psychiatric disability was the expectation that treatments will cure ill health, with a possible consequence being the conclusion that the patient has failed if treatment does not work. They also propose that framing disorders as biological or immovable can lead to simplistic assumptions about cause. For example, if BPD is discussed as a personality disorder, or bipolar as having a biological cause, they can be treated as if they are permanent. This can lead to expectancy effects, including hopelessness, both for clients and healthcare workers. The expert- patient model also means clients are expected to defer to professional perspectives on which symptoms are problematic and which helpful, which can both devalue the voice of and reinforce the role of a person as a chronic patient (Jones & Brown (2013).

There is also the issue of how to ensure treatment is effective. When funding treatment most providers want evidence that the treatment will work to cure the ailment, and controlled clinical experiments based on double-blind medication trials are the gold standard for assessing effectiveness (Akobeng, 2005). As discussed, when removing context, individual, and cultural aspects from assessing cause and effect in complex psychological illness, there is a risk of harm. Service user perspectives can help assess efficacy of treatments and interventions, and other aspects of wellbeing, such as resiliency, increased meaning in life, and the ability to feel connected to self and others. These factors are frequently missed in effectiveness testing but can be assessed by asking tāngata whaiora / service users about their experiences.

2.9.1 The Importance of Service User Perspectives: Borderline Personality Disorder (BPD)

As discussed, service user perspectives have helped understand some of the complexity that comes with 'hard-to-treat' diagnoses, which would be difficult to assess from clinical trials. One diagnosis that is frequently described as hard to treat, and is often treated with DBT, is BPD. A BPD diagnosis often comes with stigma in both mental health and community settings (Sheppard et al., 2023; Veysey, 2014). Discrimination experiences and the stigma that are associated with a mental health diagnosis are factors that affect a person's wellness journey but are often missed in effectiveness testing (Sheppard et al., 2023; Thornicroft et al., 2016). Veysey (2014) used service user perspectives in a small qualitative study in Aotearoa to understand the connection and consequences of discriminatory experiences and a diagnosis of BPD more deeply. They uncovered a strong correlation between a personality disorder diagnosis and stigma experiences, and a clear connection between increased self-harm and discrimination experiences. Their research also showed that clients believed treatment was most helpful when professionals treated them as an individual, rather than just their diagnosis or the sum of their behaviours. International studies utilising service user perspectives also showed that experiences of stigma and discrimination commonly increased with a diagnosis of BPD, especially in mental health settings, as behaviours are viewed as a personality issue and therefore within someone's control (Proctor et al., 2020; Ring & Lawn, 2019; Veysey, 2014).

Some researchers present arguments that BPD is a misdiagnosis of trauma response (Shaw & Proctor, 2005; Veysey, 2014). Fall (2020) investigated the connection between exposure to adverse childhood events (ACEs), which include childhood abuse and neglect, and a diagnosis of BPD by analysing data collected over a year in the USA from over 36,000 adults. They discovered that exposure to ACEs does contribute to the risk of a BPD diagnosis and BPD with a comorbid substance use disorder. BPD may also be misdiagnosed PTSD. Abuse in childhood increases the

risk of both PTSD and BPD, and that there is significant cooccurrence of both disorders (Bohus et al., 2020). Trauma and a PTSD response is an explanation for many BPD symptoms, such as self-harm, suicidality, and intrusive voices or imagery (Veysey, 2014). Additionally, the specific BPD symptoms of expressed anger and abandonment fears make more sense when viewed as a response to childhood trauma as opposed to being caused by a reactive personality (Schwecke, 2009). When reactions to trauma, neglect, or abuse are responded to as a personality or response issue, then abuse as a cause is obscured, which comes with a heavy price for a survivor (Veysey, 2014).

BPD is a diagnosis heavily associated with gender. Specifically, 70%- 75% of people diagnosed with BPD identify as women (Shaw & Proctor, 2005). From those women, 88% have been sexually abused. Shaw and Proctor theorise that a BPD diagnosis pathologises distress and trauma responses that are specifically associated with women or what is classed as a feminine response, and that categorizing behavioural responses to torture and sexual abuse as a personality issue clearly places the responsibility for the abuse on the survivor. Diagnosis can lift the responsibility for recovery, or prevention, off the abuser or the environment. Obscuring abuse as the cause for distress clearly fits in with wider history and social context of denying, ignoring, and downplaying child abuse and sexual abuse of women (Shaw & Proctor, 2005; Veysey, 2014). With that context in mind, people diagnosing and treating BPD need to be critically aware of the lens of gender power relations in past and current cultures.

There were additional consequences of incorrectly diagnosing service users with BPD noted in the literature. Some of these were risk of overmedication, a lack of understanding and punishment of behaviours expressing extreme distress, and the non-normalising of anger and fear as common human responses to abuse (Schwecke, 2009; Veysey, 2014). The emerging overlap between a BPD diagnosis and a diagnosis on the autism spectrum (ASD) may also represent misdiagnosis in some cases, which comes with specific risks for service users (Iverson & Kildahl, 2022). In some cases, symptoms such as black and white thinking, sensory sensitivities, and difficulty naming or recognising emotional states could be misread and mistreated (Iverson & Kildahl, 2022). Service user perspectives are an important counterbalance to necessary outsider, or expert, perspectives, as they allow more compassionate and accurate interventions that do not increase cultural alienation and discrimination experiences.

A mental illness diagnosis can be both helpful and unhelpful, depending on context. Many academic writers utilizing a constructionist or critical lens outline ways that language has power and propose that language in the media and clinical settings used to describe mental illness reflects and creates how we think about and treat people who are very distressed (Harper, 2022; Lafrance & McKenzie-Mohr, 2013, Nairn, 2007). When particular diagnostic labels are used widely, society is

not aware that people seeking mental health services, particularly those who have the most acute and chronic needs, are the ones who have experienced the worst violence and abuse and the deepest inequities in our society (Shaw & Proctor, 2005). As discussed above, BPD is a diagnosis that could be seen to obscure a person's experience and lead to increased experiences of discrimination and stigma. However, while a diagnosis does correlate with the potential for discrimination, some service users did find it helpful when told clearly that they have BPD. Reasons named were that it helped to legitimize their distress by framing it as an illness (Ring & Lawn, 2019). As this set of literature shows, diagnosis can be a useful tool to legitimise symptoms and guide intervention choices, but it is a tool that needs to be used with awareness of a wider social context and the various complex effects a label can cause. Such insights into the complexity of some of these effects are one reason why service user perspectives are important.

2.10 Service User Perspectives: Useful Interventions

Most clients referred to the DBT residential programme have multiple mental health diagnoses or complex needs, and many have been tāngata whaiora / service users in the mental health system for a significant part of their life. Certain behaviours that people have learned and use to cope with traumatising experiences, extreme difficulty or distress in the short term can make things significantly more difficult long term (Linehan, 1993). Some people who have experienced childhood trauma or chronic invalidation use non-suicidal self-injury (NSSI) to manage emotions and some are diagnosed with eating disorders and substance use disorder (Slesinger et al., 2019). Trauma can also lead to experiences such as hearing voices, experiencing flashbacks and intrusions, and severe dissociation (Read et al., 2005; Wearne et al., 2020). Many clinicians, researchers, and writers agree that sexual abuse can cause deep wounding that has a profound effect on the trajectory of a victim’s life, and can result in poor physical and mental health, as well as affect a person’s financial stability (Loya, 2015; Power et al., 2020; Shrivastava et al., 2017). Due to the typical presentations that would be treated in a DBT residential setting in Aotearoa, a literature search was conducted for service user perspectives on what other interventions worked, or have not, for a variety of complex needs.

Despite the devastating effects of chronic abuse, neglect, or invalidation, healing is possible and service user perspectives offer insight into the elements that contribute to increased wellbeing and decreased symptomology (Pond et al., 2023). An interesting insight from Lietz et al. (2014) was that many people who are diagnosed with severe and chronic mental illness do recover, but that this recovery may not be visible to clinicians, which can lead to expectations that severe or chronic illness is permanent. Potential reasons for this invisibility of recovery are people in recovery are no

longer needing input or finding other ways, aside from talk therapy, to increase wellbeing and decrease or eliminate symptoms. By assessing what recovery is, and what contributed to it from a service user perspective, it becomes possible to see a comprehensive picture of wellness (Lietz et al, 2014; Hagen & Nixon, 2010).

2.10.1 Holistic Approach

The importance of a holistic approach has been highlighted in much research (Ali et al., 2021; Chenoweth, 2014; Lietz et al., 2014; Pond et al., 2023). Smaller targets that are often not assessed but help holistic wellbeing mattered to service users (May et al., 2014). For example, when someone has found everyday functioning very difficult for a long time, things like physical health and self-care, ability to relate with others, not feeling alone, finding meaning in something or caring about something can be more meaningful than a lessening of symptoms (May et al., 2014). Various forms of spirituality were an important part of holistic healing for many participants in studies, including having a source of hope, mindfulness practices, and adhering to a belief system (Ali et al., 2021; Lietz et al., 2014; Pond et al., 2023). In a study focusing on psychosis symptoms, mindfulness practices and changing beliefs were useful ways to increase wellbeing, particularly for those who heard distressing voices (May et al., 2014). Similarly, in their study sharing the perspectives of people who had experienced serious suicidal urges and actions, Ali et al., (2021) found that addressing physical health needs, increased exercise, mindfulness, medication, as well as spirituality were important for increased wellbeing. However, some participants discussed how supportive factors, such as religious or spiritual systems, could be harmful in certain contexts (Pond et al., 2023). Service user perspectives can show the complexity and paradoxical nature of many support systems, that they may be experienced as helpful and unhelpful simultaneously.

Family involvement and experiencing healthy relationships were also seen as a necessary part of holistic care by service users (Chenoweth, 2014; Pond et al., 2023). A supportive community, healthy relationships, nourishing spiritual belief systems, and life goal attainment were viewed as just as helpful as talk therapy, and were shown to increase resilience (Pond et al., 2023). Pond et al. argue that resilience is not just an inside job of one person, but happens in context and within social systems, and increasing recovery rates meant involving clients with the people and communities in their lives. This is reinforced by other studies that highlight the importance of peer and support group interactions (May et al., 2014). Safe and meaningful connection with others in multiple environments was marked as vital for wellbeing and increased feelings of self-worth in each of these studies. These findings showed that for many service users a holistic approach that

goes beyond just biomedical or cognitive therapies is viewed as both necessary and helpful, but that a blanket approach would not work for everyone.

2.10.2 Trust and a Person-Centred Approach

Trust in professionals was a key factor in several studies focusing on lived experience. When relating with professionals, both stigma and difficulty accessing treatment had a negative impact on client wellbeing (Proctor et al., 2020). Inversely, open communication, integration into a community and a trusting relationship with professionals were seen as vital factors for success (Ali et al., 2021; Bourke, 2022; Little et al., 2018; Proctor et al., 2020; Swales, 2009). Keeping patient confidentiality was important, especially in a relationship with an inherent power dynamic, and carrying hope for clients, even when they felt hopeless about their own prospects (Bourke, 2022; Proctor et al., 2020). Communication that increased a sense of client agency, listening with empathy, alongside validating client experiences and emotions had a positive impact (Ali et al., 2021; Bourke, 2022; Little et al., 2018). Power dynamics are inevitable in a therapy relationship, but how power was wielded and the relationship to trust was seen as important in all these studies.

A person-centred approach that worked with the individual was also a common theme for different groups of people. For example, in one literature review there was a wealth of research conducted with female participants that had comorbid mental health diagnoses and had experienced trauma (Madden et al. 2021). Service user perspectives showed that a person-centred and holistic approach was seen as best, with cultural awareness and sensitivity as necessary. For Aotearoa youth experiencing serious mental health issues, individualised interventions that increased a sense of agency and nursed emerging identities were flagged as important, and improved access to services recommended (Herald, 2018). In their study focusing on people with serious mental illness, Lietz et al., 2014 reported that from a client perspective a strengths-based and person-centred practice worked best, that a hopeful outlook was vital, and that social and peer support were necessary ingredients. Clear, respectful, and empathic communication, collaboration, and a sense of safety were valued. Factors that made recovery more difficult were stigma due to diagnosis, coercive practices and the power dynamics that allowed potential abuse and stymied collaboration, and not feeling heard by clinicians and other providers (Herald, 2018; Madden et al., 2021; Lietz et al., 2014). In these studies of what was helpful and what was not, the ‘how’ of service delivery was seen as important as the ‘what’.

2.10.3 Cultural awareness

Culturally appropriate interventions and cultural awareness were named as important in several studies (Ali et al., 2021; Madden et al., 2021; Wharewera-Mika, 2012; Weenink, 2019). This was highlighted in research discussed earlier, by Wharewera-Mika, which examined and described the needs of Māori tāngata whaiora in extreme distress and their whānau. Many of her participants named Kaupapa Māori services, or specific interventions with cultural adaptions as the ones that felt the most supportive. More Kaupapa Māori services were desired. Things that were not helpful were also included. Restrictive practices were named as traumatising and discrimination and participants having less access to whānau had a negative effect. Creating culturally safer therapeutic spaces are important, especially when discriminatory environments are a risk factor for suicide for young Māori (Ali et al., 2021). Ways to create a safer space for any marginalised social group include culturally appropriate interventions and openly naming discrimination as socially traumatising (Ali et al., 2021).

2.10.4 DBT

DBT is also seen as helpful by service users. Service users felt the skills classes were helpful and practicing skills until they were automatic also useful (Barnicot et al., 2012; Little et al., 2018; McSherry et al., 2012). Chenoweth (2014) did a qualitative study in the US on how suicidal youth experienced DBT. Participants reported feeling less suicidal, less likely to self-harm, an increased ability to tolerate distress and regulate emotions, as well as healthier relationships. However, participants noted was that the terminology used in DBT was difficult to comprehend. It was also noted that family were not involved enough, showing that factors such as community and the wider context are important to mental health users when considering success.

In the few studies looking at service user perspectives in Aotearoa, DBT was described as effective. Simons (2010) investigated service user and clinician perspectives who were involved in a DBT programme. The focus was on clients with a BPD diagnosis. The clients were positive about their DBT experience, with DBT seen as difficult to do but rewarding. Weenink (2019) also looked at the effectiveness of DBT, this time for youth in a secure justice residence in Aotearoa. Relationships between professionals and tāngata whaiora / service users was flagged as important for success, as was the need for more culturally diverse staff. A small pilot study done in 2006 looked at the effectiveness of six months of outpatient DBT for people with BPD in an Aotearoa context (Brassington & Krawitz, 2006). This study found significant improvements in function and less hospital use. All participants were female, one identified as Māori/European and the other nine as New Zealand European/Pākehā, with 60% having disclosed childhood sexual abuse histories.

Consumer satisfaction was high for all participants. Learning practical skills to manage problems, achieving goals, increased responsibility, hope and happiness were reported as important parts of treatment. Overall, service user perspectives gathered in Aotearoa show DBT to be helpful, and that the relationship with staff mattered.

2.10.5 Other helpful clinical interventions

Other specifically clinically therapeutic factors were noted by service users. For example, being able to shift the responsibility for the trauma to the abuser and away from the self was experienced as helpful (Pond et al., 2023). Additionally, attaining life goals and building a sense of purpose around helping others in similar situations understand their self-worth was useful (Pond et al., 2023). And organized peer group interactions with people with the same or similar diagnoses or experiences were seen as a vital part of increasing wellbeing in several studies (Pond et al., 2023; Simons, 2010).

Some specific factors were seen as useful by participants with eating disorders (ED). Watterson (2020) focused on garnering perspectives from women in Aotearoa experiencing ED. There are few studies in Aotearoa focusing on their perspective, but eating disordered behaviour is common in women who have experienced sexual abuse and is frequently comorbid with other serious disorder diagnoses. Watterson used mixed methods to explore influential factors to onset and maintenance, as well as those linked to recovery. The most important factor for recovery was seen to be self-motivation. Participants described differing environmental and psychological factors that were relevant at certain stages of their ED. This included environmental and personal reinforcement of ED behaviours, for example weight loss compliments and the emotional relief that came with restricting, purging and bingeing behaviours.

Residential and therapeutic communities were seen as effective by service users in two large literature reviews on that topic (Madden et al., 2021; Magor-Blatch et al., 2014). Findings showed residential therapeutic communities are effective for people with severe or complex disorder diagnoses, trauma histories, and addiction issues. Success was found in improved mental health, better social engagement, as well as reduced substance use (Madden et al., 2021; Magor-Blatch et al., 2014). There is a high correlation between exposure to trauma and substance addictions, with over 90% of people entering residential and other drug and alcohol treatment programmes having been exposed to high levels of trauma (Madden et al., 2021). Trauma informed approaches were useful for, and recommended by, people who had experienced trauma and/or had comorbid conditions (Madden et al., 2021).

Reprocessing trauma memories has also been found to be helpful. In a study done by Boterhoven et al., 2021, 44 patients and 16 therapists were interviewed to explore their perspectives on the effectiveness of treatment for adults who had PTSD from childhood trauma. Participants were from different countries and treatment was either eye movement and desensitisation (EMDR) or imagery rescripting (IREM). Themes from this study centred around how difficult it is to relive trauma is for those undergoing trauma therapy, how important patient commitment and willingness was, and how trauma therapy did change patient insight, sense of self, and self-empowerment. Both therapist and patient avoidance of approaching difficult material was discussed, and how strategies to stay with treatment were important. Another interesting aspect was the learning that trauma treatment can be tolerated if willingness and planning for distress is in place, even without a stabilisation phase.

Overall, when assessing literature on service user perspectives on a variety of treatments for complex symptoms, such as voice hearing, addiction, disordered eating behaviours, and suicidality, similar themes emerged. These themes tend to differ, in wording and concept, from what is measured as effectiveness in treatment. Factors such as the importance of trust, how peer relationships and spirituality help, and how cultural awareness can improve retention in therapy add to our understanding of what works for people in therapy, and what can hinder progress. These aspects, along with the costs of serious mental distress, the effectiveness of a variety of treatments, and descriptions of DBT and residential settings, has set the scene for exploring what worked, and what did not, for tāngata whaiora/mental health service users who have been in a DBT residential programme in Aotearoa. We will explore the methodology for the research in the following section.

Chapter 3 Methodology

3.1 Methodology

The aim of this research was to gain insight into the effective and ineffective aspects of dialectical behaviour therapy (DBT) in a residential setting in Aotearoa. This was with the goals of providing tāngata whaiora / service users an opportunity to voice their experience, and to provide opportunities for clinicians to enhance their delivery of DBT. The choice of topic was influenced by epistemologies that form the community and clinical psychology lenses. These include assumptions, theories and concepts from a social constructionist perspective, logical positivism, and a DBT perspective. An inductive, qualitative study design utilising service user's perspectives, and the reflexive thematic analysis (TA) were chosen based on these epistemologies to best meet the research aims.

An inductive approach was chosen as the aim of the research to look for new insights, points of difference, patterns, or specific observations, rather than test a theory. Inductive research is a search for data that is novel and can stretch the edges of what is known already (Corley et al., 2020). Corley et al. theorise that quality inductive research is "detailed, rich, and authentic presentation of novel insights into complex phenomena" (2020, p. 161). They name that inductive research has thick descriptions that include context and look for new territories for enquiry, and that research validity should not be based on whether it reduces uncertainty, but whether it tells us something we did not know before. As one aim of the research was to provide clinicians with new understandings that may aid service delivery, an inductive and qualitative approach felt most fitting.

Community psychology theory, research, and practice influenced the research topic choice and aims. Community psychology is based on many assumptions. These include theories that community contexts and social systems impact individual wellbeing, and that factors, such as power differentials, historical contexts, and widely held ideologies influence mental health (Malpert et al., 2017). Community psychology also explicitly includes social justice values in order to change systems and societies and improve collective wellbeing (Malpert et al., 2017). Three foundational ideas from community psychology directly influenced the topic choice and data gathering. The first is the value in privileging voices of those with less power, in this case the people often framed as passively receiving treatment in psychiatric and psychological settings. Privileging the voices of tāngata whaiora / service users is one way to redress power imbalances in mental health settings and add to the shift away from solely valuing a biomedical model of healthcare (Double, 2022; McCann, 2016). The second influence was a wish to add weight to academic literature that widens the lens of what is seen to be clinically effective when treating complex and multiple diagnoses.

Privileging the voices of tāngata whaiora / service users is a move towards an emic, rather than an etic research style where the experts on what is healthy and what cures ill health do not have lived experience (Double, 2022; McCann, 2016). Research that supports lived experience as a type of expertise fits in with community psychology values, and it has increasingly been recognised that tāngata whaiora / service users are experts of their own experience and have valuable insights into not only defining what subjective distress and lack of function is, but the things that have helped and have not, including various clinical interventions (Middleton, 2013). Finally, the third influence was to investigate the impact of the environment, including the healing environment, as part of treatment. By looking at the effects of a treatment that includes a living environment and community as well as individual therapy as part of the intervention, it is possible to see and discuss common environmental factors that were and were not helpful for increases in function and wellbeing.

Community psychology approaches also commonly employ a social constructionist lens. Social constructionism frames knowledge of phenomena as a product of relating and use of language, rather than as objective truth (Burr & Dick, 2017). Social constructionism also informed the theoretical and epistemological underpinnings for this research. One of the goals of the research was to gain insight from those who are the experts of their own experience; people who use mental health services. However, the constructionist assumption is that knowledge is a co-constructed product of relating, and that objective knowledge not possible (Burr & Dick, 2017; Rubin & Rubin, 2005). To gain insights from the participants, interviews were chosen for data gathering, and Reflexive Thematic Analysis (TA) was selected to explicitly include and manage my insider perspective as a researcher. Rubin and Rubin (2005) have constructionist ideologies underpinning their work and posit that knowledge is subjective and can be used to empower people who are frequently oppressed. They assume that an interview mutually influences both researcher and participant, and that the researcher is a tool of discovery, rather than a person using a tool to discover. Based on this they suggest a researcher utilises their own personal relating style and employs reflexive methods to stay on track. They recommend that inductive and qualitative research has a flexible methodological design, to prioritize depth of understanding over focused knowledge.

Reflexive Thematic Analysis (TA) was chosen with the aid of Braun and Clarke's article (2020) and their book (2022). In the article (2020), Braun and Clarke discuss how thematic analysis allows identification of themes across a data set, and a focus on points of difference or outliers. It allows information about participant experience within a treatment setting or environment, as well as interactions with and within the environment to be visible. Additionally, reflective TA frames the

researcher perspective and subjectivity as a resource and relies on reflexivity and consultation to keep unwanted bias in check. TA is a search for themes within a dataset and through a dataset, and when interview data is used, allows a focus of attention on how personal experiences happen in contexts and through relationship.

Reflexive TA allows for relationships with participants and data to be a strength and has strategies to help manage the tendencies to bias the data (Braun & Clarke, 2022). There is a clear constructionist underpinning here. Braun and Clarke describe this approach in their practical guide to TA: "…that meaning is not inherent or self-evident in data, that meaning resides at the intersection of the data and the researcher's contextual and theoretically embedded interpretive practices." (Braun & Clarke, 2021, p.210). Based on this theory, knowledge is constructed, rather than discovered. Within this paradigm there were clear advantages to my own dual relationship as a researcher and as a staff member in the residential treatment centre. The strengths included that the working relationship could increase trust and disclosure in interviews, and as there is a shared understanding of the context, to allow a deeper understanding of what former residents referred to in interviews. Additionally, my relationship with the residents and the care for their wellbeing was the inspiration for the research. However, there were clear possibilities for bias to affect the validity of the research. This possibility meant participants may not divulge certain information if they felt loyalty to me, and there is a power dynamic in both the roles of researcher/participant and staff member/client that creates a vulnerability for participants. There was also the possibility of loyalty to my workplace getting in the way of my own accurate reporting. Reflexive TA, in particular the reflexivity journal alongside frequent communication with outside supervision, are research techniques that embraces subjectivity as a strength, while providing tools to manage bias that affects research validity.

TA also works well with clinical psychological aims. An epistemological approach that underpins many research methods in clinical psychology is empirical positivism. This includes the assertion that knowledge is the result of experience and observation, or can be refuted by the same (Miller, 1999). The assumption underlying this is that an independent reality exists separately from human thought and relating, which can be reflected through measurement and recording (Miller, 1999). One aim of the research for this paper was to provide opportunities for clinicians to enhance their delivery of DBT drawing on the voices of tāngata whaiora / service users. Qualitative research and thematic analysis were chosen to measure and record the presence of patterns of effectiveness and ineffectiveness of various factors of treatment, which Miller (1999) suggests could be seen as using a type of ordinal measurement scale. The positivist and clinical element influenced methodology decisions by informing the desire to look inductively at interview data, but with

wishes to learn specifically about effective and ineffective therapeutic interventions. This influenced the decision for the interviews to be semi-structured around questions of effective and ineffective interventions.

The valuing of empirical experiments, or direct observation alongside thorough attempts to eliminate bias and subjectivity, in clinical psychology means that effectiveness of various treatments is often assessed in clinical trials. These trials frequently test a specific treatment as a standalone intervention, and deliberately eliminate varying influences such as treatment settings, individual history, family life, and overall contexts of patients' lives (Gliner et al., 2017). A look at clinical trials assessing a treatment will show that success is frequently measured based on reductions in symptoms specific to a diagnosed disorder. However, for clients with severe and chronic distress, multiple diagnoses, and/or traumatic experiences, it is difficult to assess what specific treatments work to improve not just symptom reduction, but overall wellbeing and ability to function effectively in the ways they wish (Rosenblatt & Attkisson, 1993). For example, if someone has a diagnosis of a personality disorder, an eating disorder, is suicidal, experiences anxiety, mood changes, and severe dissociation, it can be difficult to know which treatment factors were helpful and expedient for which symptoms and causes, and which were not. Giving tāngata whaiora / service users who experience this type of distress complexity and severity an opportunity to speak about what worked and what did not could give clinicians increased options when it comes to deciding what gets tried out, or left out, when picking treatment factors to try or support complex presentations. Even though it is not possible to generalise results for specific diagnoses or individuals from an in-depth inductive and qualitative study with a small sample, it is possible that results could contribute to theories for treatment or supports for the type of client who is typically referred to a DBT residential treatment centre in Aotearoa (Braun & Clarke, 2022; Lewis et al., 2014).

Frequently positivist and constructionist assumptions and values are framed as competing theories, as if they cancel each other out (Armstrong, 2013: Cruickshank, 2012; Miller, 1999; O'Donohue, 2013). My aim, in the spirit of DBT theory and principles (Linehan, 2015) was to be dialectical with these two apparently opposing assumptions, as well as with community and clinical psychology values and practices, and search for a synthesis within this research. DBT suggests searching for and acknowledging the seed of truth in each perspective, and to allow multiple things to be true at once (Linehan, 2015). DBT also often asks clients and clinicians to assess what is effective in any given moment, rather than cling to what could be true. An example of this applied is acknowledging that a DBT client needs to accept themselves as they are and work to change themselves simultaneously (Linehan 2015). When applying dialectical thinking and prioritising

effectiveness to both theoretical perspectives, synthesis is possible. Constructionism suggests that knowledge is constructed through relating and is a product of the context of discovery rather than a reflection of objective truth, and the positivism suggests that there is an objective truth to discover, and if only we are methodical and objective in our approach, we may get close to it. By adopting both a constructionist approach; including my own viewpoint and the research context as explicitly influencing the knowledge outcome, and a positivist viewpoint; that methodical and reflexive methods will bring me closer to an effective and useful truth, I believed the research design embracing both would best help me meet my research goals. Regular discussions with my supervisor helped with the distillation of specific goals. These goals were to provide an opportunity for tāngata whaiora / service users to express themselves, and opportunities for clinicians to enhance their DBT delivery.

3.1.1 Sample Size

During the project design, the aim was to recruit a sample of four to eight participants. One rationale for the sample size was the samples used in other qualitative studies with similar aims and study designs (Chen et al., 2008; Palmer et al., 2003; Simons, 2010; Small et al., 2018). Braun and Clarke (2021) suggest that choosing a sample size is often based on what is normative and pragmatic in similar studies for similar contexts. In the inductive, qualitative studies with smaller samples examined, ones that utilised participant perspectives, sample sizes ranged from seven to eight participants.

Saturation was also investigated as a concept when looking into ideal sample size for this type of study and resulted in a preference for Brauna and Clarke's (2021) recommendation to reach 'theoretical sufficiency' or conceptual depth rather than saturation. The concept of saturation is often used in qualitative data to justify sample size. However, Braun and Clarke (2021) question the wisdom in this when using reflexive thematic analysis. Their rationale is that the concept of saturation means information redundancy, or that there are no more insights to be found and the themes that did arise in the sample are merely repeated with more participants. However, my aim in doing inductive research was to look for richness and depth, diversity, and complexity within the data, rather than to only quantify common responses.

Braun and Clarke discuss the difference between theoretical orientations, and that by choosing reflexive TA, rather than just TA as an analysis tool, one is choosing to assume that the data does not carry themes that the researcher is excavating, but that the researcher is interpreting the data and therefore the insights come from the researcher and the interview context, as well as the interviewee. Based on this theory, the larger the sample the larger the more the data input, as

individuals in their complexity are so different. Additionally, as one of the aims of the study is to give a voice to what may not be commonly heard, or consideration to a minority viewpoint, then frequency of a code or theme cannot be the only determinant of validity. With the concept of theoretical sufficiency, rather than saturation, as a guiding principle, transferability of the results became the goal over generalisability (Braun & Clarke, 2021).

Based on this theoretical standpoint, the final sample size was five, and interviews were capped once I felt sufficient depth and complexity in the data to meet the research aims. After initial analysis of the dataset, including collating all responses to specific questions, I was able to see clusters of patterns in responses around effectiveness and ineffectiveness, what was helpful and what was not, and what caused turning points (see Appendix A). From here I could see there was enough richness, detail, and emerging themes to answer the research question and meet the aim of giving my participants a voice. Practical considerations, including time frames to complete the thesis and availability of interested participants also affected the final sample.

3.2 Method

3.2.1 Ethics

The research proposal was reviewed as a full application by the Massey University Human Ohu Matatika 2. The application ID was OM2 23/24, and application title was Tāngata whaiora /Service User Perspectives on the Effectiveness of a DBT Residential Treatment Programme. This was submitted on 27 March 2023, and approved on 27 June 2023. *The Massey Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants* (2017) was utilised to design and carry out the study, and *Te Ara Tika, Guidelines for Māori research ethics: A framework for researchers and ethics committee members* (Hudson et al., n.d.) was used to ensure ethical issues were addressed in culturally appropriate ways. The *Code of Ethics for Psychologists Working in New Zealand* (New Zealand Psychologists Board, 2002) was reviewed as required. The ethics process was peer reviewed by research supervisor Associate Professor Julia Ioane. This was done via appointments where feasibility of the research and ethical issues and how to manage them were discussed. There were also discussions with management staff at TWM to discuss the practicalities and ethics of the research, and permission received from the management and Board of Trustees of Te Whare Mahana.

The Māori ethical framework in Te Ara Tika was an important part of research design (Hudson et al., n.d.). My goal was to be transparent, truthful, and caring of my participants as individuals, as people who exist in a network of belonging, and as part of a population who are regularly involved with a mental health system that is both necessary to them and has a great deal of power over their wellbeing. Tikanga, or practices to ensure values and participant mana were upheld, was considered, and options given to participants for ways to interact that worked for them. During the interviews various tikanga practices were offered to those who wished it, including beginning with our whakapapa, and karakia and/or whakataukī to start and end interviews (see Appendix C). Mana; or justice and equity, manaakitanga; or safety, sensitivity and responsibility, and whakapapa and the level of relationships were considered.

The value of ‘aroha ki te tangata’, or respect and care for people, was employed by allowing participants to meet me when and where worked best for them. The value of ‘titiro, whakarongo…korero’ was utilised in interviews, where listening and observation were the keys to understanding, and deep analysis done before conclusions formed. The value of ‘manaaki ki te tangata’ was implemented by giving a $20 gift certificate to my participants, from a place of their choosing, to honour their time and energy. I also gave participants the opportunity to read their transcript and pull out of the research if they wished, so they felt they were represented well in the

data. And all were given the option to read the final product. The value of caution, or 'kia tupato' was used also, with reflexivity around my special relationships.

Te Tiriti and the *New Zealand Psychologists Board Code of Ethics* (2002) were also consulted. To ensure protection, participation, and partnership in the ongoing research process I asked all participants if they wished to check transcripts of interviews and offered to post the final product to them once complete (see Appendix B). Protecting any Māori tāngata whaiora who chose to participate in the research, and protecting the wellbeing of the wider Māori community was vital. To manage these ethical issues, I reached out to two cultural supervisors at the beginning of the project and during the analysis stage and discussed issues with my supervisor. However, the cultural supervisors were not reachable and only one participant brought up cultural matters in the interviews. As these were in the form of suggestions for the programme, it was decided that was sufficient.

There were several specific ethical issues that needed to be addressed and explored as part of the ethical review process. First, I work as an employee at the institution being studied and have had previous contact and working relationship with the participants. In relation to the *Code of Ethical Conduct for Research* (Massey University, 2017), this brought the principle of autonomy, and in particular participant agency, informed consent, and absence of pressure into consideration. To manage agency and pressure to participate, I used several techniques. First, I consulted and communicated with my supervisor and the ethics committee. Second, I excluded anyone I had worked with in the last year from the pool of participants. Third, based on communication with the ethics committee, I wrote in the information sheet that not participating would not affect my relationship with past residents (see Appendix C). Fourth, clients in the programme have the option to sign a contract at the beginning of treatment giving permission to be contacted for research purposes, and only these clients were contacted. Fifth, any potential participants were contacted by administration staff in the programme to ask to participate, rather than be contacted initially by me. And lastly, to manage informed consent without this pressure, an information sheet describing the research and aims was given with the invitation to participate, with explicit reference to their right to withdraw from the research at any time.

Other ethical considerations included avoidance of harm, justice, beneficence, and special relationships. Avoidance of harm, especially potential harm to reputation, was managed through efforts to maintain confidentiality of personal information provided and the anonymity of participants. The principle of justice, or fairly distributing the benefits and burdens of research, was addressed by not discriminating in participant selection. Past residents were contacted by administration staff in order of the dates they left the service, working backwards, and all who

agreed to participate were part of the research until the sample size was judged big enough. To address the special relationship between myself and the residents, and myself and the DBT programme, I used regular supervision and engaged in reflexive activities to ensure research aims were met. I took care to ensure the organisation gave permission for the research and anonymised both the staff and residents in the transcripts. Transcripts were kept separately from consent forms and when writing the results and discussion care was taken to ensure anonymity. The principle of beneficence encouraged service user participation and efforts to ensure validity in the hopes to improve service delivery.

As the participants in the study were potentially disadvantaged or oppressed, they are considered vulnerable by the Code of Ethics (*New Zealand Psychologists Board Code of Ethics,* 2002). Research shows that even clients considered vulnerable have benefitted from being heard in research focusing on amplifying their voice (Ali et al., 2021). I was transparent about my relationship to the programme and residents, and clear to participants I am working with them as a researcher only and outlined alternative support options in the information sheet (see Appendix C). The principle of autonomy also states that it is important for tāngata whaiora /service user voices to be heard, which was part of the research aims.

3.2.2 Recruitment

There is one residential DBT centre in Aotearoa and all participants were recruited from the population of past residents of this centre. An email and information sheet were sent to past residents by administration staff of Te Whare Mahana on behalf of the researcher, inviting them to take part in the research. If they replied 'yes' to the invitation email, then their details would be passed on to me. Past residents who had previously agreed to be contacted with offers of research, and had signed a form with Te Whare Mahana, were contacted. Residents were contacted in 'batches' of five, with the people who had been there most recently contacted first. This was with the rationale that the programme and its elements would be fresher in mind for those who had been there most recently. However, only residents that I had not directly worked with in the last year were included in the pool of people invited. Potential participants were clearly told their participation was entirely voluntary, and that their relationship with me would be unaffected if they did not take part.

Once a participant had agreed to take part in the research, I contacted them and sent a consent form to be signed (See Appendix B). Some participants preferred this posted with a self-addressed envelope, and some were able to print it off, sign it and email back a photo. Interview times via zoom were scheduled via email, with flexible options to suit the participants schedules.

3.2.3 Interviews

Data was collected via semi-structured interviews to fulfil the aims of the research. Interview questions were approved by the ethics committee (see Appendix A). However, there was space created in the interviews for participants to develop their own account and potentially provide new insights. The last question was deliberately open-ended for this reason. If participants did leave the topic during the more specific questions, I gave them space for that in the spirit of inductive enquiry. Interviews lasted an average of one hour. The first question sought to understand what participants believed DBT was. The purpose of this question was for concept clarification, and to ensure there was similar understanding of a shared vocabulary.

Rubin and Rubin (2005) recommend that qualitative interviews are formed so they are an extension of conversation that has the research question as the focus. They recommend using extra questions based on what is said by participants and to use probes for more depth and detail to achieve 'thick description'. The authors discuss listening for meaning, nuance, and for what is missing as well as for places to expand, and responding in ways that encourage participants to disclose more depth and detail. Reflective listening was used to check accuracy, repeating back what someone said as a question. Examples and explanations were asked for, stock phrases such as 'have you got an example of that', and 'can you tell me more about that' were used. Questions to evoke depth, such as 'how did that feel', or 'what would it have been like without that element?' There were reminders that there were no right or wrong answers, and that their perspectives were valuable and interesting. Interviews did have three stages. The first was either an introduction or a catch up, establishing or reestablishing a warm connection. The second stage was the bulk of the questions, and the last phase was to reduce the intensity and move to more light-hearted or connecting topics. This was frequently when I asked what pseudonym they would like, confirm if they would like to see the transcript, and ask what type of gift voucher they would like as a thank you.

Limjerwala (2022) and their book on how to co-constuct interview with survivors of sexual violence was also referred to and some recommendations utilised. Limjerwala recommended adequate preparation, appropriate dress and punctuality, and allowing enough time for both parties to feel comfortable. They also advocated patience and attention, and that self disclosure can help establish trust. With nearly all participants I had established a trusting relationship and they knew things about my life after working together in a small town for over a year. This made the rapport and conversation before and after the interview easier than if there was no relationship. Alternately, it may have potentially affected the types of disclosure when asking about topics such as unhelpful

programme elements. However, it appeared in general that as participants were familiar with me, they did engage easily and appeared willing to share information.

All interviews were done over the Zoom app and recorded on that app as well as audio recorded on a phone. Each person agreed to being recorded and were informed they could request the recording to stop at any time. Prior to the interview each participant was asked if they consented to Read.AI, an app linked to Zoom, transcribing, and recording the session. All consent given via email was subsequently stored with consent forms. The transcription produced was not particularly accurate, and the audio recording was used to correct it, the transcript anonymised and then the zoom recording and transcription deleted. The anonymised transcript was sent to anyone who ticked 'yes' to this as an option after the interview. I did this to give participants a chance to ensure they were accurately represented. Participants were given the option to withdraw from the research for one week after receiving the transcript. For a vulnerable population that is often stigmatized and has experienced consent issues in the past and/or chronic invalidation, it felt important to offer the opportunity to withdraw after the interview. The participants did not withdraw at any stage in this research.

3.2.4 Data Storage

The anonymised transcripts were stored separately from the consent forms on the researcher's personal computer and the audio recordings deleted after the research was completed. The private computer used was password protected and no one else had access to it. Confidentiality was kept by the researcher, in particular ensuring that they did not talk to anyone at work about the data or research in ways that they could identify participants. Data will be stored on personal device of researcher until it needs destroyed. Data will be kept for seven years, according to the General Disposal Authority of NZ Universities, and disposed of by the principal research and supervisor. Cloud storage was used for non-identifiable data. The researcher and supervisor had access to the transcripts and consent forms.

3.2.5 Reflexivity

There were several important things to consider to ensure the safety and comfort of my participants, and the validity of the research. One was that I worked for the institution being assessed by participants, which presented a potential conflict of interests, The second was my prior working relationship with the participants. A third was my own interest in the topic, and any pre-formed ideas of what the participants were likely to say that could skew my analysis. I used several strategies to actively engage with these factors, to stay ethical and mindful of my participants and to

improve my research validity. The first was the use of supervision time and discussion of these factors with an outside and experienced perspective. The second was to use a reflexivity diary, which I filled in prior to doing the research to document and monitor my own influences and motivations, as well as during the research process as a tool to illuminate and examine tendencies in my own thoughts.

Special care was taken during interviews to create a warm and welcoming environment, one that facilitated trust and care, and was free of judgment. I had to be alert for times when our shared understanding of the therapy context meant a lack of detail was provided. I took care to respond to participants sharing with reflective listening, repeating back what I heard and asking if that was right. I asked for more detail and examples of what they were describing, to create a clearer picture and ensure understanding. I took care to let participants know all expressions would be anonymised and gave them the option to choose their own research name. I let them know that they were free to speak about the programme as they wished, and that independent supervision would assist me to remain unbiased in my representation of the data they were providing. One participant asked in a joking manner what would happen if they talked about my work performance negatively and I let them know that they could, while acknowledging that could be hard to do when I was the researcher.

3.2.6 Analysis

Reflexive TA has five active analytical phases and one writing phase (Braun & Clarke, 2022). The first phase is to get familiar with the data set. To do this, I read the data over several times and listened to the recording twice. I collated the data into one document and reread it while making notes and a mind map to create an overview of recurring and interesting themes. The second phase is coding. I used Microsoft Word and the comment feature to code each segment of data. This was done systematically. The idea that a code is a tool to discover meaning, rather than a 'thing' in itself, was utilised (Braun & Clarke, 2022). I ended up with 56 codes that included semantic and latent meanings. I then organised them into a table with codes on the left and quotes on the right. I made a handwritten label of each code and wrote the overlapping codes on them in small print and arranged them in clusters, noting connections and themes. The third phase is to generate themes. Patterns that appeared across and within the dataset were identified and compiled, and those that looked to answer the research questions were marked in a specific colour. Candidate themes were identified and coded data collected under each theme. The fourth phase is to develop themes and review them. I wrote a synopsis of each theme and checked the themes fit the data as a whole and the codes assigned to them, while the relationship of the themes to other literature was

considered. The fifth phase was refinement, and this was done by defining the themes and naming them, and writing the analysis, adapting the themes and associated codes as necessary.

3.2.7 Dissemination of Findings

Following examination review, findings will be disseminated back to Te Whare Mahana with a summary of findings and a presentation. Participants will be provided a copy of the thesis and offered the opportunity to meet if they wish to find out more.

Chapter Four Analysis

4.1 Introduction to Analysis

This section will present participant demographics and the results and discussion resulting from analysis of the data using Reflexive TA. In line with Braun and Clarke's (2022) recommendation, the results and discussion are presented together to avoid reinforcing the assumption that the researcher is objective and looking to excavate themes and codes in a replicable way. When using Reflexive TA with the constructionist theoretical philosophy underpinning the method, analysis that highlights rather than obscures the actively subjective and interpretative role of the researcher is recommended. It allows the results to be connected to and located within both the context they were provided and the wider contexts of existing literature. It also means less repetition. For these reasons results and discussion will be together, titled 'Analysis', in the spirit of constructionist philosophy and with inductive inquiry in mind.

After analysis, three major themes and two subthemes were constructed that aimed to answer the research question (see Figure 2). The research purpose was to gain insights into aspects of DBT residential treatment from the perspective of tāngata whaiora / service users. As discussed in the methodology section the data was viewed inductively, but with the aim to learn specifically about effective and ineffective aspects of residential treatment. Participants were asked generally about helpful and unhelpful experiences they had in the programme, as well as what factors led up to any positive turning points (see Appendix A). When organising the data into codes and themes it became apparent the factors that affected treatment and wellbeing occurred in a variety of environments and through different interventions and influences specific to those environments. For clarity and with the induced sense that environments and the types of interactions that occur in them matter to effectiveness, I have separated the three major themes to align with three main domains discussed by participants. These are titled 'Clinical Treatment is Helpful', 'Non-clinical Factors Matter' and 'Treatment Effectiveness Depends on the Quality of Relationships'. These three themes reflect deliberate clinical interventions, the incidental but impactful factors that made a difference, and the types of interactions that facilitated or hindered positive change.

In the discussion of the first theme, the participants' views on various elements of clinical treatment will be discussed and compared to wider literature. As a multi-modal treatment DBT includes several deliberate clinical interventions. These are DBT skills training, therapy sessions, and coaching support in the home environment. For the sake of clarity each will be discussed separately, along with the perception that DBT is 'hard work'.

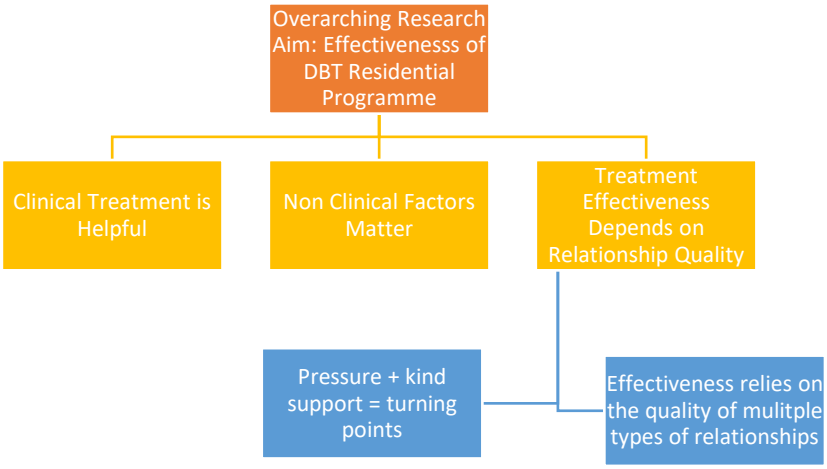
The residential programme also includes other non-DBT or non-clinical interventions, such as the recreation programme, that are not often tested for effectiveness While analysing the data, it became apparent different non-clinical activities, as well as the environments they happened in, had a large impact on therapeutic outcomes. The impact of these non-clinical elements is explained under the second theme; 'Non-clinical Elements Matter'. To see the impact of each environment more clearly, this theme is divided into the residential environment, the Tākaka community environment, and the home environment of the participants. This theme also includes the impact of interactions and overlaps between clinical psychological interventions and medical interventions for physical unwellness.

The last theme is about the importance of the quality of relationships to treatment effectiveness. This theme on relationships contains two subthemes. The sub themes are titled 'Effectiveness Relies on the Quality of Multiple Types of Relationships' and 'Pressure Plus Kind Support Equals Turning Points'. The first subtheme showcases how the quality of both professional and non-professional relating impacts therapeutic outcomes. The second subtheme focuses on turning points and explores the specific dynamics and patterns that lead to them, as described by the participants.

Participant quotes have been provided to illustrate each point. They are set apart from the text for clarity and each person's chosen pseudonym is at the end of their quote. Ellipses are used to indicate an omission in the text, for example repeated words, words not relevant to meaning, or interviewer questions or acknowledgements. Interview dialogue was occasionally added to add clarity.

Figure 2

Themes



4.2 Demographics

Demographic information was gathered via interviews or requested by email. Participants were asked age and ethnicity/ethnicities with the possibility of giving a response that was not pre-selected. In this instance, and with a small sample, self-identification was perceived to be the best option, rather than providing options to choose from. Gender was asked for but not recorded in the final analysis in case it made participants identifiable. The age range is described in blocks of ten years to also make participants less identifiable. The average age of the participants is 46.6 years old. A summary of the demographics can be seen in Table 1.

Table 1

Demographic Information

Age	19-29	30-39	40-49	50-59
	1	0	1	3
Ethnicity/Ethnicities	Māori	Māori/Pakeha	Jewish New Zealander	New Zealander
	2 Ngai Tahu 1 Nga Puhi 1	1	1	1

Note. N=5.

4.3 Theme 1: Clinical Treatment is Helpful

4.3.1 Introduction to the Theme

In this section the participants' view on various elements of clinical treatment will be discussed and compared to wider literature. As a multi-modal treatment DBT includes DBT skills training as a group, coaching in the home environment to aid with skills generalisation, and individual therapy. Each aspect of clinical treatment was described as helpful, and occasionally problematic, in specific ways. To clearly explain which interventions the participants' found helpful and unhelpful, including the impact of each intervention, they will be discussed separately with any necessary information on the intervention added. Additionally, when talking about DBT interventions, the idea that DBT is 'hard work' was repeated by many participants, so this will be covered in this theme as well. Despite the hard work, overall, every participant said DBT treatment was helpful for them on their healing journey.

> I think Te Whare Mahana is one of the most valuables programs in New Zealand… It's definitely given me a life that I could never, possibly ever imagine I'd be at (Ana)

> DBT is an awesome program. I think that it should be incorporated in schools. It should be in the prisons…It's life skills, that's what it is, and it really is how to, how to communicate effectively, how to understand myself. It taught me a lot. It really did. (Kereru)

> I think that if I hadn't have done Te Whare Mahana, and hadn't done all that treatment, I would have been dead by now for sure. (Esther)

4.3.2 DBT Skills Training

In the first formal question of the interview, participants were asked what they understood about DBT. Most participants started by describing the DBT skills they had learnt. Skills classes are a big part of DBT treatment, and clients learn mindfulness and relationship skills as well as techniques to help manage emotions and distress (Linehan, 2015). Over the course of the interviews different aspects of the clinical treatment were named as effective, however the DBT skills were named as helpful most often and participants provided rich detail describing how they continue to use specific skills to improve their lives and relationships at home.

> And every now and then I'll do something, and I'll go oh, that's a stop skill, you know, and I'll put a pebble on it because it's just integrated. I'll start getting flustered and, and the next

thing you know, I'll be standing there, my feet on the ground, curling the toes and going, I can see blue, I can yellow, green, red. And I just start automatically. (Esther)

It was evident that skills had made a difference in all the participants' lives. Most described being able to better communicate, ask for what they needed, create healthier boundaries, and feel emotions in ways they had not been able to before. Skills that aided communication and healthier relationships were seen as important by several participants, as were skills to manage extreme emotions. Being able to see other people's perspectives was seen as consistently important for cultivating empathy, relating to others well and for emotion regulation, both while in the residential centre and at home.

I reckon it's skills to stabilize yourself into real life living…It takes borderline personality, and it makes it normal and gives you skills to deal with the extremes of borderline so that you can pretty much cope in a real world without those extremities of emotions and judgments. (Esther)

I've become more, a bit more compassionate and a bit more understanding too, and I look, I've opened up to looking at other things that could be happening and understanding that people have, you know, people have their own stuff going on. (Kereru)

Repeating skills practices until they were overlearned and integrated was described by participants as helpful for them to both learn the skills and be able to use them automatically. The positive impact of staff consistently presenting skill learning and use as behaviour alternatives was also frequently described by participants. More than one participant named 'living and breathing' the skills' as effective for them long term.

The hardest thing was me just not being able to understand it until I did. And that goes back to the consistency of the staff where it just…they just have to keep going and going and going until it clicks sort of thing. (Ana)

They are in there, the skills that I learned and different situations. The repetitiveness was really helpful. (Kereru)

Service users who have been through DBT treatment internationally have echoed these findings (Chenoweth, 2014; Little et al., 2018). Skills relating to emotion regulation and relationship enhancement have been seen as valuable, and many studies utilising service user perspectives discussed the effectiveness of overlearning skills until they are automatic (Barnicot et al., 2012; Little et al., 2018; McSherry et al., 2012).

It appeared relevant that most participants named skills when thinking about what DBT is, but did not name therapeutic interventions as often, or in as much detail when thinking of what was helpful for them. For some, the focus on skills to manage life threatening behaviours before other interventions could take place or be effective appeared to have an impact. Two participants discussed that the real healing happened for them after leaving the residential part of the programme but gave the programme the credit for setting the groundwork for that to happen.

> DBT is very skills based, well it is skills based obviously and that like gets a bad rap. Well, it did for me when I was a teenager because it was just always …not focusing on the core issue. And when you're in that skills based… stopping life threatening action, then it's…like I would get frustrated and be like, why aren't we, why are we not looking deeper in this? And so, yeah, like there's probably, there is judgments and things about having to do skills and not focusing on the deeper stuff….However, I know I couldn't have got to that trauma based or whatever you want to call it, 2nd stage of therapy, unless I had been in the residential phase to stop the, I hate word, behaviours, actions, things that I was engaging in and things I was doing. (Chelsea)

> I think and this is going to sound a bit strange, but I think what Te Whare did for me was even my life out to a level where I could go and get better. (Esther)

It appears that for these participants the skills training aspect of the programme was helpful in practical and applicable ways. This finding is backed by other literature on the effectiveness on standalone DBT skills training (Cavicchioli et al., 2020; Ritschel et al., 2021; Valentine et al., 2015; Warner & Murphy, 2022). Studies have shown a reduction in substance use and an increase in ability to regulate emotions for people struggling with addiction, as well as high satisfaction with skills training for those with an ASD diagnosis (Buono et al., 2021; Kienast et al., 2014; Ritschel et al., 2021). Other gains have been improvements in coping ability and social function and a lessening of depression and anxiety symptoms (Valentine et al., 2015).

4.3.3 Skills Coaching Onsite

As needed skills coaching is a prescribed part of clinical DBT (Linehan, 1993). In outpatient settings, Linehan recommends that therapists make themselves available to coach their clients through difficult situations outside of therapy hours (Linehan, 1993). Coaches are the staff at the residential centre that are always available to mentor and encourage skill use when residents feel distress, even at night. This happens when the residents are onsite and offsite. When residents are offsite, for a few hours or a few weeks, they can contact a coach by phone 24/7. The support and consistency of skills coaches was remembered gratefully by all participants and named as a helpful and important part of treatment. Several participants described times when they were about to engage in an ineffective behaviour, sometimes life threatening, and being able to talk to a coach in that moment helped them through.

> I knew there was something else that I could do, I could pick up the phone. I could talk, you know. (Kereru)

> You know, somebody might do a behavior and it can really trigger you and so having the coach is there. On hand at night and it used to happen during the day too, of course during class, but having them being there when you become really unwell is really, really helpful. (Kereru)

The care and support of coaches was noted by all participants, especially during the evenings and nights when there was less structure.

> I still can smell the pomegranate tea and the coach was, you know, in there with me when I was throwing up and just, you know… they knew what to do and that just seemed supportive. I guess you never forget that. (Kereru)

Working with and getting to know so many staff had an impact. A variety of people were seen as providing an array of insights into different situations. This was seen as helpful role modelling for participants own dialectical thinking, as well as felt as generally supportive.

> I think it was the combination of different people, different staff, coaches, so you could always get different points of views, you know. Like everybody looks at things differently,

> so you always get a more rounded view because you have that…that many more people to give insight. (Ida)

> I can't think of a time where I saw anybody pissed off or frustrated or anything. So I do remember that as well and if I do feel like that, having…a better control over, over my emotions. (Ana)

As needed skills coaching is an essential part of DBT, but as it is recommended to be done by an individual's therapist it is limited in scope and frequency compared to a wraparound residential programme (Linehan, 1993). There are also mobile phone apps that can support as needed skills coaching online which have shown to be effective for helping with intense emotions and urges (Rizvi et al., 2011). This type of in-person support, role modelling, and relational sharing of different perspectives was seen as a highly effective intervention that had lasting impacts on their lives. It is a factor that could be unique to a residential setting.

DBT uses behavioural principles, and personal connection, to increase the likelihood of effective behaviour and attempts to extinguish old behaviour patterns (Carmel et al., 2016). When someone engages in target behaviour, such as using or self-harm, warmth is deliberately modulated down. When someone is being skilful, warmth is modulated up. Some participants in the study found the increase of connection with coaches after skilful behaviour was helpful.

> Like one-to-one time with coaches after I've done something right as well, like that was important to me. And that was really like, that's free reinforcement, you know. It's just 15 min with a coach, but that was really, really helpful. (Chelsea)

However, there were notable times for some participants when coaching was difficult to manage. This was when warmth was withdrawn, in line with DBT principles, after engaging in a target behaviour.

> One of the big negatives is a withdrawal of warmth thing…That didn't work at all. That triggered up a whole lot of stuff. Like when I came back from my relapse. (Esther)

Two participants found the withdrawal of warmth in their times of vulnerability to be challenging and potentially life threatening. One example occurred when there were potential

medical issues with symptoms that had a psychological crossover and another when a participant was feeling highly suicidal after a period of relapse.

> Just the withdrawal, the warm thing, you know, I think that I mean…I know it's a standard DBT response, but I think that could be…possibly individualised a wee bit…You know, based on the situation, not just the standard. This is the way we do it and everybody goes cold because to be perfectly honest, I think if CMH staff hadn't picked up the pieces we would have all been having, we wouldn't be having this conversation because I was pretty busted when I came back… (Esther)

> Like how a DBT point of view, if someone wants to have a crisis or an episode or whatever, you come in if they're responding to you, like engaging with you, you'd like stay and do the activity. If they're not, you'd leave. But with like at the start, not knowing what was going on with the seizures, you know, staff come and see I'm not with it, then they'd leave. (Chelsea)

In both instances the withdrawal of warmth and attention from coaches was seen as ineffective. A search through academic literature did not turn up anything about warmth withdrawal or modulation being controversial, but a more casual google search did show a lot of social media discussion about the ethics of this practice from service users (The Nice-ish Psychologist, 2023). This is a potential area for future study where service user perspectives could shed light on the effectiveness of behavioural contingencies in a variety of circumstances.

Occasionally, the irritation of being an adult and being told what to do by someone else would also impact coaching effectiveness. Many participants discussed the intensity of the residential environment, how small and restrictive life can feel, and about their urges to be free of those restraints and pressures, even for a short time.

> …or just people in general telling me what to do really. But it really heckles me when it's younger…and I was look you're the same age as my daughter go to your room (laughter). Come in here and tell me to be quiet at eight o'clock. It really rarks me up (laughter). (Ida)

> Me, (Resident's name) and (Resident's name) went up to one of the restaurants and had a meal and we were sitting there having glasses of wine and we saw (Resident's name) walking up the road, and we had to hide them. But we came back, ate a few mints, and

nobody questioned it. Yeah, so I think that it's because you're going to get people who are going to do that stuff because it's a very high-pressured environment. (Esther)

Overall, the learning and over-learning of skills, alongside consistent and ready access to skills coaching was experienced as life changing and helpful. Hearing multiple points of view and observing different ways of doing things from supportive staff who knew their mental health journey and cared about them also appeared to have a significant impact on the effective use of skills in relationship and emotion regulation. This is possibly a positive effect of treatment in a residential DBT setting that may not happen as strongly in an outpatient setting. The potential downside of a residential environment is the intensity of the space, the giving up of some natural adult freedoms, and the possible consequences if that same warmth that makes a difference is withdrawn at the wrong time. There is no research on the effectiveness of as-needed skills coaching in a residential setting by a multitude of staff. However, there is research on use of phone coaching in a DBT outpatient programme as a predictor for therapeutic change (Edwards et al., 2021). Results showed that frequency of phone coaching was associated with less suicidal urges, less self-harm, and less substance use. This is consistent with the findings of the current study.

4.3.4 Offsite Therapeutic Support

Offsite support is clinical interventions, such as therapy and coaching, in the participant's home environment. Offsite support happens in two ways. The first is the supported three-monthly visits with family and loved ones during residential treatment. This is built into the programme structure and the preference is they practice their skills with the people they will be with after treatment, with professional support. And the second is six months of 24/7 telehealth support provided at the end of the residential part of treatment. Both forms of offsite support for transition back into their eventual homes and communities were seen as useful by all the participants.

Yeah, just integrating some home life and people at home into treatment so that we're not just going home and doing it all on our own. (Chelsea)

We went home every three months, so I got to see my family in which I was really, really grateful for. (Kereru)

Ensuring generalisation of skills is an important part of DBT, and this is typically done through phone coaching (Swales, 2009). One purpose of regular home visits during treatment at Te

Whare Mahana is to ensure skills that have been learned or mastered in the residential setting can generalise to a client's home environment. A big part of my job at the residential service has been to organise these trips home and put plans into place to help them generalise their skills. This is theorised to help with the final transition back to the community after a lengthy treatment stay. These visits also aim to help residents manage homesickness and stay connected to their support systems at home. There is no research that supports regular visits home during a DBT residential stay that is not focused on youth and adolescents (Nickerson et al., 2007). However, as the home visits positively impacted several participants in this study, the possibility that supported home visits during residential treatment help clients generalise skills may warrant further investigation.

Home-based services was also found to be effective. This is the six months of telehealth support after residential treatment ends. Home based services includes therapy sessions, sessions with a support worker such as a social worker or occupational therapist, and as needed coaching.

> Yeah, I think home base, home based services was a fucking brilliant idea. Especially for me. Cos I really got in shit…I went to a house with no power and no running water…(Ida)

> I can think of situations where I… like one situation…like my drinking was definitely a big thing for me, like using it as a crutch I guess. Oh god there's so much, so yeah, a time where I was on the way home and ... Something had happened and I was overwhelmed, and I knew that there was a booze shop coming up. The last one on the way home, and I rang and spoke to (Coach's name). He answered the phone and I, you know, like just that support, just being able to talk through that situation really was a big turning point for me. (Kereru)

Most research on a successful transition out of residential service appears to be focused on youth (Nickerson et al., 2007; Patel et al., 2019). However, it is apparent that some form of continuity is helpful in ensuring clients have their home support systems on board with their treatment goals and identity changes, and to keep clients motivated to do the things they need to do to stay as well as possible (Nickerson et al., 2007; Patel et al., 2019). Participants in this study found it most helpful to have trusted staff holding the link from residential services to community living, and it is possible that ensuring a successful transition is one key ingredient for clinical success.

4.3.5 Therapy

The main clinical intervention of DBT is talk therapy. When asked what DBT is, therapy was named as a part of DBT by only a few participants, but when discussing other questions all of them talked about their therapy journey. Therapy helped participants understand themselves and their traumas, to retrain their brain, and to learn to be vulnerable.

> Definitely having two therapy sessions a week. Yeah, that was awesome. I mean you could only dream of that outside Te Whare Mahana. So I embraced that a lot. (Ana)

When DBT is taught standardly, it progresses in stages (Linehan, 1993). The first stage is designed to target life threatening behaviours and once they are under control the second stage can begin. In this second stage emotional suffering is targeted and problem solving for core issues can begin. This can include some form of memory reprocessing such as exposure therapy. Despite the overall residential DBT programme being named as helpful and effective, some participants felt it set them up with skills so they could get well, and treat core issues, in other ways and contexts.

> For me… it wasn't until I left. The understanding of the whole, the stage one, stage two, and how I found the best work I did was in the home base and with my work with (therapist name). Because that was real therapy, what I like to call real therapy. (Chelsea)

It was also named as hard work, and that learning and integrating the skills and treatment took a long time, and for some it was not long enough to settle into the programme, get behaviours that were getting in the way of treatment under control, and then sufficiently target PTSD symptoms or other core issues. For some, life factors also got in the way. For example, physical injuries that interfered with cognitive functioning and the necessary learning delayed one person's healing journey, and for another losing a very close support person and loved one in the middle of treatment meant it was difficult to stay focused at a crucial time.

> I mean it took a long time, as you know, with my bumps to the head. And it took a long time for me for things to kind of sink in, and it also helped to give my brain a bit of time to heal as well. (Kereru)

One participant did their second stage of therapy while in the 'Home Based Services' part of treatment. This is the six months of telehealth support offered to all residents on their return home.

She expressed finding that aspect rewarding, and acknowledged the difficulty she would have had trying to tackle those issues with such high distress.

> And so when I got home and got to do broader therapy and actually work on the problems and I know I couldn't have done that at the start because behaviours would have got in front of being able to work on the problem and that you have to stop the behaviours before you can work on the problem. (Chelsea)

Exposure therapy was named by three people as useful, although one person saw it as 'just dipping the toe in' and another as less effective than it might have been due to personal circumstances at the time. All three said they wished they had more time to do additional exposure therapy. Eye movement desensitisation and reprocessing (EMDR) was named as effective. This is also a trauma memory reprocessing model that is not DBT but used in the residential setting when it is seen as the best choice for an individual.

> Definitely exposure therapy, yeah. Probably wished that I had a little bit more time in doing the exposure therapy. Well, just a little bit more would have been really good. through the EMDR was really helpful. It was really helpful actually, that really. That kind of helped put these traumas away on a subconscious, unconscious level. (Kereru)

> Yeah. Taking my armor off, letting my guard down and, and trusting and unfortunately it happened way too late because I would have benefited...but it takes me that long anyway. but yeah, I would have really …if I had been able to do that at the start. It would have been so much more beneficial for me. (Ida)

In other literature some form of exposure therapy or memory reprocessing is seen to be effective for those experiencing PTSD symptoms (McLean et al., 2022). This type of therapy was seen by tāngata whaiora / service users in other studies to change insight and identity (Boterhoven et al., 2021). EMDR has also been shown to be effective in treating PTSD (Schubert & Lee, 2009), although not without some controversy (Kenchel et al., 2022). While the participants in the present study did find second stage therapy helpful, there was a general sense that there was not enough time spent on this phase of treatment in the residential part of the programme.

Several participants described the importance of a two-way relationship in therapy and directly compared their DBT residential one-on-one therapy with current therapeutic relationships.

These participants felt their community-based therapy was going slower due to a less reciprocal relationship with their therapist that meant it was harder to build trust with them.

> It probably doesn't get as personal for you guys with us. But it did enough for me to the extent where I could see that Okay, these people are just bloody human beings like me, you know, seen shit, you know, done this, done that, they had their struggles just like me, and it's kind of like…yeah. Because with therapy here you don't get to ask questions about anything but yourself. (Ida)

> It's very different now. I'm only just like therapy this week with my current therapist. I got angry because I'm like, I don't understand where I stand with you because we're just sitting down staring at each other for an hour and a half every week. (Chelsea)

These findings reinforce outcomes in other studies (Little et al., 2018). A literature review of research utilising service user perspectives on DBT saw many other participants valued self-disclosure and a more reciprocal and collaborative therapeutic relationship with their therapist (Little et al., 2018). This style of relating is encouraged in DBT and it appears it may be a mechanism for change (Little et al., 2018; Swales, 2009).

Overall therapy was helpful for participants, even if it did not eliminate or resolve the core issues for the majority of these participants. Most felt therapy set them up to continue or take up other interventions with more success and less life interfering behaviours while living in the community. One participant did feel their core issues were resolved after their DBT residential treatment and went on to work successfully in the mental health industry.

4.3.6 DBT and Hard Work

All the participants talked about the hard work necessary to engage in the therapeutic interventions. Some of the hard work was due to the intensity of the programme and some due to the environment itself and living so closely with others who were frequently experiencing distress.

> Te Whare gave to me… it measured up to everything that I expected, not in the way I expected it. You know, I didn't expect to have to do any work. I thought it's going to be a reasonably quick fix and it's probably the hardest thing I've done. Probably the toughest thing I've ever done. It's not an easy program at all, you know. (Esther)

> And you're so wrapped up in everything and your world becomes so much smaller. (Chelsea)

> We both had to learn to use the skills very, very quickly or we ended up having a fight in the corridor as we almost did. And I think that was the best part for me is learning the skills in the classroom and then having to take them and apply them in a full-on life. So when I came out to the real world, it was really easy because it wasn't so… You don't get those environments all the time. You don't get five other people all traumatized and reacting at the same time. (Esther)

In other studies looking at DBT effectiveness in Aotearoa there have also been similar findings, with DBT improving function and being seen as hard work and useful (Brassington & Krawitz, 2006; Simons, 2010). Literature looking at the cultural implications of skills training has brought up issues with the skills focused on building and maintaining relationships (Haft et al., 2022). It is notable that none of our participants felt the skills classes or practices needed cultural adaption, but that that they may need adapting to meet more learning needs. DBT skills learning is predominantly from a textbook, and several participants talked about the delivery being heavy on the homework and paperwork side of things. The heavily cognitive element of learning and paperwork was seen as both difficult and helpful by participants, with some suggestions that embracing more diverse ways of learning could be helpful.

> I mean a lot of a lot of the stuff is quite interesting that I sort of expected the psychology part of it, like the counselling with therapist to be different than what it was, but it always just seemed be filling out forms. You got to do this form and this report and that report, you know, it's different than what I expected. Not realizing that they're actually deep work. (Ana)

> So probably just the way that it's not lecture style learning for classes would be huge change for everyone, for like all the residents, all the different types and styles and diagnoses of resident and stuff going through. I mean, yeah, it's very book heavy and if you're dyslexic, if you're neurodivergent, if you're whatever, like, how are you supposed to fit that mold? (Chelsea)

Literature looking at the cultural implications of skills training has brought up issues with the skills focused on building and maintaining relationships (Haft et al., 2022). It is notable that none of our participants felt the skills classes or practices needed cultural adaption, but that that they may need adapting to meet more learning needs. In service user perspective studies focused on youth, comprehension of DBT terminology and formatting was also found to be difficult (Chenoweth, 2014). Some authors have theorised that the therapeutic world appears to be, or needs to be, adjusting to different ways of presenting material and therapy for neurodivergent individuals, as opposed to focusing on adjusting the individual to the environment (Irvine, 2019; Moyer, 2023). This appears to be a growth area for DBT and therapy in general, with newer resources such as 'The Neurodivergent Friendly Workbook of DBT Skills' slowly emerging to support clients and therapists (Wise, 2022). As several participants felt the skills learning took a lot of time and effort cognitively, and as clients presenting with ASD, ADHD, and other types of neurodiversity do often try DBT treatment, ways to make the learning more accessible could be a useful avenue to explore.

Due to the hard work necessary, self-motivation was seen to be an important factor for success. Participants noticed the difference that their own motivation made to treatment, but also noted that others in the programme with less apparent motivation were perceived to struggle with the workload and intensity.

> …she was talking to me about it and she goes would you recommend anybody to go there, and I said a hundred percent. I would. But only if they're really interested in actually working on themself. Otherwise, it's a waste of time, you gotta want it. (Ida)

Self-motivation is discussed in the literature as one of the key factors necessary for healing, which is supported by the observations of the participants in this study (Ryan & Deci, 2008). Clients who struggle with substance use and behavioural issues, particularly if they have been given a diagnosis of BPD, also have been recorded to struggle with motivation (Bornovalova & Daughters, 2006). DBT has specific strategies to increase self-motivation, such as asking clients to write up a pros and cons for a target behaviour, playing devil's advocate, and increasing hope (Bornovalova & Daughters, 2006; Linehan, 1993). Research asking tāngata whaiora / service users specifically about the effectiveness of the motivational techniques deliberately used in DBT, and whether they have lasting results may be useful. Participants did discuss repeatedly that hope was an important factor for staying with treatment and will be discussed more fully as part of the last theme.

4.3.7 Theme One Conclusions

The research purpose was to gain insights into the effective aspects of DBT residential treatment from the perspective of tāngata whaiora / service users. Each clinical aspect of the programme proved helpful in some way. This included the skills training, as-needed coaching, talk therapy, and offsite support. The effective parts of the clinical aspects of the programme were overlearning and practicing the skills with support, active role modelling, and coaching help to assist skills learning and integration. Skills that helped with emotion regulation and relationships were talked about most often as the ones that impacted everyday life. Therapy was seen as helpful, but with this sample there was a theme of participants feeling like they needed more time for the second stage of therapy and targeting their core issues. As discussed in the following sections, most participants talked about the importance of trust in the therapeutic relationship and the time it takes to build that trust. Self-motivation was seen as a key factor, particularly as the DBT residential programme was experienced as an intense environment with more relationship and learning challenges than community interventions. Grit and fortitude, as well as consistent and varied professional support were seen as necessary for making it through to the end. In summary, the clinical aspects of residential DBT treatment were viewed as valuable and helpful.

4.4 Theme Two: Non-Clinical Factors Matter

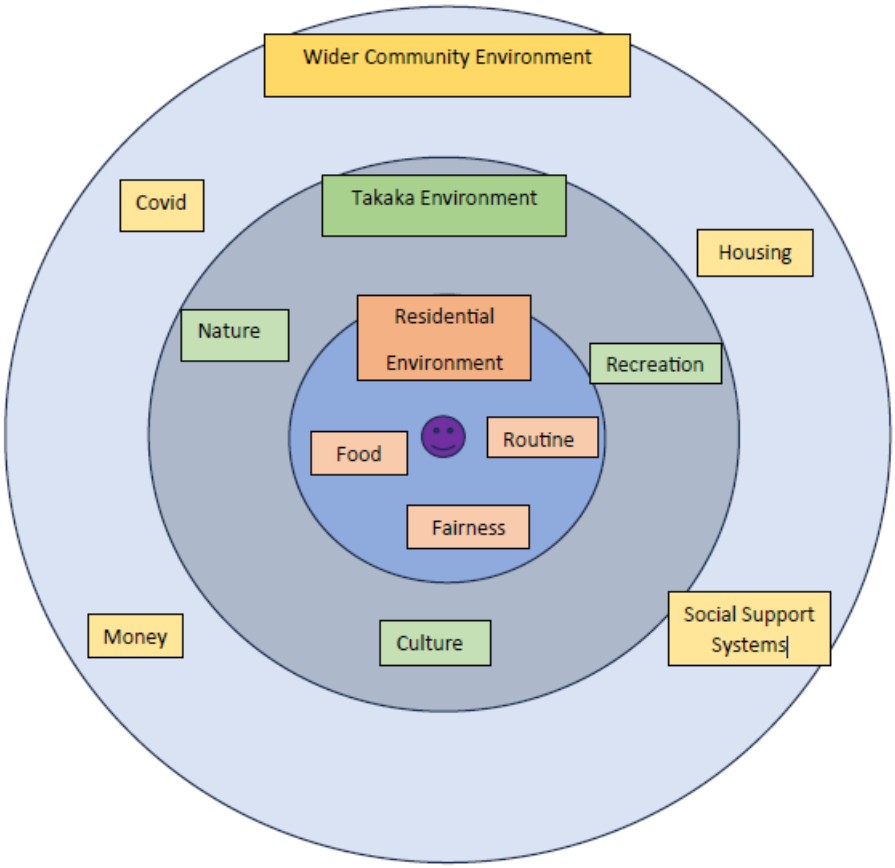
4.4.1 Introduction to the Theme

Various non-clinical factors made a difference to participant wellness and improvement. Many of these aspects were related to the environment and the relationships that are specific to a type of environment. This could be the setting that elicited certain behaviours or interactions, or be spaces that participants interacted with. Some factors were effective, some were ineffective, and some were both. To clearly show how each environment impacted effectiveness, I have divided the theme into four parts (see Figure 3). They include the residential setting, the Tākaka community is the physical location for TWM, the wider community settings the residents come from, and physical health. In the residential setting several factors were due to a flatting-style living environment, such as practicing relationship and functional life skills. These relate to fairness, food, and routine. Some factors related to the Tākaka environment and include interactions with nature and the wider community. Some factors related to the wider community environment, and included influences such as money, housing, covid, and social support systems. Another important factor for many participants related to their physical health, and interactions between them, the programme, and outside medical professionals. This was particularly important for those who experienced a crossover between their physical and mental health symptoms.

When discussing aspects of their treatment time that were helpful and unhelpful, all participants talked at length about parts of their experience that are not deliberate parts of DBT treatment, or the residential programme. These aspects are not typically assessed as mechanisms for change when testing for treatment effectiveness, however they come up repeatedly in research that utilises service user perspectives (Akobeng, 2005; Ali et al., 2021; Lietz et al., 2014; May et al., 2014; Pond et al., 2023; Roussouw, 2008).

Figure 3

Environmental Factors Impacting Treatment



4.4.2 Residential Environment

Behaviours and learning that happens in a residential environment could be seen to impact treatment effectiveness in positive and negative ways. Sometimes the elements specific to the residential setting did both. Many of these factors, such as fairness, food, and routine, come up due to the flatting style setting in a residential environment. One important aspect that came up frequently and in depth was the importance of fairness.

> And to me that's unfairness. I think that was a bit…that really, really stuck out…. We were trying to push that everybody should be open to being breathalysed and randomly (drug) tested. You know, because we've be getting urined for you…but (Resident's name) was going into town and, buying six packs of vodka and hiding them in a room and having a drink at night and there … was no checks on it and so it felt really, really bad. (Esther)

People who were in treatment and struggling with addiction felt that unfairness most of all, and they felt stigmatised by the obvious random drug testing and checking of parcels. Being treated differently from others who were not directly targeting substance use in treatment had an impact in a way it would not in a setting with one specific focus, for example a drug rehabilitation centre.

> Or just even, just even to be labelled druggy because I'm doing a bloody test. But I mean, why ask do you do a fucken piss test right? So it's very obvious. Yeah, it's my dirty little secret. I don't want everybody to know. (Ida)

Being treated differently was reported to impact relationships and participants said it led to resentment and further cues for people already struggling. If another resident was known to being engaging in a behaviour that was not allowed in the residential setting or cues others towards that behaviour, this was reported to be tough on those witnessing it.

> Because what happens, everybody gets angry at her and gets upset with her, so then she gets ostracized even more, which pushes her into her bad behaviour. And it escalates and just it spirals out of control. (Esther)

Consuming alcohol and drugs were brought up as cueing, or triggering strong urges to copy the behaviour, but obvious restricted eating behaviours and signs of self-harm were also mentioned.

> Well, I mean I got triggered by (Resident's name) all the time, but that was just me and my early stages of treatment, not (Resident's name) specifically… But if there was someone else self-harming all the time or something there, then I would just bounce of someone like that. (Chelsea)

Being a witness to other people's behaviours is likely an unavoidable part of being in a residential setting with such varied targets. Seeing other people's distress in action led to an increased need to manage their own cues, some resentments, and judgements, as well as worry for their peers. For many participants, these difficult and impactful situations led to an increase in understanding of others, and some long-lasting friendships despite fraught arguments.

> I think there was a big clarity moment that, you know, lots of people have trauma and had deep stuff going on and their reactions are often because of that trauma. But if you look beyond the trauma, you could see that there was, it's not the real them. Yeah, and having that level of empathy was really, really good. (Esther)

However, a few participants reported some relationships, especially associated with other residents who showed low motivation and who they perceived to be treated differently remained fraught.

Other factors related to the community flatting situation were the importance of opportunities for personal space and autonomy, both in time and in the physical environment. Having one's own bedroom, one's own space for personal items, increased a sense of fairness and aided relationships in an environment where people live and work.

> My own bedroom. That I could move around, that I could make it look how I wanted, and that I knew was mine and it wasn't going to get taken away from me. (Chelsea)

> I know they got another fridge, but they gave us more space and the pantry and all of that stuff. That was really good because that give everybody their own space…Because I think …when you live so closely emotionally, it's really good to have…a little bit of physical space… simple things like, you know, having a shelf on a fridge may not sound a lot, but if you're sharing a fridge with a resident and then you and that resident have a fight, you know, it cracks. They're real little things, but important things. (Esther)

Food, and how meals were prepared, was another 'little thing' that appeared to have a big impact, as all participants talked about it with passion.

> Well. You got those meals sorted out yet? (Ida)

During my own time working at Te Whare Mahana there have been several different formats for meal preparation and sharing. Sometimes the residents took turns to cook dinner for the whole group every night, rather like a cooperative flat, and at other times they did this once a week and were catered for or cooked independently the rest of the week. Regardless of the format, it mattered to different participants in different ways. For example, one participant valued the nightly

cooking highly and continues to cook from scratch for herself now. Other participants were happy to be catered to, but it was dependent on the cook and the style of food.

> I still do that, I cook every night. Every single night I cook for myself. It was very good to get into that routine where because everything's just so easy accessible now, you know. It was stressful for some people, but you know, there was help, you know, everyone's willing to help when it's your turn. So I think that was for me that was a really good life lesson that this is what we must do to stay well. (Ana)

Some of these themes appeared to relate to the one described in the coaching section, where the strain of being an adult in a restricted environment for a long time had an impact. Choices about things like food and having some physical space of their own, alongside being able to make some decisions about the space they lived in for a year or so are likely things that adults need in such a structured environment.

> I find this at any residential that I've stayed at. When staff make overarching decisions about how the house is run or like how the house is supposed to be or if we can or can't have that or things like that…I would get real frustrated because I'm like, I live here. You guys go home at the end of the day. Yes, this is your job. Yes, you're around the house every day during the week, but like, we're the ones that actually live here, like, can you consult with us if you're making a change about that? (Chelsea)

The degree of choice and independence in various areas in the residential setting impacted the participants in complex ways. Structure could be restrictive, but it was also seen to be helpful. Participants named that having a routine was helpful, whether it was regular cooking, being administered medication in a supported way, or having a daily check in of emotions and skills needed for the day. After having a routine for a substantial amount of time in the residential programme participants were able to carry it over to their home life in ways that added to their wellbeing.

> Look also another one that's really helpful was the medication. I really didn't understand that I wasn't taking meds properly. I really learned about how to use them, that sunk in, how to use and how important it is to take my medications and be a bit more, more confident with what I need, what I want, and what I don't want. (Kereru)

> So, I do still do a lot of things...This, this is my possy. I'm out in my shed and I'll do. ..I'll sit out here morning coffee, vape and do a morning check in. (Ida)

4.4.3 Tākaka environment

The Tākaka environment also had an impact on people. This includes the natural surrounding that consists of forestry and nature, the rural aspect, the two-hour distance from a city, and the people who choose to live there. The beauty and nature immersion were mentioned by all the participants. Being able to visit beautiful places regularly during recreation and in other free time was seen to be useful.

> Beautiful, absolutely beautiful place. I keep saying to everybody, Why the fuck did I come back here. It's beautiful down there. (Ida)

Part of one skill to manage extreme emotions involves using a change in water temperature to manage high distress. Ice water is usually used and often the face is immersed. Jumping in cold rivers for the temperature change was mentioned as helpful, as was being able to be so easily immersed in nature. One person liked that it was far away from a main centre, but also talked about how difficult it was to travel home due to the distance and the sensory overwhelm of a whole day travelling.

One way that residents related to the wider Tākaka community and the beautiful natural spaces around them was through the Recreation programme. Recreation, or 'rec' is a programme element and was talked about at length and with fond enthusiasm by all the participants. It is a day each week dedicated to a group outing, some kind of activity, or learning and practicing a craft. Many of these activity days are spent exploring the beautiful natural resources in Golden Bay, including bush walks, beach swims, and visits to well-known landmarks. Other activities directly involve a variety of lessons. Boxing, dance, yoga, horse riding, kayaking, and other adventures, as well as lessons in crafts pull in the expertise of people in the community and get the residents involved with other people and environments. These community environments and interactions impacted the participants in many positive ways. For example, many participants had new experiences, which carried over to their life at home after treatment.

> Just going out and actually going in a group for bush walks. I'd spent time in the bush a lot, but not actually just going for walks. And just hanging out at the beach again, like I did when I was younger, you know. (Kereru)

> And I think too the Friday rec day and getting out and seeing and learning about the place was…that was amazing. That was just a bonus really. That was just amazing. I do so much at home that I never did before. I swim. I went camping. I went in a kayak…I never ever did that stuff before. (Ida)

> We did mindfulness exercise on the sea and their kayaks, and experiences like that are just amazing… like just doing things like that, out of the ordinary and getting people out of the comfort zones and, you know, really…. Pushing. Stuff like that. It, it does make a difference later on when you leave. Yeah, there's a lot more confidence to try something when you leave that you would not normally do. (Ana)

One participant had never been able to swim before, and ended up getting in the water with her peers and coaches because it looked fun and she felt safe with them. Now she takes her grandchildren swimming. Others talked about engaging in walks as part of their routine and practicing activities without substances. Being involved in planning the day was valued. Each person found it increased their confidence to try new things.

> Just going out, doing things that doesn't involve alcohol. Going out and doing, going and doing things straight, you know, just and learning, like there's all these other different things that I've never tried before and I've never, I've never done. (Kereru)

However, recreation was a programme element that frequently involved pushing the self to do new and highly physical activities, be in new and potentially overstimulating environments, and expose some participants to relational tensions.

> And also having people on Rec that understood different, like sensory needs and like different abilities of being over stimulated and like being able to take care of those things and plan that for Rec was really helpful cause it's a huge day of the week. (Chelsea)

> Often our rec days were very late or completely destroyed and changed. Because of the lack of staff. So somebody had to stay home with (resident's name) and so we couldn't do this because they couldn't take one [Staff member]… That wasn't once or twice. That happened week after week after week after week. And I think yeah, there was quite an unfairness in that as well. (Esther)

Creating ways to include people was important to the last two commenters. One valued the chance to learn and practice managing sensory overload in a variety of situations, while the last participant suggested more staff on to manage any distress that might get in the way of a group outing.

Our participants' views on the recreation programme backs up other literature on the topic. Studies show that being in natural spaces helps humans feel better (Howell & Passmore, 2012). Their enthusiasm and vivid descriptions also support the assertion that recreation activities can contribute to recovery and increase self-esteem and social inclusion for people with mental health challenges (Litwiller et al., 2017; Picton et al., 2020).

However, there were downsides to living in a community with a strong subculture, despite the access to natural spaces.

> With Tākaka…it's more environmental than DBT treatment, but with Tākaka so healthy living, clean living, sugar free, vegan, everything like that. That made me turn really disordered… thinking and stuff as well…And it was very disordered and it was really hard to be struggling with an eating disorder and…well relapsing in one when everyone is so focused clean eating, sugar free…Not the residents, but if you had Te Whare in Auckland you wouldn't be having that problem. (Chelsea)

A community culture that espouses alternative diets is an environmental aspect that cannot be controlled, and DBT recommends not changing the environment to manage maladaptive behaviours, but rather learning the function of the behaviour and replacing it with functional behaviour that serves the same purpose (Linehan, 1993). However, aspects like this one, and living in a place surrounded by trees and rivers instead of houses and roads, could point to the effects of living in residential setting that is far from a client's typical environment for such a long time, and how humans are shaped in small and large ways by environments we spend a lot of time in. This includes if our mentors and role models live in those environments and come with their own beliefs about what constitutes wellbeing.

> And if I would be having my snack or meal or whatever and they're coming with their healthy salad or whatever and telling me about their low carb keto diet or whatever they're on…and I know you're not there for eating disorders. But like it was hard for the coaching to match the of the medical side of what was going on. (Chelsea)

The rural small-town aspect of Tākaka also meant staff and resident privacy could be hard to uphold. Some participants were aware of life events in staff lives via connections to others in the community, which brings up questions and reflections about how to maintain healthy boundaries and privacy in a small-town setting.

> And the (staff member), you know, just that whole drama with all of that and the secrecy around it and people talking around town about it…and, you know, so we all knew, but nobody knew, you know, and the secrecy and all of that. (Esther)

There is literature that discusses how to make and maintain healthy boundaries for clinicians but less guidance for clients undergoing intensive treatment and managing privacy and potential stigma in a place with few shops and meeting spaces (Scopelliti et al., 2004). Scopelliti et al. highlight that the size and isolation of a community impact professional boundaries, with the likelihood of unavoidable social contact with clients increasing with the smaller populations. Tākaka is a town with one supermarket and one main road, which means inevitable social interaction in casual ways. Scopelliti et al. discuss ways to manage expectations to be on duty when not at work, confidentiality issues, and the importance of clear boundaries. They suggest the responsibility is for clinicians to be transparent about their limits and actively collaborate with clients to take all environmental contexts into account.

Often when discussing effective clinical interventions, the setting and community surrounding a treatment centre is not considered. However, the Tākaka community environment had impacts on wellbeing in surprising ways. Regular adventures and interactions with and within nature made a difference to ongoing wellbeing for most of the participants. And other factors also mattered, such as encounters with a diet subculture and needing to navigate boundaries and privacy issues in a place with a small population and limited social spaces. These factors illustrate that even environments not directly connected to treatment can make a difference.

4.4.4 Wider Environment

Aspects of the wider social and physical environment also impacted treatment effectiveness. Included in the wider environment are structural and institutional influences, such as housing availability and access to adequate finances, as well as factors in participant's home lives, like the understanding and availability of a social support system. For many participants, stressors around basic survival made it understandably hard to focus on treatment goals. This included having physical vulnerabilities due to chronic injuries, low income, and nowhere suitable to stay on home visits, or live when treatment ended.

> Things that didn't help... Finances…The financial situation was really challenging at times. (Kereru)

Several participants had difficulty finding suitable homes directly after treatment, which deeply impacted their ability to stay well.

> It's like, yeah, if there was, if somebody needs a home, it would be so good if there was something right there and then and then you know you guys are able to work with us in our new home and it's kind of like, yeah, I think do you find that a where people they got home and they haven't really got us a space. (Ida)

A study by Wright and Kloos (2007) backs this finding by showing a correlation between better wellbeing outcomes for people with severe mental distress and favourable housing environments. Trying to focus on being skilful and insightful is difficult when managing physical illness, poverty, and homelessness and could be said to be extra difficult for those also still struggling with PTSD symptoms and addiction urges (Henwood et al., 2015). Other literature discusses how many psychological treatments are focused on what is happening within an individual, with the assumption that if thoughts and feelings are sorted, then function and wellbeing will follow (Kiyimba & Anderson, 2022). Kiyimba and Anderson discuss that this view minimises environmental impacts, including poverty and stigma. If a person has a lot of psychological support in a residential setting and makes many gains, it is difficult to assess how those gains can be maintained when the social support system at home is lacking, or when there is homelessness or inadequate housing to contend with. As some authors have discussed, chronic mental unwellness does affect financial stability and physical health, which can keep people stuck despite intensive psychological interventions (Loya, 2015; Power et al., 2020; Shrivastava et al., 2017).

Other aspects of the wider environment that had an impact were the types of social support systems people had, and how invested they were in supporting the participants once home, as well as how much they knew about DBT.

> You know how we walked it, talked it, breathed it, we were with people that were using these skills all the time. When you go home, other people don't know the skills, so it could be quite easy to lose that. (Kereru)

Some participants experienced some isolation in this area when they returned home. For example, a few loved ones of one participant were substance users, which had a large impact on both their wellness journey and their personal safety.

> Well, I don't, I don't know that it was such the meth, but it was definitely the company that you get with that. (Ida)

One participant shared their wish that the programme was more culturally sensitive and involved family and other support systems in a more systemic way. They had a recommendation that this aspect of treatment be augmented to improve overall effectiveness.

> Well, I wasn't living at home but you know, like my family involved and stuff, so. I don't know, just some family like conference calls every month or something like that, just to keep everyone in the loop of where things are going. Not even I like, not even meaning traditional family, if there's people in people's lives, friends or whatever or you know, their support system. (Chelsea)

Increasing cultural and family support to mental health tāngata whaiora / service users is a recommended part of treatment in Aotearoa (Kingi et al., 2018; New Zealand Psychologists Board, 2002; Rossouw, 2008; Tudor & Rodgers, 2021). Additionally, this observation and request fits in with Māori health models, including Te Taha Whānau [2] of Durie's Te Whare Tapa Whā (Durie, 1985). With most residents travelling far from their loved ones to take part in the programme, and their transition to wellness happening mostly out of sight, integrating Te Taha Whānau and inviting a wider social network, rather than just immediate family, to share skills and progress makes sense.

[2] Support of family/extended family network

Regular home visits do help people transition at the end of treatment, and our participants showed that continuous support while at their homes and in their communities made a difference. And for those who found a more supported landing, healing could continue with less external stressors.

> I changed and I learned different skills and I started to getting inkling of getting better, but the real…what do you call it, the real, when my personalities all come back together as one happened, more so when I moved in with this family, actually when I started to live a normal life again. And it was like everything snapped together again. (Esther)

Some larger environmental factors were events that happened before and after residential treatment. For example, the death of a loved one, bad news about physical health, homelessness, or covid lockdowns. These also impacted effectiveness by interrupting treatment and by causing extras stressors and uncertainties in people's lives. Social support mattered at these times, and made a difference when difficult life events occurred, whether it was from a loving family, helpful professionals, or a spiritual support system.

> Like in the past they would have really floored me and I think I had moments of this feeling really disappointed. Shocked, really upset. But then I…I got my Christian faith and that helps and living each day for itself, you know, I got my little mate, little dog. (Esther)

Other literature utilising service user perspectives backs this up. Support from family and the wider community, as well as experiencing healthy relationships is seen as vital (Ali et al., 2021; Chenoweth, 2014; Pond et al., 2023). Spiritual belief systems that provide connection, hope and peace are viewed as helpful for service users across the world (May et al., 2014; Pond et al, 2023)

The environmental setting is often excluded when looking at treatment effectiveness (Kiyimba & Anderson, 2022). However, the participant's stories showed that wider environmental factors mattered to them and their wellbeing. Whether it was the residential setting and needing or appreciating personal space and autonomy to make choices. Or adapting to a small town in a remote and natural environment. Or needing to focus on basic survival and reintroducing a new identity to the people back at home. Theory based on ecological models of human behaviour suggests that the environment and the people in it need to be understood together (Wright & Kloos, 2007). Other authors emphasise that wellbeing and mental health happens not just inside a person, but inside a context and web of access to resources, social systems, and communities (Pond et al., 2023). When

looking at the participants experience through this frame, rather than focusing on healing as solely an inside job, or something that happens in a clinical relationship, it becomes possible to see spaces and places where treatment effectiveness can be augmented.

4.4.5 Physical Health

Physical health was an important topic to many participants. Some had physical injuries or illnesses due to past traumas, some had ongoing health issues, and some had experienced an overlap between physical and mental health symptoms. Regardless of origin, how the physical illness was, or was not, managed while in the programme impacted the participants in many ways.

> Because I had brain injury, brain swelling and other injuries. The medical side of it. … So just, I think being able to… actually deal with some of those injuries while I was there would have been more helpful, but I think the program kind of focuses on, you know, on our mental state. (Kereru)

Currently, and during the stay of these participants the programme had an onsite registered nurse. The participants with physical health problems were very appreciative of the nurse's input, but most physical health issues were managed by the general practitioners (GP) at the nearby medical centre. In Tākaka the nearest emergency service and hospital is a two-hour drive away. For clients who have chronic health issues, or psychologically based issues that affect health such as an eating disorder, the relationships with medical health professionals are necessary and important.

> And I built this relationship with the GP centre as well. And (Nurse's name) had really noticed that. And it was like also the one-on-one time with (Nurse's name) on a Tuesday. And so when Covid hit and the Clinical Manager or the GPs or whatever decided you don't need all that medical monitoring anymore, then that was like ah…like that's not really how it works. I'm still really deep in this relapse. I saw it as like no one cares kind of thing. But (Nurse's name) had understood that that time on a Tuesday was actually really important, medically or not. (Chelsea)

For one participant with multiple and complex physical injuries, including a head injury that affected memory, having a comprehensive record of what happened medically, as well as psychologically, was vital. However, they experienced that the medical centre did not keep records in ways that helped them with such chronic issues and some of the threads of what physical

interventions were necessary and fundable were lost. This had a lasting impact on their ongoing health after once more moving to a new city.

> I've got a battle on my hands with trying to just get an operation like a cataract done. (Kereru)

> Just having those notes there for my injuries while I'm in the programme, that that would have been more helpful if there was able to be like this is what's actually we're noticed with me and the burning in my, my back. And noted that because the doctor never actually put anything down. It's working a little bit more with the doctors. So things are, you know, things are noted. (Kereru)

The differences between how DBT uses warmth modification as a behavioural contingency and how the medical system increases care for behaviours that have a psychological component was highlighted for one participant. DBT staff may respond to skilful behaviour, such as eating or managing distress skilfully, and show less warmth when a resident is not behaving effectively, whereas the medical system necessarily responds to escalation of physical symptoms, such as weight loss or changes in blood health (Carmel et al., 2016).

> …probably just…for me, obviously there's a lot of physical health stuff that went on, eating disorder, seizures, whatever. There was all different aspects of it and probably just not having that down to a fine T in the program was quite difficult. And so it was just a bit tricky when (Nurse's name) had the nurses hat on and the doctors had their medical side on, but you guys having the mental health stuff and it just not quite overlapping, so that was probably a bit difficult. (Chelsea)

As discussed in the literature review, non-specialised DBT is not designed to monitor prescriptive food planning. For those experiencing eating disorder and other distress symptoms, care focused solely on the eating disorder or just using DBT has been known to fall short, particularly if eating disorder symptoms become life threatening (Federici et al., 2012). Some adapted DBT models have shown to be effective with binge eating and bulimia nervosa variations of eating disorder, but less for anorexia or complex ED presentations (Ben-Porath et al., 2020). For restricting style eating disorders, having medical professionals directly involved in treatment is recommended (Ben-Porath et al., 2020).

Research on the links between physical and mental health show there is a crossover, with physical and mental health impacting one another (Ohrnberger et al., 2017). Ohrnberger et al. (2017) and other writers have directly or indirectly quoted a previous Director-General of the World Health Organisation who advocated that crossover. The Director-General, Dr Brock Chisholm, said "without mental health there can be no true physical health" (Kolappa et al., 2013). These writers argue that people struggling with mental distress are more vulnerable to illness, injury, and being met with discrimination in the health system (Ohrnberger et al., 2017). Ohrnberger et al. and Kolappa et al. also argue that physical health conditions can lead to mental health problems, and that the resulting complexity impacts care for already struggling individuals. The participant feedback and other literature suggest that increasing physical and mental health together would be most helpful for participants.

4.4.6 Theme Two Conclusions

The different aspects of managing physical and mental health symptoms simultaneously affected our participants. Due to the likelihood of physical health needs cropping up for people who have complex mental health needs, regardless of diagnosis, looking at ways to streamline access to and implementation of physical and psychological care could be useful. One possible avenue is to increase awareness about the importance of easy and low-cost physical health care to funders of interventions for psychological injuries. There is an argument that secure housing, enough money to live on, physical health care and social support are as necessary as clinical interventions when it comes to improving wellness, which is supported by the perspectives of these participants. While some of these factors can be supervised, recorded, and referred to other agencies through a residential programme, real change in these areas requires systemic and structural shifts.

4.5 Theme Three: Treatment Effectiveness Relies on Relationship Quality

4.5.1 Introduction to The Theme

The third theme is about how the quality of relationships makes a difference to treatment effectiveness. For these participants the quality of care and regard mattered during crisis points and in professional and other settings. This theme is divided into two subthemes, with the first subtheme explaining the overall theme and the second subtheme honing in on how relationship quality affected turning points. The first subtheme is about the quality of relationships in different contexts and highlights the importance of healthy interactions in multiple contexts for consolidated healing to take place. In this subtheme, the importance of the quality of a variety of relationships will be explored, including peer relationships, professional relationships, and relationships with family, and friends. The second subtheme is about turning points, and how the quality of professional relationships appeared to facilitate motivation.

4.5.2 Sub-theme: Effectiveness Relies on the Quality of Multiple Types of Relationships

Based on what all the participants shared, the quality of relating had an impact on the effectiveness of their treatment. This included peer relationships, therapeutic relationships, and relationships with whānau and the home support system. The relationships with other residents, or peer relationships, positively affected most participants, and the quality of the relating impacted their wellbeing. They described feeling 'normal' by seeing and relating to others with similar trauma and/or symptoms and coping behaviours.

> Emma: So what would be one of the things that helped you the most, do you think?
> Kereru: Okay. I think when I was living in with other people, definitely.

However, flatting with other people struggling to manage behaviours that typically affect relationships also impacted wellbeing, stress levels, and cued/triggered participants towards their own coping mechanisms or memories of past traumas. This was seen as both difficult and helpful, in the way a boot camp is helpful. "If you can do it here (use skills), you can do it anywhere.", with the implication that in the outside world other people don't behave the same way and life is not as intense relationally. Even when peer relationships did not start well or went askew, they became a space to practice skills and develop empathy and alternative points of view.

> When you live with people, there's, there's lots of different situations that arise all the time. You know how you have residents living there, new people coming in with the different,

you know… with their traumas. Being able to walk it, talk it, live it, breath it, was really, really helpful. (Kereru)

So, it's an extreme. The residential part of it. So, you learn the skills in the classroom and then you throw us all together and we all like, if I think about (Resident's name) and I reacting to each other... Now we're best of friends.... We both had to learn to use the skills very, very quickly or we ended up having a fight in the corridor as we almost did... So when I came out to the real world, it was really easy because it wasn't so… You don't get those environments all the time. You don't get five other people all traumatized and reacting. (Esther)

Seeing others struggling with the same symptoms also helped normalise people's experience, sometimes for the first time.

And I sat in one of the teachings and I suddenly realised that everybody in the room had the same thing that I had, and I never really met anybody else who was as crazy as me. And realizing that there was actually a label for it and it was a proper thing and that other people experienced it. I think that was a great eye opener. That made me feel, I suppose, normal. Yeah. (Esther)

They made and practiced friendships. Participants grew close to one another, often supported one another, and worried about one another.

So they live in your house and then you're very, very close and then there's blood everywhere and they get put in an ambulance and taken away and you are not allowed to be told where they are, when they back, how badly they're injured, what's going on and that in a normal environment, that wouldn't matter. But when you're that close to people in the same house, it really does affect you. It really knocks you about. …but it gave me a lot of empathy. (Esther)

The care and friendship that came from being in treatment also helped participants.

I think. …having someone close like me and (resident's name) helped a lot. Having that camaraderie or whatever they call it. (Ida)

> Like eventually building a relationship with (Resident's name) was really, was really good and that was really helpful. (Chelsea)

The closeness and trust that grew helped some participants try things they normally would not, such as overcome a deep fear of water.

> Yeah, and the, I think it's more the fact that like (Resident's name) and (Resident's name) getting in there and (Staff's name) and (Staff's name) getting in there and, and everybody's having fun…And I know they're not gonna hold me under or not gonna, you know… It's, it's safe to actually get in the water with them. (Ida)

> It (cooking) was stressful for some people, but you know, there was help, you know, everyone's willing to help when it's your turn. (Ana)

Often, when looking at treatment effectiveness, the impact of peer relationships in the treatment environment is not considered (Akobeng, 2005). However, research focusing on service user perspectives has shown it to be an important factor for increasing wellbeing, which supports what is shared by the participants in this study (Lietz et al., 2014; Pond et al.,2023; Simons, 2010). Research looking at the effectiveness of peer support within a recovery model show that it may increase perspective, hope, and motivation, counter self-stigma, and increase social activities and fulfilment (Davidson et al., 2006). Some findings when looking at peer-led support groups for people with severe distress symptoms showed that commitment to the group was related to wellbeing gains, and that feelings of isolation lessened and life satisfaction increased for many participants (Davidson et al., 2006).

A possibly interesting area of study may be the usefulness of peer relationships in a residential setting. People with a diagnosis of BPD, or those struggling to regulate their emotions, often have problems maintaining relationships (Mehlum, 2009; Linehan, 1993). During DBT skills classes in the residential programme, clients actively learn and practice relationship skills. Having ready access to skills coaching and a group of peers that are flatting together to practice with in a residential setting could be the seen as a useful training ground for relational success in other aspects of life.

Just as peer relationships had an effect, the quality of relationships with people at home also had an impact on treatment. As discussed in the earlier themes, some participants had adverse circumstances and a mixture of supportive and unsupportive relationships to return to. For those who had a harder landing on return, the quality of relationships at home made a difference. Participants were viewed as changed, and the emergence from treatment embraced as a new start, and others were open to learning skills to help them on their journey.

> My family are like huge and [said] man that place has really helped to change you, you know, how you are… I'm not as aggressive as I used to be and probably reactive to certain behaviours. I can kind of think things through. They are in there, the skills that I learned and in different situations. (Kereru)

People with even a partially supportive social system generally fared better at their new start, even if there were housing or financial worries. In general, most participants commented on how helpful it would have been to have their home support system more involved in their treatment and skills learning, to make that transition smoother.

> But I remember when I came back to talk to the residents and was like Resident or someone said like, oh, was like your family involved with anything and like, no, not really. Like so culturally there being understanding. (Chelsea)

> …It would also not only help me, but I have, it helps my family and it helps my friends and I have so many friend, friends and family that ask, they want to know more and they want to, they want to learn and um, I just, it would really help me to just keep going with it because I kind of feel that I'm, I'm losing it a little bit. And there's that fear of, and it is fear, that fear of like I don't want to lose the skills that I've learned. (Kereru)

Being accepted by the support system at home, and being able to use skills with them was identified as helpful in the establishing of a new, healthier identity.

> … it's just being, being accepted for who I am. I don't have to be anybody I'm not. I'm just Esther, I'm not the sub total of my past and that's an ongoing process. (Esther)

Although for some, it also meant cutting some people out of their life.

> Well, just… being able to ask, feeling confident and actually going no I don't want that in my life, I don't want to be around that person or this is what I need for me. Where I was not confident in asking the things that I needed to make my life easier or help me know, and being able to say no. (Kereru)

The desire to be there and be well for family was also a motivating force for some participants.

> I still struggle to get in the shower at times as well, that still happens, but I know I can. Like especially if it's for my grandkids, I know I can push myself to do that for them and just suck it up, walk it off, swim it off whatever, you know... Yeah. (Ida)

When treatment is occurring out of sight, and a newer, healthier set of behaviours or identity is emerging, taking the final transition into account is a vital part of ensuring treatment gains are consolidated where they are most needed. The quality of relationships at home mattered in this regard, as did the social support system investment in a client's ongoing wellbeing. Studies showcasing service user perspectives echo this finding, with many expressing that experiencing healthy relationships is necessary to healing (Pond et al., 2023).

Increased whānau participation in treatment could be one way to improve treatment effectiveness in the long term. As discussed in the literature review, involving whānau networks in treatment planning and implementation is seen as effective and culturally sensitive practice (Ali et al., 2021; Chenoweth, 2014; Durie, 1985; Kingi et al., 2018; Kiyimba & Anderson, 2022). When residential treatment is far from people's homes and diverse families, deeper thought on how to put this into practice in an effective way, and ensure adequate funding, could be helpful. Since covid, telehealth sessions for family therapy have been increasingly utilised, with moderate to strong evidence that it is efficacious (McLean et al., 2021). This supports our participant's suggestion that monthly telehealth conferences that include friends and extended family could be the best option.

The quality of professional relationships also had an impact on treatment effectiveness for the participants. The relationship with the therapist mattered to all the participants, and trust was seen as a vital factor.

> The skills definitely, definitely help, but the think the most helpful part of that program is being able to trust, you know. It really is the staff. Just being treated with compassion and understanding. Definitely trust is a massive one. (Kereru)

> I just felt like…you, the team, you guys didn't know that I was getting frustrated with (first therapist's name)… And so it's kind of like that really helped to have that, to have that transition. And working with (second therapist's name) was like very different, and we had a really, I think, quite a special relationship working together. So that was a good turning point as well. (Chelsea)

The importance of a therapeutic relationship based on trust is a factor commonly recurring in research utilising service user perspectives (Bourke, 2022; Proctor et al., 2020). The therapeutic alliance is commonly held up as a vital treatment aspect in research investigating mechanisms of change (Baier et al., 2020). Participants in other research studies needed to feel valued, respected, and not judged to be open with their therapists (Little et al., 2018). Many also named therapist disclosure and less of a power imbalance as important factors for inducing trust, which was also strongly advocated for as a vital factor in this research (Little et al., 2018). In this study, several people named two-way relating, based on therapist disclosure, as an important ingredient for trust and compared this deeper relationship to a much more one-way interaction with a current therapist at home.

> Yeah, because with therapy here you don't get to ask questions about anything but yourself. But see, I've been in therapy (at home) with her for two and a half years and I know that she got a kid, but she wouldn't answer that question… So where there (at TWM), it didn't take me that long, but there was more interaction from other, you know, it wasn't give, give, give, I hate that… Like hey lady I'm not going to kidnap your kid, alright, I'm not gonna stalk you… I'm not gonna, you know, it's just, hey, I'm a mother, you, you're doing therapy with me, like I'm a mother, you got kids. (Ida)

> Oh yeah, a hundred percent because like I mean. I'm a person that likes to get along with people and can get along with people and build relationships with people and stuff like that and like like… physical touch is like a real big thing for me as well. And so like being able to regulate in a way that you're just… It's very different now. I'm only just… like therapy this week with my current therapist. I got angry because I'm like, I don't understand where I

stand with you because we're just sitting down staring at each other for an hour and a half every week. (Chelsea)

DBT encourages therapists to use self-disclosure to build and maintain a therapeutic alliance (Kohler et al., 2017; Linehan, 1993). Therapist self-disclosure is recommended to enhance the therapeutic relationship when weaving Māori cultural principles into therapy sessions, (Kingi et al., 2018). It is also seen as an important element in international studies looking at cultural adaptions of DBT, although it did depend on the culture (Halt et al., 2022). For the people in this study who discussed at length the difference in therapeutic relationships they have now versus their DBT therapeutic relationships, the power imbalance was mentioned several times.

Yeah, And I mean like some of the younger ones, like (Coach's name) and (Coach's name), and like you and can't think of…(Coach's name), I can't think of who else. But like, you know, it's just like normal. I mean obviously it's not a normal because they've got a job to you guys have a job to do and stuff, but like …There's not a huge power imbalance. (Chelsea)

There were several perspectives on professional boundaries and how they facilitated connection, lowered a power imbalance, and increased a sense of feeling cared about.

Emma (researcher): Does that change like how, how much you would disclose about yourself? Or does it change how you interact with her?
Ida: Yeah, that, I think, that's why it has taken this long. Yeah, yeah, so it was more, a more of a give and a take.
Emma: Okay, yeah, and that helps you to maybe to trust it quicker?
Ida: Yeah, Cause you get to know that person as well, I know jack shit about her. Two and a half years later. I know you guys a lot.

We'll say more the fact that it wasn't like therapy here where I go to therapy and it's all about me for one hour and I come back again. There, it's more of an interaction. It's a fuller relationship as such. (Chelsea)

Power dynamics and the importance to clients in how they are managed also make an appearance in other service user research (Ali et al., 2021; Bourke, 2022; Lietz et al., 2014; Madden

et al., 2021). In these other studies coercive practices and discrimination attributed to diagnosis were seen as unhelpful, whereas empathic and respectful communication, and collaboration were seen as necessary.

In a residential setting, especially in a small town, with only six clients at a time who stay for a year on average, both closeness and an awareness of boundaries with staff become inevitable. This fuller relationship had negative consequences at times. Some hints of crossing professional boundaries were noted, for example, hints of private information to comfort worried friends if someone went to hospital.

> But then, but then you have staff who are a little bit more…open with letting slip things they shouldn't be like. (Esther)

However, the closeness with staff helped some participants learn and practice friendship skills and was a useful vehicle for role modelling emotion regulation and relational behaviours with healthy boundaries.

> You know, what was really good was um, we got, I think like when you finished one of the levels you could, you could go out for the day with your favourite worker…We went to Whararikі one time together. Yeah, just chilling out with someone…If you can gel with… a worker like that, it's sort of like practicing having a friendship too. Um having someone, like a reward to go out with one of the staff members. It's good practice. (Ana)

The interweaving of the various relationships, and the quality of those relationships appeared to affect treatment effectiveness. Healthier, kind, and more reciprocal relating made a difference to these participants, whether with peers, loved ones, or professionals.

4.5.3 Sub theme: Pressure Plus Kind Support Equals Turning Points

Each person described their turning points, or moments that led to greater wellbeing. Despite the turning points being in different situations, all had factors in common. The first was that many big turning points involved a type of crisis, such as an enforced break in the programme. There appeared to be an external pressure that resulted in an increase of internal pressure for each participant in response to their situations. Due to these pressures, there was a need for self-reflection and a gathering of the necessary motivation to create change for the self.

> I think there was clarity that I could either stay the way I was, or I could get better. And it was that simple. It was like if you want this or you don't, if you don't want it, you go, because there's plenty of people that do. (Esther)

Another commonality was that each participant that had been through a crisis that resulted in a turning point was also given a show of kindness and hope by at least one professional mental health worker and supported through the transition into a place of increased motivation and determination to continue to work hard.

> Emma (researcher): What caused the biggest turning points? What really helped?
> Kereru: The support. It's definitely all the support that I have.

For several participants the external pressure was due to a DBT programme limit being reached. For example, one participant was put on a programme break, which is time out of the programme to assess the programme suitableness and personal motivation. As part of this they were given reflective written work to guide their process.

> So they gave me a programme break and put me in the middle of Tākaka on New Year's Eve. And gave me a wise mind reflection and said, 'you stay in the motel room, you're not allowed to go into town where they're all partying and sort out whether you really want to get better.' And that was a defining moment. That wise mind reflection was probably life changing. I think, to be honest, I wasn't happy with it at the time…Yeah, So that was a big moment. (Esther)

The pressure from the programme and the internal pressure alongside written self-inquiry helped this person regroup and recommit to the hard work necessary for healing. Another participant had a similar experience. Their turning point was when they were sent home to continue their DBT journey outside of residential services.

> But it meant that I took control of my recovery from then forward because it was… I couldn't blame the DHB anymore for not giving me extra time, extra funding. I couldn't blame you guys at Te Whare for not doing this, not doing that, because you had done everything and it was me that…it was like on me now, and that was…what I had hated about treatment before was because people would put things on me. I didn't like that, but

now like it felt like a different sense of control, a positive sense of control that I was now doing, like I couldn't blame anyone else. (Chelsea)

The support during these transitions was vital, especially as it was a consequence and had the potential to be destabilising.

> …it was under my control. I couldn't blame. I, I couldn't be the victim anymore. Like, yeah…I knew for that going forward, that, like it was up to me. And now the hard work starts of being at home, but also like I was in a good head space and like things went really well, like I transitioned really well. That it was a positive experience. It could have gone the other way very easily, but…yeah. (Chelsea)

DBT uses contingency management, based on operant conditioning theory, as a treatment strategy (Carmel et al., 2016; Linehan 1993). Positively reinforcing desired behaviour is one of those strategies and can include warm and genuine engagement. When target behaviour occurs, natural and deliberate consequences can be a response strategy. This may include modulating warmth down, expressing genuine disappointment in the behaviour (not the person), or written work to analyse the behaviour. Outpatient DBT also has a well-known consequence, that if a client misses four sessions, then treatment is immediately stopped and cannot be restarted until after a set time and client proving their own motivation going forward (Linehan, 1993). A programme break, or the programme deciding that residential treatment should end are consequences that could be perceived as punishing or induce hopelessness. However, for these participants, caring support after reaching a programme limit became a turning point rather than a catalyst for self-punishment or shame.

On another occasion after a behavioural relapse, residential treatment came to an end for a participant and the external and internal pressure was very high. In this instance, programme limits and the consequences that came with them, as well as a reduction in felt warmth from staff did appear to induce or increase hopelessness. However, kindness and support from one staff member who worked outside the residential centre helped them through a highly risky time.

> Like when I came back from my relapse. You really don't know…like if you guys knew how close I was to suicide, you would have had me locked up in a psych ward very quickly. I was minutes away from it every day. The only reason I didn't was because (Community Mental Health Staff member's name) realized that I was in a very dangerous position and he

> broke all the rules and told me, 'you ring me whenever you need to, you come and see me'. And we had lots of chats and lots of coffees and lots of cuddles because he said to me there and even he said to me 'You know, look they're just being a bit too cold on this, he said, but you have hurt a lot of people and so I understand why he said, but it was really harsh, really, really hard. (Esther)

This example suggests that kind support mattered to the participants, even when programme or professional limits were met. It also highlights a potential grey area between effective behavioural consequences that can reinforce motivation to improve versus less effective ones that merely increase hopelessness. The question of what to do when people with coping behaviours that exceed personal or programme limits who are also at high risk is also raised. When treating people who have experienced suicidal ideation chronically for many years, assessing for acute risk needs to be done frequently, matter-of-factly, and with the idea that repeated hospitalisation to problem solve intense suffering and distress can be reinforcing for some people (Mehlum, 2009). In situations such as these, where a person is experiencing high external and internal pressure and needing to regather their personal motivation for not only change but for staying alive, some of the complexity of both experiencing and treating complex and severe mental distress comes into sharp relief. It does appear that the level and quality of support can make a difference, and in the situation above, one person's care kept hope alive, which helped this participant stay on their healing journey.

Another combination of external and internal pressure plus external kind support became a turning point for a participant after DBT treatment. They were volunteering for a mental health programme and helped manage a situation with another emotionally dysregulated person. There was an inquiry that included the police, and after reflection this participant wished they had handled the situation differently. However, they were offered a job by the people who witnessed their capability, and this elicited a job offer. The external pressure, supportive encouragement, and the internal reflection and motivation became ingredients for a turning point.

> …then they hired me for the job. They started paying. Because of the incident, but I didn't think it was justified…Right, okay, I'm, I'm going forward with this, you know. I'm gonna do the best I can and never do that again. So I'm very good at doing learning from my first mistake and not doing it again. So that turning… that scenario, turned to you know me getting a mental health and wellbeing level four certificate, getting two jobs, you know, being very reliable and consistent and all that jazz. (Ana)

For another participant the kindness and care that was shown by a staff member during a difficult time also made a difference. However, this appeared to add to increase their internal pressure in the form of guilt for exposing them to a stressful situation, which then became a turning point. For this participant, some very stressful things had occurred, and they reacted to those incidents while on the phone with a staff member they cared about and who cared about them.

> … poor (Staff's name) was on the phone the whole time…Well, I was thinking afterwards like fuck me days, poor (Staff's name). Oh, my God, that would have been tragic for her. I was disgusted with myself. I was so disgusted with myself… When I thought about that and thought about (Staff's name) and, and, and everything everybody had done down there for me and then…throwing it back. Fuck, that's not nice. Yeah, people fuck up. Yeah, things happen. Yeah, but still, at that time, that was so not cool for her…And that's when I got out of that house… And that's when I'm like I can't smoke that shit anymore. (Ida)

Holding hope for the participants, even when they were feeling their worst and had lost sight of it was helpful.

> The desperation when I rang (Staff member's name) and I was standing there on the bonnet of my car, a noose around my neck ready to jump. I'll never forget this. (Staff member's name) saved my life. She gave me hope. (Esther)

This holding of hope in a professional relationship, even when the client has lost sight of it, has shown up as a crucial factor for success in several studies, as is the validation of people's feelings and experiences (Ali et al., 2021; Bourke, 2022). This type of kind support has been flagged as a necessary ingredient by many service users, and alongside the therapist pressuring for change and the ongoing task of self-reflection resulted in a turning point for one participant. They named taking off their metaphorical self-protective 'armour' as a crucial moment, and that trust cultivated in the relationship along with ongoing self-reflective work was what led to it.

> Emma: What do you think caused that? Caused you to take your armour off? What led up to that?
> Ida: (Therapist's name) is pushy (laughing)… I'm going to blame it on her. She's got it (my armour) in her office and she won't send it back to me, and sometimes I think I really need it (laughter).

Emma: So it was (Therapist's name)? She did your trauma therapy didn't she? …What was it? Apart from being pushy (laughter).

Ida: I don't know. Maybe it was, maybe it was some of the different stuff that she gave me to do each week just to help me to get to that stage.

Emma: You mean the exposure stuff? Or skills practices?

Ida: Well, help me get to the stage where I'm gonna trust somebody enough at least to say what, what the fucks going on. Why I dissociate, what happened when I was being brought up, what, you know, and I mean I'm still only just touching on some of that… still.

This dynamic of accepting a client for who they are while pushing for change is a fundamental tenet of DBT (Linehan, 1993). It appears from our participant's sharing that when this combination of kind support and pressure for change works, it does facilitate or support turning points. More research on whether this specific set of interventions is an effective mechanism for increasing motivation could show some interesting results. However, as our participants recognised, in the end it was down to their own determination to work hard and stick with the process.

Well, you know, it's, it's hard because…. It's the person that's, that's got to keep pushing through the boundaries of, you know, keep pushing yourself outwards…that is sort of the major. (Ana)

4.5.4 Overall Theme Summary: Treatment Effectiveness Relies on Relationship Quality

The importance of the quality of relationships to increasing wellbeing and helping treatment effectiveness was emphasised by participants. Kindness and support were important ingredients for turning high pressure situations into turning points, and motivation and consolidation of emerging healthy identities was aided or impeded by a variety of relationship factors with peers, loved ones, and professionals. The importance of peer and therapeutic relationships are themes that cropped up regularly in local and international studies (Bourke, 2022; Lietz et al., 2014; Pond et al.,2023; Proctor et al., 2020; Simons, 2010). Reciprocal relating, based on self-disclosure, was perceived to be a necessary ingredient for building and maintaining trust, both in this study and in other research (Alit et al., 2021; Bourke, 2022; Little et al., 2018; Proctor et al., 2020). This makes sense for a treatment population with high likelihood of an abuse history (Hirakata, 2009).

Chapter 5 Conclusions

This chapter provide and overall summary of the research, a presentation of key findings, strengths and limitations of the research, recommendations for clinicians, and potential areas for further study.

5.1 Summary

The main aim of this research was to investigate the effective and ineffective aspects of DBT residential treatment from the perspectives of tāngata whaiora / service users. As a result, the research provided opportunities for clinicians to enhance their service delivery and for tāngata whaiora / service users to voice their experiences. The review of the literature in Chapter Two set the scene for the study. This included descriptions of the costs and barriers to mental health services for people experiencing severe and chronic mental distress, which provided rationale for improving services in ways that decrease costs to tāngata whaiora / service users and the wider community. DBT, residential treatment, and the treatment centre in this study were described, and the effectiveness of a variety of interventions were outlined, to help readers discern if the results would transfer effectively to other contexts and service users. The literature review also included rationale for using service user perspectives to measure treatment effectiveness, and effective and non-effective interventions identified by tāngata whaiora / service users were discussed. The conclusion was that service user perspectives offer unique insights into how to improve services.

The study methodology and methods were discussed in detail in Chapter Three and were influenced by epistemologies that form community and clinical psychology lenses. These were mostly based on social constructionist theories and assumptions. An inductive and qualitative approach was employed, and reflexive thematic analysis (TA) utilised to analyse the data. Past residents of the DBT residential programme that I had not worked directly with for one year were invited to be part of the research and five people agreed to participate. They were interviewed over zoom using semi-structured questions.

Analysis resulted in three main themes and two subthemes. The first two themes were titled ‘Clinical Treatment is Helpful’, and ‘Non-Clinical Factors Matter’. The third theme was titled ‘Treatment Effectiveness Depends on the Quality of Relationships’ and contained two sub-themes titled ‘Pressure Plus Kind Support Equals Turning Points’, and ‘Effectiveness Relies on the Quality of Multiple Types of Relationships’. These were described and discussed in relationship to past literature in Chapter Four. These themes illustrated that treatment effectiveness was dependent on the quality of different types of relationships and related to different contexts and environments. These included professional and non-professional relationships and environments.

The first aim of the study was to give participants a voice. To meet this aim participants were given the opportunity to talk about what was helpful and unhelpful during their time in the DBT residential programme, and what factors contributed to positive turning points. All the participants answers had rich detail and covered many areas. The summary of key findings, based on the data from participants is below. Overall, findings showed that residential treatment was helpful for them, and that there are areas for improvement. The second aim of the research was to provide opportunities for clinicians to improve their service delivery. Recommendations from the data and past literature are in the recommendations section. Based on the key findings and gaps in the current literature, potential areas for further study conclude this chapter.

5.2 Key findings

There were three key findings, related to the three themes that were identified in this research and will be summarised below.

5.2.1 Key Finding One: Clinical Treatment is Helpful

The three main modes of delivering DBT were all helpful for the participants. These included learning skills, talk therapy, and coaching to help with skills generalisation. Learning DBT skills was helpful for learning emotion regulation, gaining perspective, and relating to others, and overlearning the skills was particularly useful. This was in part so they became automatic, but also because they are perceived as hard to learn or complicated. The difficulty of learning skills when neurodivergent, emotionally fraught, or experiencing physical issues also meant overlearning was useful.

DBT therapy also helped the participants, but for most it laid the groundwork for more healing in other contexts. The general sense was that after the first stage of general DBT, there was not enough time to also focus on thoroughly addressing PTSD style-trauma memories in the residential centre. However, for many participants, increased trust based on a two-way relationship with staff was perceived to speed up the therapeutic process.

Skills coaching helped all participants. Helpful factors included having in the moment help when they needed it, having multiple perspectives to draw on, being cared about, and the role modelling of healthy relating and emotion management. However, with both coaching and therapy, the withdrawal of warmth when there was high vulnerability, or the complexity of physical illness was perceived as risky and unhelpful. Offsite coaching support was viewed as very effective for participants. Having access to 24/7 coaching and therapeutic support in the home environment

during regular visits and on the final return to the community helped participants generalise their skills at home.

5.2.2 Key Finding Two: Non-clinical Elements Matter

Environmental factors impacted treatment effectiveness. This included the residential environment and its intensity, but also the small rural community the residential is situated in. Wider environmental concerns, such as housing, finances, and social support also impacted implementing and consolidating treatment gains at home.

The residential environment itself helped participants in surprising ways. Living in a residential treatment centre was described repeatedly as intense. Intensity related mostly to peer relationships and the hard work necessary to heal. The interpersonal intensity helped and hindered participants. It helped them to practice both emotion regulation and relationship skills and normalised their experiences of living with mental distress. However, participants were also cued by other's behaviours, affected when treated differently by staff, and exposed to other people's deep distress. The general sentiment was that if you could do skills in that environment, everywhere else would be easy in comparison. Another element adding to the intensity was that personal space was precious and normal adult freedoms were curbed.

Physical health also impacted treatment effectiveness and the crossover between psychological and physical injuries and illnesses and the difference in how they were managed in different settings impacted participants.

5.2.2 Key Finding Three: Treatment Effectiveness Depends on the Quality of Relationships

Relationships matter, and the effectiveness of all the therapeutic interventions appeared to be based on the quality of professional and other relationships. Success, in terms of how long both insight and consolidation of learning took appeared dependent on healthy modelling and relating with staff, whānau, family, friends, and people in other community settings. For these participants many turning points came about due to a crisis, such as a programme break. Despite some extremely difficult circumstances, kind support from professionals translated into new motivation and a positive move forward.

The research results support the assertion that overall, a DBT residential programme is helpful for tāngata whaiora / service users. In addition, the research provided an opportunity to present the views of tāngata whaiora / service users. Next will be a summary of the study strengths and limitations and to meet the research aim to provide ideas for improvements to clinicians, below that is a list of recommendations.

5.3 Study Strengths and Limitations

This study has many strengths and limitations. One strength is the use of a qualitative methodology to gain insight into a complex treatment environment. DBT is a multimodal treatment and when treatment is delivered in a live-in situation understanding what helps and what hinders can be difficult to assess quantitatively. Qualitative and inductive studies can provide detailed information and shed light on complex circumstances and issues and induce new areas for consideration (Nowell et al., 2017).

Thematic analysis is a research method that is useful for investigating differing perspectives, finding patterns within a complex data set, and highlighting surprising ideas (Nowell et al., 2017). Thematic analysis was a strong choice when looking at how to answer the research question using service user perspectives. However, it also can be tricky to assess how thorough a researcher has been in their analysis, and the flexibility of the method can lead to inconsistencies (Nowell et al., 2017). Results from thematic analysis are seen to be more valid and trustworthy when there has been a lot of interaction with the data, peer debriefing, and thick descriptions of participants and settings so that readers can assess transferability. Documenting the theoretical basis for decisions made during the process is also recommended, and reflexivity around values and rationale is vital (Nowell et al., 2017). The researcher regularly engaged in supervision and critical reflection to ensure systematic and thorough, as well as descriptive work.

Another strength of the research was the privilege of gaining insight directly from tāngata whaiora / service users. Information from tāngata whaiora / service users can complement effectiveness testing based on symptom reduction, hospitalisation rates, and comparisons between treatments. Open ended questions allowed participants to add information and insights that may have not been considered, which could provide useful ideas for further research or improvement of services. However, a variety of bias affects common to interviews and self-reports may mean service user accounts are not accurate. These could include response bias, recall bias and observer bias from participants, as well as interviewer bias (Jager et al., 2020). Social desirability bias, or the desire to be viewed favourably by the researcher, or reluctance to give negative feedback, could also be a factor (Kemmelmeier, 2016). Additionally, participants who responded to the invitation to the research may have different perspectives and experiences to those who chose not to commit to the process.

The final number of participants was small. This presents a limitation in that findings may not be generalised. However, if descriptions are adequate, findings may be transferred to other

settings with tāngata whaiora / service users who have similar backgrounds and presentations, or therapeutic settings using DBT or with a residential treatment.

The insider perspective of the researcher also presents as a strength and a limitation. Reflexive thematic analysis is built on a constructionist theoretical foundation and within that is the assumption that assessment relies on the judgment of the researcher (Braun & Clarke, 2022). My insider perspective meant there were possible insights and prior knowledge of the environment and participants that aided inductive inquiry. Having knowledge of the residential and local environment, and DBT treatment, meant I was able to describe and understand these aspects in a way a researcher on the outside of the settings could not. This insider knowledge could help with the study transferability. However, the likelihood of bias due to my fondness for and investment in the settings is also high and could affect my descriptions and interpretations. I have worked as the care coordinator in the residential setting and was more closely in touch with a social work perspective on client care than many other staff. That meant I was closer to the impacts of housing, money, social support, and how to generalise skills at home. When asking every researcher's 'so what' question and prioritising which parts of the very rich data to share, these factors may have crowded out others in importance due to their apparent relevance to me. A reflexivity diary and time with my supervisor were used to ensure I stayed as true as possible to the data and did not choose based solely on my sense of importance, but what came up thematically.

As noted repeatedly by the participants, trust is an important factor in a professional relationship with people who have experienced severe and chronic mental distress. Results, backed by other research, show a two-way relationship increases a sense of trust (Bourke, 2022; Kingi et al., 2018; Kohler et al., 2017; Little et al., 2018; Proctor et al., 2020). I had worked with many of the participants and had established a two-way relationship with them. This meant they may have disclosed more information and more details to me than to someone they did not know and trust. However, those that had worked with me on the social work aspects of their life may have been more likely to bring up those factors, out of familiarity and loyalty, and participants may have left out negative aspects of their treatment in some of their stories to protect me or other professionals I work with. In contrast, the people who willingly signed up for the study all shared that the programme had changed their life for the better. Potential participants with less enthusiasm for the programme may have chosen to not participate.

There is also the potential conflict of interests with my employer and my clients. I tackled this problem by discussing issues with my supervisor and using reflexivity. Reflexivity involved carefully noting any feelings of discomfort and being alert to subtle urges to interpret the data in anyone's favour. My care for the residents that I work with was a motivating factor for ensuring

their voices were prioritised over my own, and their concerns and suggestions for more effective services are given air. The data also showed that the participants deeply valued their treatment time, and the people who worked with them. Sharing that information is also important for professionals in the mental health industry. In my experience, it increases resiliency. I do believe that offering an in-depth insider look into service user perspectives on a treatment used for people with severe distress is a useful piece to add to the puzzle.

5.4 Recommendations for Clinicians

Braun and Clarke (2022) have a theory about transferability being more important than generalisability when using reflexive thematic analysis and qualitative research. With enough description of the environment, participants, and processes, consumers of research can see if the results will apply in their environment, with their clients, and using the processes they do (Braun & Clarke, 2022). Based on this theory, and with transferability the goal, the sample number in the study matters less than the descriptions of the setting and data in terms of whether the results will be relevant in other settings (Braun & Clarke, 2022). With this rationale in mind, the specific recommendations are as follows:

1. Ongoing support after treatment has ended is important.
    - The recommendation is to not only ensure professional support and ongoing coaching, but also a format for clients to continue a peer support group and/or skills practice group.
    - Improved processes to help family, whānau, friends and other social supports of clients to learn skills and support their loved one when they transition home.
2. More diverse delivery of skills training.
    - Increased ways to help people with learning difficulties, injuries, or neurodiversity absorb and practice the skills teaching.
3. In a setting with different behaviour targets look closely at interventions that have the potential to increase stigma and/or relationship difficulties. These include people with substance use and eating disorders.
    - For example, awareness around potential stigma associated with obvious drug testing or parcel searches.
4. Physical space and some autonomy matters.
    - Ways to ensure adults in a restricted setting for long periods of time can maintain their independence or feel a sense of personal space and freedom could be useful.
5. Structured recreation time was effective.

    - Time in nature, learning new things, and practicing relating in a more casual atmosphere helped to build confidence, encouraged people to incorporate new and healthy activities into their lives, and modelled how to have fun without the support of the usual coping mechanisms.
6. When people have their survival needs met, they can more easily focus on doing the hard work necessary for healing.
    - More funded support for people with chronic physical issues.
    - Framing secure housing, financial security, and social support as necessary as clinical interventions for maintaining wellness.
7. More funding/support for physical symptoms.
    - A more integrated approach to psychological and physical illness.

5.5 Potential Areas for Future Study

This research was inductive, and several areas looked promising for further study. It could be interesting to review the effectiveness of specific behavioural contingencies from service user perspectives. This could include warmth modulation and treatment breaks, and how they affect motivation. Additionally, the question of what to do when someone exceeds professional or programme limits but is still at risk could be investigated, and whether the pressure to change, in the form of a supported programme limit or boundary, does increase self-motivation.

Learning DBT skills looks to be effective for many people. Testing effectiveness of the current DBT teaching and learning material for neurodiverse people, who have varying needs, could show interesting results. Additionally, reviewing and exploring ways to make DBT more accessible for this population could be fruitful and increased ways to consolidate those skills in multiple environments also appears to be important. Another area of interest could be to look deeper into the ways adults can introduce a new, healthier identity to friends and family in the home environment after treatment. If proven effective, simple, and comparatively low-cost ways to consolidate treatment gains after a residential stay could help people to stay well long term.

Some studies on the effects of the environment may also help improve wellbeing. Research on how to help clients manage boundaries, power imbalances, and privacy in rural and low-population areas could be useful, and the advantages of peer relationships in a residential setting as training for real life interactions could be investigated. This could be of service to those who struggle with relationships.

5.6 Conclusion

Overall, time in a DBT residential worked for these participants, and this supports other research that shows that DBT and residential treatment are both effective for many people experiencing severe and chronic distress (Ali et al., 2021; Batchelor, 2005; D'Anci et al., 2019; Kothgassner et al., 2021; Panos et al., 2014; Robins & Chapman, 2004; Tsirides et al., 2021). By asking tāngata whaiora / service users about their experiences, many aspects of treatment and the environmental setting that are not typically assessed for effectiveness were highlighted as important. These aspects, for example the importance of peer relationships, time in nature, and a two-way relationship with a therapist were shown to increase wellbeing for these participants. These aspects, and others like them, are commonly highlighted as important in other research that utilises the perspectives of service users who have experienced severe and chronic mental distress. There is a possibility that clinicians and others who work regularly with people experiencing mental distress to improve services by integrating service user perspectives on what worked and did not work for them. With everyone working together, offering multiple perspectives, and greater wellbeing as the goal, services may continue to improve.

He Waka Eke Noa.

We're all in this together.

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Appendix A: Interview Questions

List of interview questions

Questions will be open-ended with an inductive aim.

1. Given that you completed the DBT residential treatment programme a year or so ago, what do you understand about what Dialectical Behaviour Therapy is?

2. During your time of treatment what do you think were the things that helped you the most?

3. What do you think caused your biggest turning points?

4. What things did you find unhelpful, if any?

5. What was it about the programme that worked best for you?
    1. In what way?

6. Is there anything you would change about your experience and the programme?

7. Is there any other comment you would like to make?

Appendix B: Consent Form

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read, or have had read to me in my first language, and I understand the Information Sheet attached as Appendix I. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time.

1. I agree/do not agree to the interview being sound recorded.
2. I agree to participate in this study under the conditions set out in the Information Sheet.
3. I would like a copy of the transcript of my interview: Y/N
4. I would like to receive a copy of the final report and have added my email address below. Y/N

Declaration by Participant:

I _____ [print full name]_____ hereby consent to take part in this study.

Signature: _____ Date: _____

Email address:

Appendix C: Information Sheet

INFORMATION SHEET

Tēnā koe

You are invited to take part in this research. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to participate, thank you for considering this request.

Ko wai ahau / Who am I?

Ko Emma toku ingoa. Ko Furness toku whānau . Ko Ngai Tahu me Ngati Pākehā oku iwi. No Otepoti ahau. Inaianei kei Tākaka ahau e noho ana.

My name is Emma Furness. I am Ngai Tahu and Pākehā descent and hail from Dunedin, although currently living in Tākaka, Golden Bay.

I am conducting a research project in order to complete my Master of Arts postgraduate qualification, majoring in psychology. This is through Massey University.

I also work at Te Whare Mahana as the Care Coordinator and am passionate about the health and wellbeing of tāngata whaiora / service users /Tāngata whaiora .

The aim of my research project is to gain insight into the effectiveness of a DBT residential treatment programme from the perspectives of Tāngata whaiora /tāngata whaiora / service users .

This research will involve in-depth interviews with past residents who have lived at and been treated in the Dialectical Behavioural Therapy (DBT) residential Te Whare Mahana.

He aha te whāinga mō tēnei rangahau / What is the aim of the project?

The aim of this project is to gain an understanding from Tāngata whaiora /tāngata whaiora / service users about your experiences in a DBT residential programme. I will explore what worked, and what did not work well to ensure your perspective is heard and with an aim to improve services.

Ka pēhea tō āwhina mai / How can you help?

This is your invitation to participate in my research. I am keen to hear your experiences of the DBT residential programme and ways you think it can be strengthened or supported. I am seeking up to an hour and a half of your time so I can ask you questions. Your responses will be kept private and confidential. If you agree we will talk online and I will voice record the interview.

As koha to show appreciation for your time a supermarket gift voucher of $20 will be given.

Ka ahatia ngā kōrero ka tukuna mai / What will happen to the information you give?

This research is confidential. This means that I and my supervisor will be aware of your identity but the research data will be combined and your identity will not be revealed in any reports, presentations, or public documentation.

Only my supervisors and I will read the notes or transcript of the interview. The interview transcripts, summaries and any recordings will be kept securely until they are destroyed.

Ki te whakaae mai koe, he aha ō mōtika hei kaitautoko i tēnei rangahau / If you accept this invitation, what are your rights as a research participant?

This research is voluntary. You do not have to accept this invitation if you don't want to and not participating will not affect any relationship you have with me now or in the future. If you do decide to participate, you have the right to:

- Request we start the interview process with karakia, whakataukī, and/or sharing whakapapa, and finish with karakia or whakataukī.
- You can choose to get a summary of findings and opt to meet after the research is finished and ask questions about the research results.
- You can choose to not answer any question or stop the interview at any time, without giving a reason.
- You can withdraw from the study by contacting me at any time until one week after I've sent your interview transcript to you to read.
- If you withdraw, the information you provided will be destroyed or returned to you.
- Ask any questions about the study at any time.
- Receive a copy of your interview transcript.
- Provide information on the understanding that your name will not be used unless you give permission.
- Be given access to a summary of the project findings when it is concluded.

If you have any questions, please don't hesitate to ask. If you decide to participate, please respond via email or phone to our admin team and I will be in touch.

Role clarification: *If you have had a working relationship with me in the past, please know I'll be in the interview in the role of a researcher curious to hear your experience of the DBT programme, and not as a staff member of the DBT programme.*

If you need extra support before, during, or after the interview, please let me know and we can arrange this.

Mehemea ngā pātai, he raruraru rānei, me whakapā ki a wai / If you have any questions or problems, who can you contact?

If you have any questions, either now or in the future, please feel free to contact either:

Name: Emma Furness

Role: Researcher

Email Address: [redacted]

Supervisor:

Name: Julia Ioane

Role: Associate Professor

School: Massey University

Email Address: J.Ioane@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 2, Application OM2 23/24. If you have any concerns about the conduct of this research, please contact Associate Professor Fiona Te Momo, Chair, Massey University Human Ethics Ohu Matatika 2, telephone 09 414 0800 x 43347, email humanethics2@massey.ac.nz.